

# Improving access to psychological therapy: The Doncaster demonstration site organisational model

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*In this paper we describe the theoretical rationale, evidence base and model adopted by the Improving Access to Psychological Therapies demonstration site in Doncaster.*

**W**ORLDWIDE, MENTAL health problems are both common and disabling (World Health Organisation, 2004). The subject has attracted considerable recent policy interest, including a campaign by *The Lancet* (Horton, 2007). For many people with severe mental health disorders the personal impact can be severely disabling.

However, the public health burden (as opposed to personal health burden) of mental health problems is dominated by so called 'common mental health disorders' (CMHD). Anxiety and depression constitute around 97 per cent of the total prevalence of mental health disorders (Office of National Statistics, 2000) and are thought to account for at least 50 per cent of the days lost to disability (Andrews et al., 2001). However, the vast proportion of health and social services mental health spend is on serious disorders such as psychosis. In contrast, significant sums of money are spent on supporting people with anxiety and depression who are out of work, through the payment of incapacity benefit, a form of support to people who are unemployed through long-term sickness.

This cross-subsidy of mental health care has been identified as both unacceptable and ripe for reform. The economist Richard Layard has estimated that the UK spends £7–10 bn on benefit payments to people with mental health problems. As Layard succinctly puts it:

There are now more people on incapacity benefits due to mental problems (850,000) than the total numbers of unemployed people on Job Seeker's Allowance. If unemployment was once the most prominent source of misery, it has been replaced by mental illness. (Layard, 2004, p8).

Layard also made the point that the cost of providing effective mental health care, particularly evidence-based psychological therapies is tiny in comparison (Centre for Economic Performance, 2006). Through a persistent high-level political lobbying campaign he persuaded the UK government to fund a programme to address the woeful provision of therapy. For despite National Institute for Clinical Effectiveness (NICE) guidelines in anxiety and depression (NICE, 2004a, 2004b), sufficient numbers of recommended treatments are not delivered by services as they are currently configured and funded (Bebbington et al., 2000). Only 24 per cent of people with common mental health problems receive any treatment for their difficulties, mostly in the form of medication (20 per cent), with only 9 per cent receiving another form of therapy or counselling in addition to or instead of medication. Worse still, only 1 per cent of people receive an evidence-based psychological treatment as recommended by NICE (Office of National Statistics, 2000).

As well as the economic argument, other commentators have argued along moral lines. Terms like 'affluenza' (James, 2007) and 'social recession' (Lawson, 2007) have been used to describe the rise of depression or 'unhappiness' (Layard, 2005) in modern societies. All are united in identifying the

need to address the problem. While some argue for societal action, Layard has proposed a series of 'treatment centres' to treat depression using evidence based psychological therapies in order to restore people to happiness and economic productivity (Layard, 2006).

The Improving Access to Psychological Therapies Programme (Care Services Improvement Partnership, 2007) is a multi-million pound effort to test the Layard hypothesis that large scale expansion of evidence-based psychological therapies will increase both the happiness and productivity of the population. In order to obtain agreement for the recently announced £173 million increase in spending from the UK Treasury (Department of Health, 2007), the programme has had to embark on a series of 'proof of principle' exercises. The first of these was the establishment of two 'Layard centres' or demonstration sites, where the basic premise that investment in psychological therapies will increase wellbeing and decrease reliance on incapacity benefit is being tested. The two centres, in Doncaster and Newham, adopted different operating principles: the London site a specialist 'replacement/referral' model familiar to specialist mental health services; the Doncaster site a 'collaborative care' model more common in the US and in UK primary care. (For a summary of different organisational models see Bower & Gilbody, 2005a.) Of the two, in terms of usual organisational practices in psychological therapies the Doncaster site is a less familiar model to UK psychological therapies practitioners and service managers. This paper, therefore, describes the clinical organisational model implemented by the Doncaster centre and the theoretical and empirical rationale for its adoption.

### **Theoretical and empirical background to Doncaster's organisational model**

The Doncaster model was designed following reviews of three principle sources of evidence: the clinical effectiveness of low- and high-intensity variants of cognitive behaviour therapy (CBT), the organisational effective-

ness of collaborative care and the evidence for stepped care. These evidence-bases were used to design a model of care which would explicitly reflect the philosophy of primary care and public health. Treatment had to be delivered according to these principles and was explicitly focussed on delivering care to high-volumes of people. The Doncaster model had to be able to accommodate an expected referral volume of greater than 5000 patients per annum.

