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# Implementing Stepped Care at Scale

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# Access

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# Alan Kazdin 2010, American Psychological Society Convention

- *“If the goal [of psychological therapies] is to reach a small number, and to exclude those in need, particularly those in minority groups, particularly those in rural areas, especially those who are elderly, especially those who are young — if that is our goal, we are doing great.”*

# Staring into the emptiness

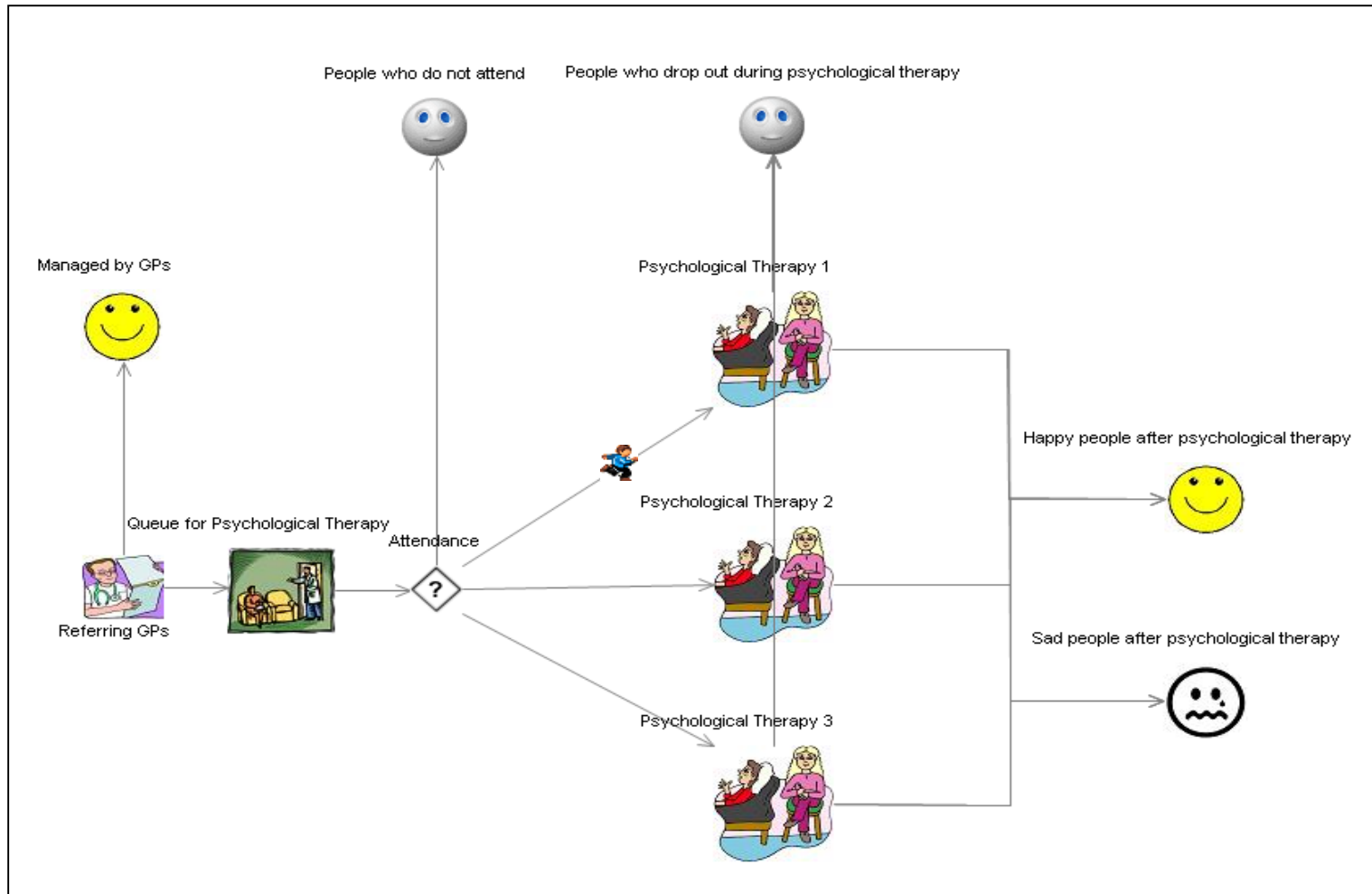
- *“During the early part of the 21st century, to be anxious or depressed was to stare across an abyss, empty of assistance. The chance of receiving succour of any kind was dependent on a pernicious lottery of professional whim, personal finance and postcode. To be old, poor or non-English speaking served merely to widen the chasm. Anxiety and depression were states that were ironically both stigmatising and little valued. The idea that non-drug treatments should be routinely available to bolster low mood or relieve anxiety was relegated to society’s pending tray.”*

