

Response to commentaries on 'Improving access to psychological therapy: The Doncaster demonstration site organisational model'

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WE ARE GRATEFUL to both the editor and the commentators for the opportunity to test the temperature of the reception to the Doncaster model. Not surprisingly, that temperature varies from warm, through tepid to icy cold.

Before responding to specific themes raised by commentators we would like to acknowledge Peter Bower (personal communication, 2007) for reminding us that improving mental health services, particularly in primary care, has five dimensions. Firstly, we must improve access such that service provision should meet the need for services in every community independent of geographic location. Secondly, that such services should effectively improve people's lives in terms of health status, function and quality of life. Thirdly, we must distribute resources efficiently to maximise health gains to society. Fourthly, resources should be distributed equitably across the population independent of culture, creed, class or other social identifier. Finally, what we deliver should be patient-centred and as 'closely congruent with, and responsive to patients' wants, needs and preferences' as possible.

In the UK, previous attempts to improve services have included education and training to primary care generalists. Whilst laudable and arguably scoring well on access, efficiency and equity, such initiatives have not been effective (Gilbody et al., 2003) and could be criticised for poor patient-centredness. Consultation liaison and collaborative care models are systems level interventions that have been developed to retain the advantages of education and training whilst addressing

the effectiveness and patient-centredness deficits. Conversely, starting from the opposite organisational position, replacement referral models score highly on patient-centredness and effectiveness but are much weaker in terms of access, efficiency and equity. Stepped care is a system which attempts to address this through improving access, efficiency and equity whilst retaining effectiveness and patient-centredness. Pilling and Roth muse about the mechanisms of effect and the relative efficacy of collaborative care and replacement referral models. It is important to remember that their ideas are indeed speculative and we absolutely agree that they should be tested empirically. As we note above, effect sizes are not the only metric and outcome frameworks based on sophisticated analyses of the concept of access (Gulliford et al., 2001) should be utilised in any analysis.

Neither system is perfect nor clearly defined. Paxton and Cape are quite correct in challenging us about the model of collaborative care we use. We would argue that, far from being as closely defined as they state, collaborative care is a very heterogeneous concept (Bower et al., 2006). Our version is based on a protocol developed from a clinical trial (Richards et al., 2006; 2007) and squarely meets three of the four criteria for a systems level intervention: a multi-professional approach to patient care, a structured patient management plan and scheduled patient follow-ups. In terms of the fourth criterion – enhanced inter-professional communication – in our view the case managers have a central role providing information and acting as a treatment conduit for patient-centred con-

sultation liaison from expert clinicians to patients and GPs. This places Doncaster's organisational method firmly in the consultation liaison camp. Pilling and Roth suggest that greater GP integration could be achieved through worker dispersion. We note that there is a tension between centralisation and dispersion. Too much dispersion can damage service equity through multiple and different waiting lists or micro service models. In Doncaster we have wrestled with this tension and our compromise has been to allocate case managers to groups of GP surgeries geographically. We have retained a centralised referral system to allow managers to ensure that access to services is equitable across the borough.

A number of commentators question the concept of a psychological therapy 'dose', Gilbert wonders about the boundary between support and therapy, and Kellet and Matthews go so far as to suggest that almost none of our patients have been getting therapy at all. We disagree. Space precludes us from entering into the 'what is therapy?' debate, but we contend that alternative means of accessing psychological information and support (Rogers et al., 1999) are just as much therapy as the traditional system. Case managers and therapists in Doncaster work through a supportive therapeutic alliance, whether that is on the telephone or face to face.

Lower dose was not meant to imply a lesser intervention. There are many examples from other areas of health care where more intensive interventions have no more efficacy than something far less invasive or burdensome. Indeed, to take the example suggested by Holford, exercise, lifestyle self-management and psychological interventions are considerably more effective than surgical interventions in cardiac rehabilitation (Department of Health, 2000). We certainly agree with Holford, and Pilling and Roth, that low-intensity work is qualitatively different to high-intensity therapy, requiring different competencies. However, many behaviours exhibited by our case managers and by patients in the programme are similar to those one would observe in high-intensity therapy. For the present, therefore, we will

have to let the concepts of dose and difference sit, albeit uncomfortably, together.

Some commentators rightly raise the issue of patient choice. We have to remember that our base case is that 75 per cent of people with common mental health problems receive no choice whatsoever and that a bare 1 per cent receive a psychological therapy which has an evidence base. Our view is that in a patient-centred service where patients exercise choice, that choice should be informed and supported by competent workers. We also know that in all healthcare systems, most patients will be guided by those very same workers, indeed will often cede decision making to them. This makes it paramount that workers are trained, informed and properly supervised in information gathering, information giving and shared decision making. Furthermore, choice is not a single event: people can choose more than one intervention at the same and at different times. For Kellet and Matthews to presume that the majority of our patients are on medication and that case managers are merely medication compliance managers would be to severely misread our account. In actual fact, a majority (74 per cent) of patients are helped through a specially designed recovery programme which was written following an extensive analysis of published patient preferences and experiences of help-seeking (Khan et al., 2007), together with ideas from the recovery movement and a recent evidence synthesis questioning the therapeutic dominance of the cognitive paradigm (Ekers et al., 2007), both ideas aligned with suggestions made by commentator White.