### **The clinical effectiveness of low- and high-intensity variants of CBT**

The most recent reviews of psychological therapies conducted by NICE (2004a, 2004b) recommend CBT for both depression and anxiety. Although CBT is not the only recommended psychological treatment, the skill set and clinical materials required are much more available in both clinical and educational providers than other alternatives (e.g. Interpersonal Therapy for depression). CBT was, therefore, selected as the principle psychological therapy for use in Doncaster. One great advantage in choosing CBT is that variants have been developed which can be characterised as both low-intensity and high-intensity. This allows the same theoretically consistent and empirically valid treatment to be delivered in different 'doses' according to patient need and response. High-intensity treatments usually involve considerable therapist input akin to traditional therapy models. In contrast, low-intensity treatments emphasise patient self-management with much less contact between mental health workers and patients, for example by the use of guided self-help.

In randomised controlled trials, the controlled clinical effect size for high-intensity CBT is large, ranging between 0.89 for depression (Pilling & Burbeck, 2006) and 1.6–2.9 for anxiety disorders (Clark, 2006). CBT is, therefore, less effective in depression than anxiety disorders with an effect size for depression (0.89) just over half that for generalised anxiety disorder (1.7). The effect size for low-intensity CBT for depression is very similar to high-intensity CBT (0.8; Gellatly et al., in press) but more varied

and generally less so for anxiety disorders (range 0.18–1.02; Hrai & Clum, 2006), although low-intensity CBT for generalised anxiety is large at 0.92.

#### *The evidence for stepped care*

Although the evidence for the efficacy of some psychological therapies is strong, the evidence for their organisation is less so. NICE guidelines for depression and anxiety recommend that treatments should be organised along a 'stepped care' model. Stepped care has two fundamental principles. Firstly, treatments delivered should always be the 'least restrictive', in that the burden on patients should be as low as possible whilst achieving a positive clinical outcome (Sobell & Sobell, 2000). This principle is usually interpreted as the delivery of a low-intensity treatment such as guided self-help, unless other high-intensity treatments are indicated. Secondly, stepped care should be self-correcting (Newman, 2000). This refers to the systematic scheduled review of patient outcomes to assist in clinical decision-making using validated outcome tools such as symptom schedules. Although based on the common sense proposition that it is as harmful to overtreat as undertreat common mental health disorders, NICE guidelines provide little evidence to support the implementation of stepped care.

A narrative review of stepped care (Bower & Gilbody, 2005b) concluded that stepped care has the potential to improve the delivery efficiency of psychological therapy but that the exact form of stepped care to maximise patient benefit is unclear. There are two possible ways stepped care might be implemented. One, the pure 'stepped' approach, allocates a low-intensity treatment to all patients and uses the scheduled review principle to 'step-up' patients who do not benefit from the initial intervention. In contrast, a 'stratified' approach initially allocates patients to interventions at different steps according to objective measures of their symptoms. Both approaches have benefits and disadvantages and NICE hedges its bets by recommending both systems simultaneously (NICE, 2004a). In the stepped approach the

danger is that some patients may be inappropriately allocated to a weaker 'dose' of treatment and the duration of their contact with services is extended. In the stratified approach the danger is that services may take a very risk-averse approach and opt to over-treat many people, compromising the efficiency of the system as a whole. As noted by Bower and Gilbody (2005a), the benefits of stepped care could be compromised if complex assessments and treatment allocations require significant resources. Indeed, a stratified approach relies on the ability to accurately predict who would not benefit from low-intensity treatments – so called 'aptitude treatment interaction' (Sobell & Sobell, 2000), the evidence for which is questionable at the very least. In practice, it might be that versions of stepped care take a balance between the two approaches, although the degree of emphasis on stepping or stratifying could alter system performance dramatically.

#### *The evidence for collaborative care*

An area where the evidence for organisational models is much stronger is in 'collaborative care' (Von Korff & Goldberg, 2001; Simon, 2006). Collaborative care is a 'systems level' quality improvement approach consisting of a multi-professional approach to patient care, a structured patient management plan, scheduled patient follow-ups and enhanced interprofessional communication (Wagner et al., 1996; Gunn et al., 2006). It has been comprehensively tested in depression management. A recent systematic review (Bower et al., 2006) found that the combined effect size for collaborative care in 36 studies was relatively modest but that the actual models implemented on the ground in trials were extremely heterogeneous. Using meta-regression techniques to identify the critical components of this complex systems-level intervention, the review found that the effectiveness of collaborative care could be optimised by including within it the employment of case managers with a specific mental health training who also receive regular expert supervision. Recent UK trials incorporating these effective ingredients achieved

effect sizes between 0.42 and 0.63 (Pilling et al., 2006; Richards et al., 2007). These effects were achieved merely by restructuring the organisation of treatment, since collaborative care is a quality improvement intervention that does not add additional therapeutic ingredients but merely optimises the delivery of existing pharmacological and psychological treatments. Essentially, a case manager ensures that patients remain in contact with mental health care services and that they get the maximum benefit from their chosen intervention, pharmacological or psychological. In the most successful UK protocol, case managers conducted most contacts on the telephone and delivered a mixture of medication management and low-intensity CBT (Richards et al., 2007).