Richards, D.A., Br. J. Wellbeing, 2010

# Access – a multi-dimensional concept

- *Availability*: an adequate supply of treatments
- *Utilisation*: the treatments people actually receive
- *Effectiveness*: improvements in health status, function and quality of life
- *Cost-effectiveness*: improvements achieved at a sustainable cost
- *Equity*: treatments delivered to the population according to need; unrestricted by the ability to pay, geographic location, culture or other moderator
- *Patient-centredness*: services provided in line with people's expressed preferences and needs

# First – the old picture



# Problems with the usual picture

- Single solution
- Low volume
- Specialist
- High intensity
- Burdensome

.....Queues  
(but it works if you can get it)

# Modifications: Stepped Care

- Modification of the *psychological referral* model to maintain benefits (i.e. effectiveness and patient-centredness) by providing personally tailored evidence based treatment, while minimising problems (i.e. access and efficiency) by delivering treatment in a ‘low-burdensome’ manner.



# Stepped Care

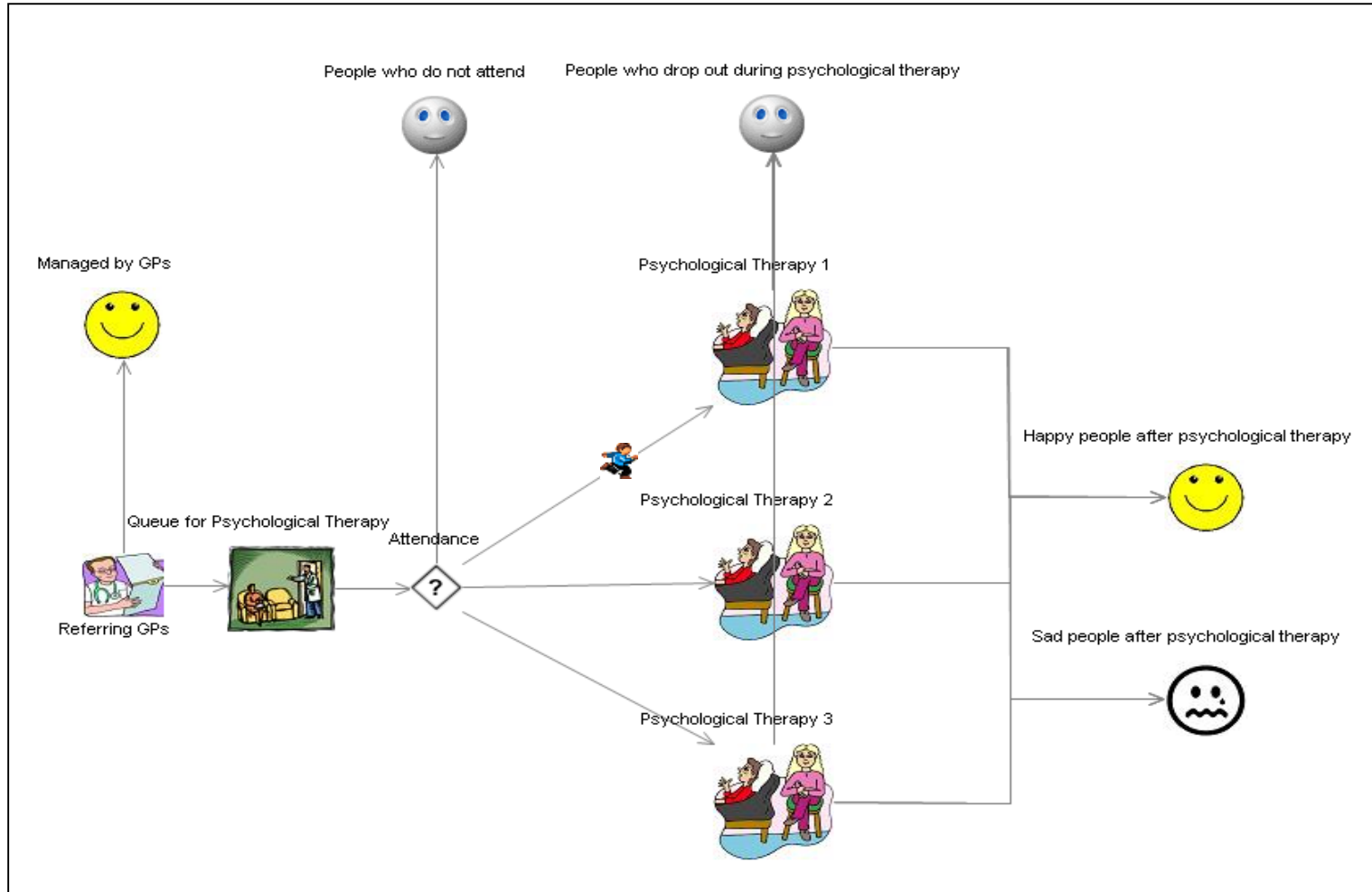
- Two principles
  1. *'least burden'*.
  2. *'self-correction'*
- treatment received by a patient should always be the least restrictive, delivering good outcomes whilst burdening the patient and the health care system as little as possible
- a system must be in place to detect non-improvement leading to alternative more intensive treatments being offered