John and Vetere suggest that patients may be pressed into telephone treatment and may struggle to express their need for an alternative. The irony is that in most services the reverse is true – one either attends the clinic at the therapist's convenience or one does not receive treatment at all. In Doncaster, the default position may be the telephone, but all initial appointments are face to face, some additional sessions can be organised face to face if the patient requires it, and 25 per cent of patients receive all their treatment in the traditional manner. We

arrived at this system after conducting two qualitative research studies of patients and professionals undertaking collaborative care (Richards et al., 2006). Of the two groups, it was the professionals that expressed the most reservations. Patients were very supportive of telephone treatment.

The final aspect of choice arises from our application of the stepped care self-correcting principle through automated supervision. Supervisors are alerted to review patient progress by both clinical outcomes and by time in treatment. Unlike traditional services which rely on therapists to bring cases forward for discussion and where therapists can easily persevere inappropriately when patients fail to progress, in Doncaster all patient progress is reviewed automatically at least every four weeks. At this point new choices, within the low-intensity framework or by a step up to high-intensity treatment, can be discussed. Once on a track, there is no need for a patient to remain on it. New treatment choices are always available. We would like to reassure Kellet and Matthews that case managers are careful not to reinforce 'failure-related schemas'. We agree that the manner in which a treatment programme is explained to patients will set up expectancies and stepped care must be carefully 'sold'. However, previous studies have found that low-intensity treatment is more likely to positively socialise patients to a therapeutic model than be an aversive experience (Mead et al., 2005). In contrast, patients find referral 'downwards' in the expertise chain a far more negative experience (Ben Wright, 2007, personal communication).

A number of commentators ask us for data. It was not our remit to write up the outcomes of the Doncaster demonstration site; we must leave that to another day. However, after one year of collecting and monitoring routine outcome data we felt secure enough in its success to describe the model implemented. In brief, we have received 4000 referrals, 80 per cent of whom exceed diagnostic thresholds for anxiety or depression and two-thirds of whom have had levels of distress at a moderate/severe or severe intensity. These are not people with simple step 1 and 2 prob-

lems, as assumed by Gilbert. Nonetheless, our clinical, functional and employment outcomes replicate those observed in clinical trials, figures confirmed by the external evaluation of our data by the London School of Economics. A more detailed analysis is in preparation and will be submitted for peer review shortly.

A further concern in many of the commentaries was the apparent lack of a public health and biopsychosocial focus to the Doncaster model. We are acutely aware of the social determinants of health and the need to redress structural deficits within our current 'social recession' (Lawson, 2007). Once again, space precluded our describing the way Doncaster's partnership is in fact doing this. As we state in our article, the Doncaster demonstration site was set up as part of a wide-ranging partnership of health, employment, voluntary sector, business and patient communities. We do not believe that societal and individual therapeutic actions are mutually exclusive. Our strong conviction is that, as depressed societies regenerate, we must enable those who are currently excluded to take part – whether that be through family life, community engagement, employment or voluntary activity. Depressed and anxious people do not readily engage in community activities within cultures emerging from societal depression. We must make sure those who are social excluded through mental distress have the same opportunities as everyone else. Treating their distress is one important strand of action towards social inclusion. Nonetheless, we agree with Gilbert that embedding mental health care in societies themselves is an important goal and have indeed recently suggested such a strategy (Richards, 2007a).

Many commentators worried about our workforce's structure and its health. Lavender and White wonder about the lack of applied psychology, as indeed we do too. When we set off to design our service we simply had no access to clinical psychology as such, although we did have other personnel with psychological treatment expertise. There are many places in the UK where this situation prevails. We are very grateful for the subsequent appoint-

ment of Dr Felix Davies and his applied psychology input, improving the leadership and multidisciplinary perspective to Doncaster's service. There is a lesson here for the UK expansion of psychological therapies. Unfortunately, most applied psychologists have interests and expertise outside of primary care (Lavender & Willis, 2007). Applied psychology expertise may be difficult to source in the early development of new IAPT services.

In terms of worker competence, we know from our systematic reviews (Bower et al., 2006; Gilbody et al., 2006) that specific – not necessarily professional – mental health education predicts better outcomes for patients. Our case managers have received just such training. They are extremely competent in using both specific and common therapeutic factors. Like some of our commentators we worry about the stresses inherent in a high volume service. We know that, as in many fields of occupation, it is not so much the job's 'stress fingerprint' but organisational issues that cause difficulties. Case managers express frustration at organisational barriers such as lack of access to computers, cramped working conditions, long journeys across town and difficulty finding empty consultation rooms. We are mindful of the potential of burnout mentioned by many commentators – indeed high volume working is not to everyone's taste – but we wonder about the com-

parative situation experienced by therapists after high-intensity treatment of four to six patients daily. Is burnout any less prevalent in this situation?

We reserve our final response for the commentary by the Midlands Psychology group. Neither of us has seen the film they base their title on so we probably missed some allegorical references. Nonetheless, we found their commentary witty and amusing, albeit frustrating in equal measure. This group were the most scathing about the 'Layard' programme and the nature of the scientific endeavour underpinning the growth of CBT-based psychological therapy. It is easy to be critical. Indeed, one of us is a trenchant critic, if not of CBT at least of the CBT community (Richards, 2007b). However, this group offers no coherent alternative vision. We do wonder how they would have responded to the 4000 people who sought help from our service last year and how they would have set up a service to reduce distress, disability and social exclusion. Rhetoric is all very well, but maybe it is about time they set up their own competing 'experiment'. In the mean time, we will continue to refine our model and offer what we believe is a challenging but compelling vision of psychological treatment for the future.

Further information can be obtained at the Doncaster PCT's IAPT demonstration site website: www.doncasterpct.nhs.uk/iapt.asp

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