### **Implementation of the Doncaster model**

The Doncaster demonstration site was set up by a wide ranging partnership of health (PCT and specialist mental health trust), employment agencies (Job Centre<sup>+</sup> and condition management programmes), the voluntary sector (such as Mind), the business community (coordinated by the Doncaster Chamber of Commerce) and vigorous representation from patients. As such the IAPT service is one part of this system that aims to address issues of work and well-being.

Within the partnership, the IAPT Doncaster clinical model is a 'stepped' version of stepped care where low- and high-intensity CBT is delivered by a mixture of case managers and therapists using collaborative care as the organisational delivery model. All patients with depression, and most patients with anxiety disorders, are allocated to a low-intensity treatment programme as the default first step. Most clinical contact between case managers delivering low-intensity CBT is conducted on the telephone following a first face-to-face assessment session, usually conducted by case managers. Scheduled reviews of treatment outcome are automated via a bespoke IT system which alerts case managers and supervisors to review cases at least every four weeks. Clinical decision-making is facilitated by sessional outcome measures and scheduled clinical case management

supervision. Patients are stepped up to high-intensity CBT if a clinical review detects a lack of improvement and the patient wishes a more intensive treatment. A small number of patients are allocated directly to high-intensity treatment where no evidence based low-intensity alternative is available, for example for patients with post-traumatic stress disorder. Low-intensity treatments for depression and anxiety include a bespoke written 'Recovery Programme for Depression' (Lovell & Richards, 2006) and commercially available written materials for anxiety disorders (Williams, 2003). Computerised CBT is also available for those patients who choose to use it. For patients who choose not to accept the CBT treatment model offered, other services such as counselling and voluntary sector provision are available via signposting. Case managers also assist patients with pharmacological treatment via medication support, although prescribing decisions rest with the patient's GP.

Fourteen case managers were recruited from the local community. No prior educational level was specified. Case managers were selected on their interpersonal aptitudes and commitment to working in mental health. Very few had had experience of delivering mental health care in the public sector, although some had had personal experience of mental health problems and a number had worked in the voluntary or user-organisation sector. Six additional case managers were previously employed as 'graduate workers' in Doncaster. All newly recruited and existing workers were trained using a specially commissioned programme from the University of York, tailored to the clinical model and the competencies required. The programme was a mixture of classroom-based clinical simulation and workplace supervised practice. Supervision of case managers is undertaken weekly, where all cases flagged by the IT system are reviewed. Automatic trigger flags include all new patients, all patients at four-weekly intervals, all patients with high outcome measure scores and any patient the case manager wishes to have discussed.

Therapists are qualified mental health professionals with an additional qualification

in CBT. Therapists see all patients stepped up to high-intensity treatment, either directly or after period of low-intensity treatment from case managers. Therapists also supervise a number of case managers and act as 'duty managers' (see below). Most face-to-face low- or high-intensity treatment occurs in GP surgeries or other community venues. Telephone case management is conducted from a special 'hub' where call centre technology allows case managers to read and input notes and clinical outcome data directly to the IT system whilst talking to patients using hands-free head sets.

### **Patient pathways in the Doncaster model**

The standard patient pathway is initiated by a GP referral after a patient has presented to the GP and the GP has identified an anxiety or depressive problem. Other routes of referral from partner organisations, including self-referral, are also possible. Referrals are made by fax to the central hub, where it is processed. The referral form includes space for the patient's contact details, including telephone number. Ordinarily, the duty manager attempts to ring the patient the same day the referral is received to discuss their needs and the IAPT service. If both duty manager and patient agree to proceed, the patient is allocated a case manager based on a mixture of geographical allocation and caseload. The case manager then contacts the patient, again usually by telephone, to arrange a first appointment within the next two weeks, usually face-to-face in the patient's general practice surgery.

At the first appointment the case manager conducts a patient-centred assessment, including a risk assessment, and asks the patient to complete a battery of clinical outcome measures. The case manager then gives the patient written information appropriate to their problems, discusses treatment options and arranges a next appointment, usually telephony based. If any significant active risk of harm to self or others is detected, the case manager will initiate the appropriate risk management protocol. At the first telephone follow-up contact, the case manager reviews the treatment options

offered and initiates a low-intensity treatment CBT programme for anxiety or depression. Mostly, this uses the written materials although case managers also support patients in the same way should they wish to use computerised CBT. Subsequent contacts are generally on the telephone and include sessional outcome measures so that case managers are able to receive online real-time feedback of patient progress as they are conducting all treatment sessions.