# Low Intensity CBT – a definition

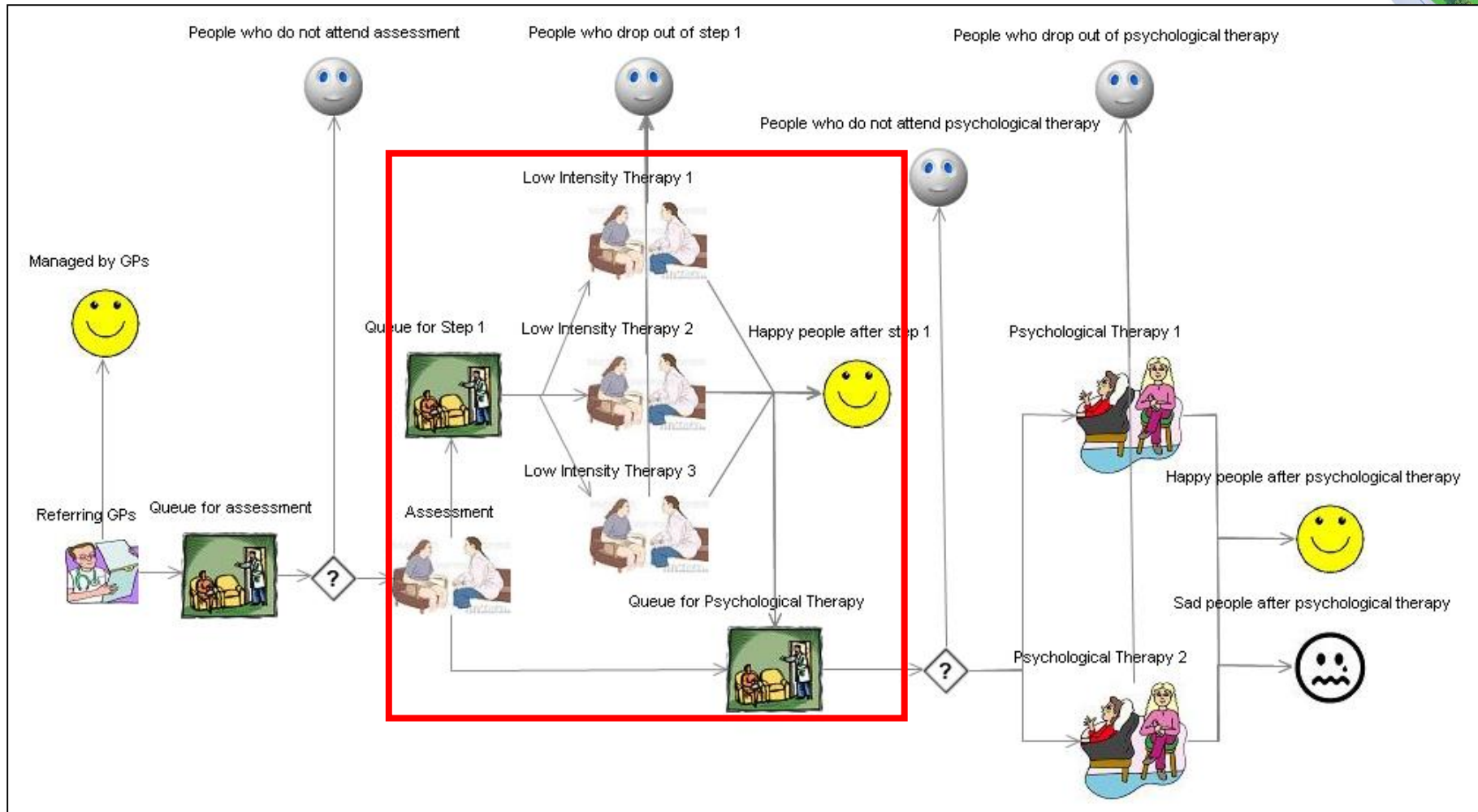
- Low intensity CBT interventions require fewer resources than the traditional individual therapy model in terms of:
  - The amount of time the clinician is in contact with the patient
    - short-term CBT groups,
    - fewer/shorter sessions with or without self-help books, computer CBT etc.,
    - stand-alone, non-therapist guided interventions
  - Using paraprofessionals, peer supporters etc. specifically trained to deliver low intensity CBT interventions
  - Use of less intense content, self-paced, on own time, bite-size pieces, etc.

