Text of Presentation by David Richards on Stepped Care: Evidence, controversies and reform

Developing Psychological Therapy Services in the South East

Thursday 8th March
The London Art House, Islington, London

My name is David Richards. I am Professor of Mental Health at the University of York and architect of a new clinical method used in the department of Health's 'Improving Access to Psychological Therapies' (IAPT) Programme Demonstration Site in Doncaster.

Some background: my team and I were asked to do a job in Doncaster. We were asked to design a system which would open up psychological therapies to the many thousands of people with common mental health problems currently denied access. We chose to do so using a 'stepped care' system.

For the current situation is a frank obscenity. In any one year 164 in 10000 of the adult UK population will experience a diagnosable bout of anxiety or depression – a level of social and economic burden exceeded only by cardiovascular disease. I look around this room and know that there are people here who have experienced such difficulties. Even if we ourselves are lucky enough to have escaped what Churchill called his 'black dog', it would be an unusual one of us indeed who does not know someone else in our family or social circles who has not been so fortunate.

Why did I use the work obscenity? Because, we know how to treat these conditions. We have medicines which are effective. Incredibly, we have psychological treatments which are as effective as medicines. Psychological treatments which have been subjected to the same kind of placebo controlled clinical trials as those we demand of drugs. And yet, of those 164 people annually, only 40 will receive any treatment at all, 15 will get some form of probably ineffective talking treatment and a mere 2 will receive an evidence-based psychological treatment. For most people in distress, and service opt-ins. Can you conceive of any other health condition where such a situation would be even remotely tolerated? I think not.

As Richard Layard has pointed out, the cost to our society is in the region of 2% of the UK's GDP. Of course, the cost to individuals can be 100% of their own GDP.

Under pressure from Layard and as a consequence of a labour manifesto commitment, the Department of Health has set up two Demonstration Sites to model how this situation could be remedied. There are two possible solutions of course. The first is to expand the traditional services, to provide a 100-fold expansion of psychological therapies practitioners, to break every single PCT budget in the country many times over. The second solution is to take a radical, reforming, progressive approach. A stepped care approach. In Doncaster we set out to radically reform the provision of psychological therapies. We have done our job. However, in doing so we have been accused of operating outside the evidence base.

In some respects we are vulnerable to such a charge. But I ask you. How can you *innovate,* how can you *progress* and how can you *reform* without operating outside the evidence base?

So to design a reformed service we engaged in three arguments. Firstly, we have had to take evidence from outside the literature usually utilised by psychologists. Secondly, we have used some of the strategies suggested by the MRC to understand complex interventions. And thirdly, we have stepped into an overtly political arena.

Our first argument is about evidence. There is no doubt that cognitive behavioural therapy is as effective as many drug treatments, indeed for some conditions in the long term it is more effective. But the problem with the evidence base is it arises because people ask questions. The answers you get depend on who asks those questions. Sadly, people with mental health problems are not usually involved in asking those questions. How do they want to receive treatments?

To get the answers, you have to turn for advice to another evidence base. It is the evidence locked up in the voices of people with mental health problems. It is the evidence in the recent report from MIND, the Sainsbury Centre and their partner organisations. It is in the narratives collected and published by Professors Linda Gask and Anne Rogers at the University of Manchester.

We took note of this evidence when we designed the Doncaster system.

- People with mental health problems say 'we want help at the moment we pluck up the courage to admit our needs'. So everyone in Doncaster is telephoned the same day we receive their referral. They receive a service within 24hours.
- People say they want us to explicitly acknowledge their own strengths and coping resources. So we designed a CBT clinical delivery method which empowers people, assists them in the self-management of their distress and focuses on their recovery.
- People say they want a service which is convenient and accessible. So 75% of our work is conducted on the telephone.
- And finally, people say they want a culturally competent service. So we recruited new workers. Case managers. New workers from the same *culture,* the same *class* and the same *community* as the people we serve. To operate *in* the community, *with* the community and *for* the community.