The use of real-time clinical outcome measures enables rapid decision-making. Formal reviews of patient progress are conducted every four weeks. Depending on patient progress, decision making may include advising the patient to remain in low-intensity treatment for another four weeks, to discharge from active treatment, to step up to high-intensity CBT or to refer to alternative services requested or required by the patient.

Other pathways exist, including immediate referral to high-intensity treatment for patients where there is no viable low-intensity alternative or where the patient has had previous experience of CBT or a previous unsuccessful trial of low-intensity therapy. Some patients do not accept the IAPT service offered and so are signposted to other partnership services such as counselling, the voluntary sector or the Job Centre+ condition management programme, or advised to return to their GP. Some patients are referred with serious mental health problems and require services from the community mental health services or even crisis services, to which they are directed. The large majority of patients, however, are cared for in the standard pathway.

### **Development of the Doncaster model**

A number of developments to the model were required following initial implementation. Firstly, the volume and nature of referrals necessitated the development of a 'duty manager'. This role, undertaken by an experienced worker or therapist, receives all referrals and contacts the patient directly. In addition to the consistent management of high volumes of referrals, this role was

developed to cope with the small number of referrals who required treatment from specialist mental health services. Identification of these patients and negotiation of care pathways was beyond the competence of case managers. A duty manager also enables a consistent approach to the 24-hour contact target for all new referrals, since if this job was allocated to individual case managers it might not be met if case managers were out of the hub engaged in face-to-face work. Finally, duty managers have access to data on individual case manager workloads and can allocate appropriate patients to those case managers with caseload and case-mix capacity.

Secondly, computerised CBT (cCBT) is an evidence-based and potentially useful low-intensity treatment. However, CD-ROM-based programmes do not sit well with the telephony-based collaborative care delivery model in Doncaster. Hardware based in specific venues requires case managers to travel to these sites and remain with patients whilst they are undergoing cCBT sessions. Laptop computers have been purchased to facilitate flexible delivery of cCBT, but travel time is still onerous and if a patient does not attend a planned session case managers cannot always use the time productively in undertaking telephony-based follow-up with other patients. This reduces the efficiency of the Doncaster delivery system. Internet-based cCBT is preferred and Doncaster is now trialling internet-delivered cCBT for both depression and anxiety.

Thirdly, supervision of case managers by CBT therapists takes them away from patient-focused treatment. Furthermore, even with additional training, therapists may not be the best equipped to deliver high-volume case management clinical supervision where the requirement might be to discuss the clinical progress of up to 20 patients per case manager per week. Traditional therapy supervision models adopt a therapist-driven agenda whereas case management supervision requires a service driven agenda. Finally, many therapists find it difficult to give high-volume, low-intensity advice to case managers when they themselves are operating from a low-volume, high-intensity clinical

paradigm. As a consequence, the bulk of supervision of case managers is now mostly undertaken by a specialist individual backed up by a specific few therapists with small numbers of case managers each.

Finally, despite a service which sees less than 10 per cent of patients stepped up from low- to high-intensity treatment, Doncaster has developed a small waiting list for high-intensity CBT. This is mainly a consequence of the local difficulty in recruiting qualified therapists and the diversion of therapist time into case management supervision. Although most therapist time is now devoted to face-to-face high-intensity treatment rather than supervision, continuing difficulties recruiting CBT therapists limits the ability of the service to provide even the small numbers of high-intensity treatment required. This factor is likely to be a critical capacity-limiting issue for the national roll out of the IAPT programme.

## Conclusion

The Doncaster Improving Access to Psychological Therapies demonstration site is testing a stepped care model of psychological therapies provision where the initial default therapeutic option for almost all patients with anxiety and depression is a form of low-intensity CBT delivered through a telephony-based collaborative care system. The system was designed to reflect a primary care and public health philosophy by enabling easy access and the delivery of effective treatment to large volumes of people with common mental health problems in Doncaster. Case managers, specifically trained for the role, are supervised by workers with additional therapeutic mental health or CBT expertise. Patients who do not improve or for whom there is no low-intensity option are stepped up to high-intensity CBT assisted by an IT patient information management system with automated flags, triggered by response to and duration of low-intensity treatment. The operationalisation of the twin principles of stepped care – a low burden treatment as the initial default and a self-correcting system of outcome-based decision making – is subject to current evaluation. Whilst capac-

ity problems still exist, these reflect the difficulties in recruiting workers with the required skill-set rather than a dysfunction in the model *per se*. Currently, Doncaster is meeting all its patient access targets and clinical outcomes and patient satisfaction, to be reported in a subsequent paper, are excellent.

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