*The Oxford Guide to Low Intensity CBT Interventions.* (2010) Eds. Bennett-Levy, J., Christensen, H., Farrand, P., Griffiths, K., Kavanagh, D., Klein, B., Lau, M., Proudfoot, J., Richards, D.A., White, J. and Williams, C. Oxford, Oxford University Press.

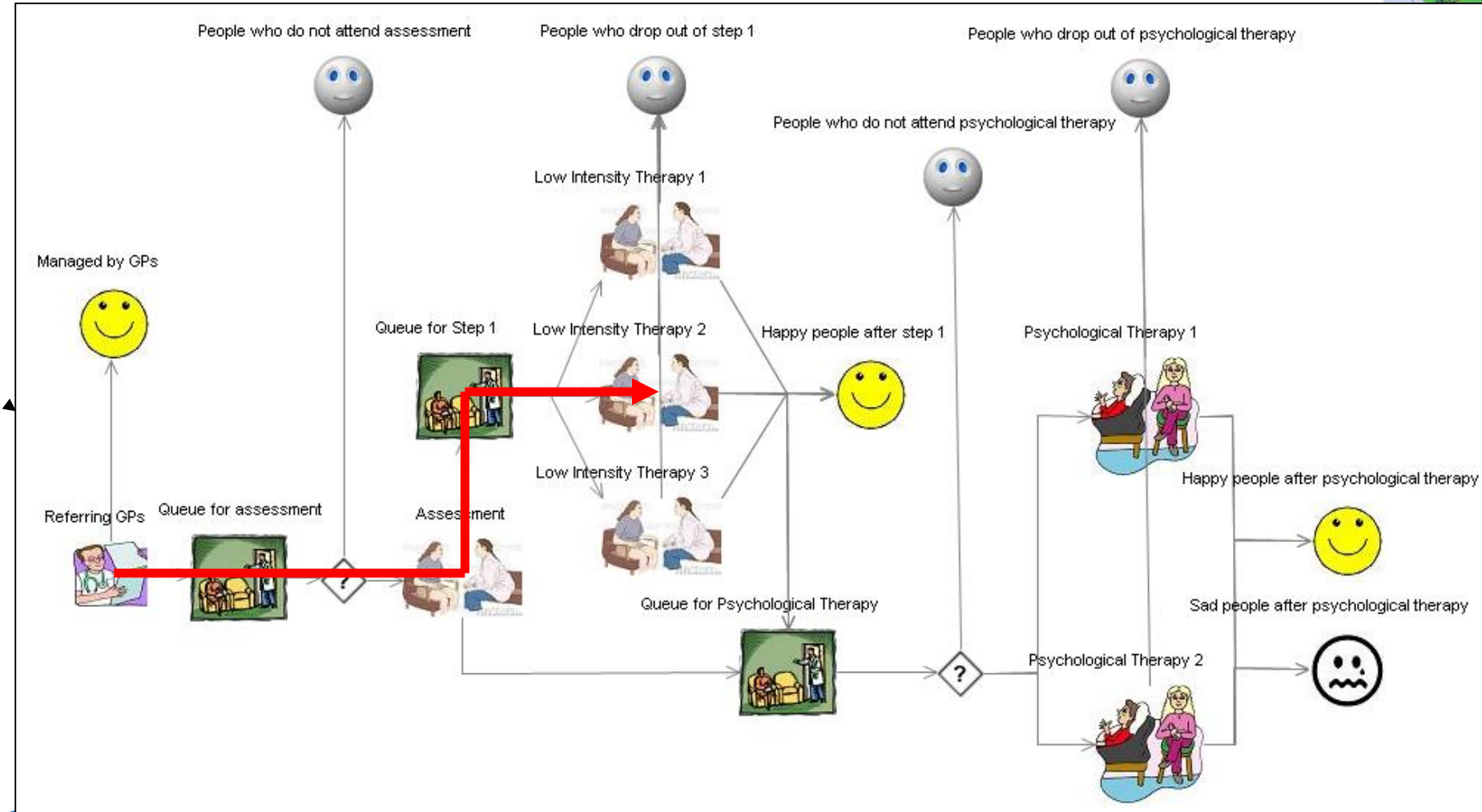
# The old picture