Case management is real evidence, although until we brought it to the attention of UK psychologists, it was unknown in the UK. There are actually 34 RCTs, mainly US based, on around 12,000 patients showing that telephone case management can effectively deliver evidence based drug and psychological treatments to high volumes of people.

Our second argument was organisational. We have conducted one MRC funded RCT of organisational approaches based on the US models where we showed we could achieve at least as good results here in the UK. Essentially, patients have no problems with psychological treatment delivered via the telephone, its existing professionals that won't but it. Patients also appreciate the combination of medical and

psychological management, something psychological therapists generally fight shy of. Finally, patients greatly appreciate the low-intensity nature of our case management intervention. Traditional therapy is an intense business. Some people need this. But certainly not the majority of people. Case managers are able to treat the vast proportion of patients with anxiety and depression using a theoretically sound, CBT-based guided self-management programme. We developed this in our second MRC trial.

Our third argument is political.

There have been similar moral panics in other areas of public service, most notably the police service, where people have demanded greater safety, quality and police visibility. In response to this, the Labour administration has adopted a reformist, modernising approach whereby new resources are only released if they are accompanied by radical innovations in service delivery. The police service and traffic management are examples where, rather than employ a few more traditional workers, new support officers have been developed and deployed in far greater number.

These workers are now undertaking activities previously carried out by traditional public service professions – activities which in the past had been thought to be at the core of traditional professional elites, they are now an accepted part of public service delivery, highly popular with the public and a resounding success.

Our case managers are the Community Support Officers of psychological therapy. We have specifically trained them to a high standard of competence in low-intensity cognitive behaviour therapy and medication management. Where more intensive therapy is required, our cognitive behavioural therapists can provide this in the stepped care system. Case managers are also supervised extremely regularly.

The belief that psychological therapy is only safe in the hands of established professional elites flies in the face of this broader public sector reform movement. Even if more psychological therapy is made available, traditional ‘one size fits all’ systems paradoxically reduce rather than increase choice. In psychological therapies we have assumed everyone needs a Rolls Royce when actually a little city runabout does the job of getting to the shops just as well and in a more convenient manner.

In summary, therefore, the drive behind reform in all other areas has been to improve the quality of core services such as policing, traffic support and teaching through approach which will lead to increased access to core services. We have done our job. We have shown that reform and progress is not only desirable but is eminently possible. In the first five months of our site’s operation, more than 2000 people in Doncaster finally got access to treatments they had previously had no chance whatsoever of receiving.

There is now a bid into the comprehensive spending review. Its seems to me that the Secretary of State and the Treasury now have to make two choices.

The first choice is easy. Richard Layard has made a cast iron case for increased funding. Those of us who have been campaigning in this area for the last ten years or more are very grateful for his recent arrival and his cogent articulation of this case.

But there is a second choice.

- It is a choice between a system which will perpetuate existing inequalities versus a system which will embed psychological therapies in people's own communities.
- It is a choice between investment in a system which has failed us in the past versus investment in change.
- It is a choice between investment *without* reform versus investment *in* reform.

Case managers – the Community Support Officers of psychological therapy – are the progressive, reform-minded solution to this choice.

I like to leave you with a picture – or rather two pictures.

The first is what might come to your minds had I asked you to imagine a psychotherapy service. Here, highly paid professionals speak one to one with people in consulting rooms for 55 minutes every week. The throughput is slow and sedate, no more than four or five people come through each room every day. There is an imaginary queue stretching for many miles outside the door.

Now imagine a room with 20 workers in it, seated at computer terminals, wearing headsets, using data from their computers to assist them as they talk to patients on the telephone. Every 30 minutes they make another call to another patient. By the end of the week 300 or more calls have been made.

This last picture might sound futuristic. Its not, its what happens every day in one place in the UK – Doncaster. If the government get it right, in five years time it will be happening all over the UK. If they get it wrong, we're back in the world of long queues, inequality and despair.

Thank you.

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