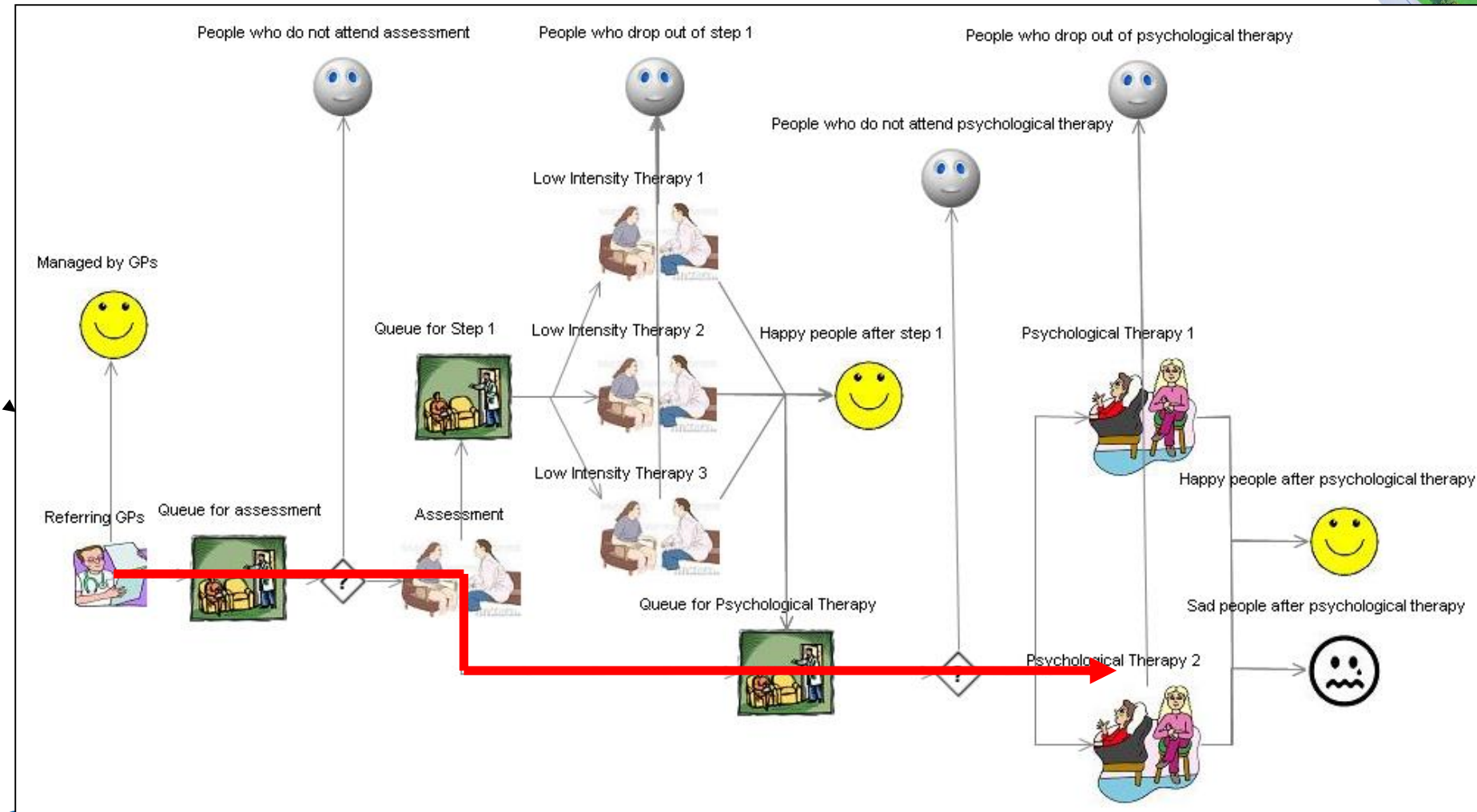
# A New Picture



# Stepped Care: Low-Intensity Path

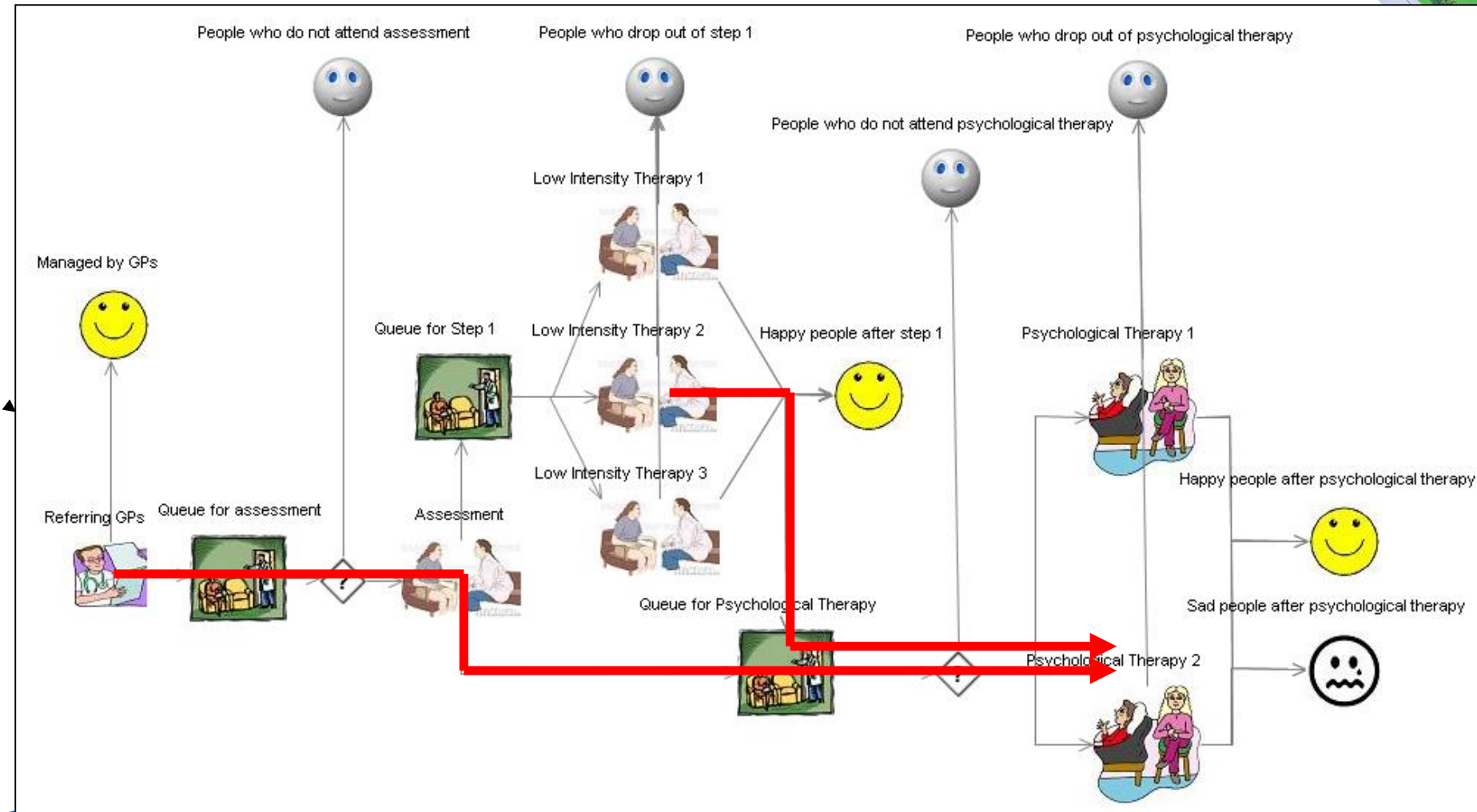


# Stepped Care: High-Intensity Path 1

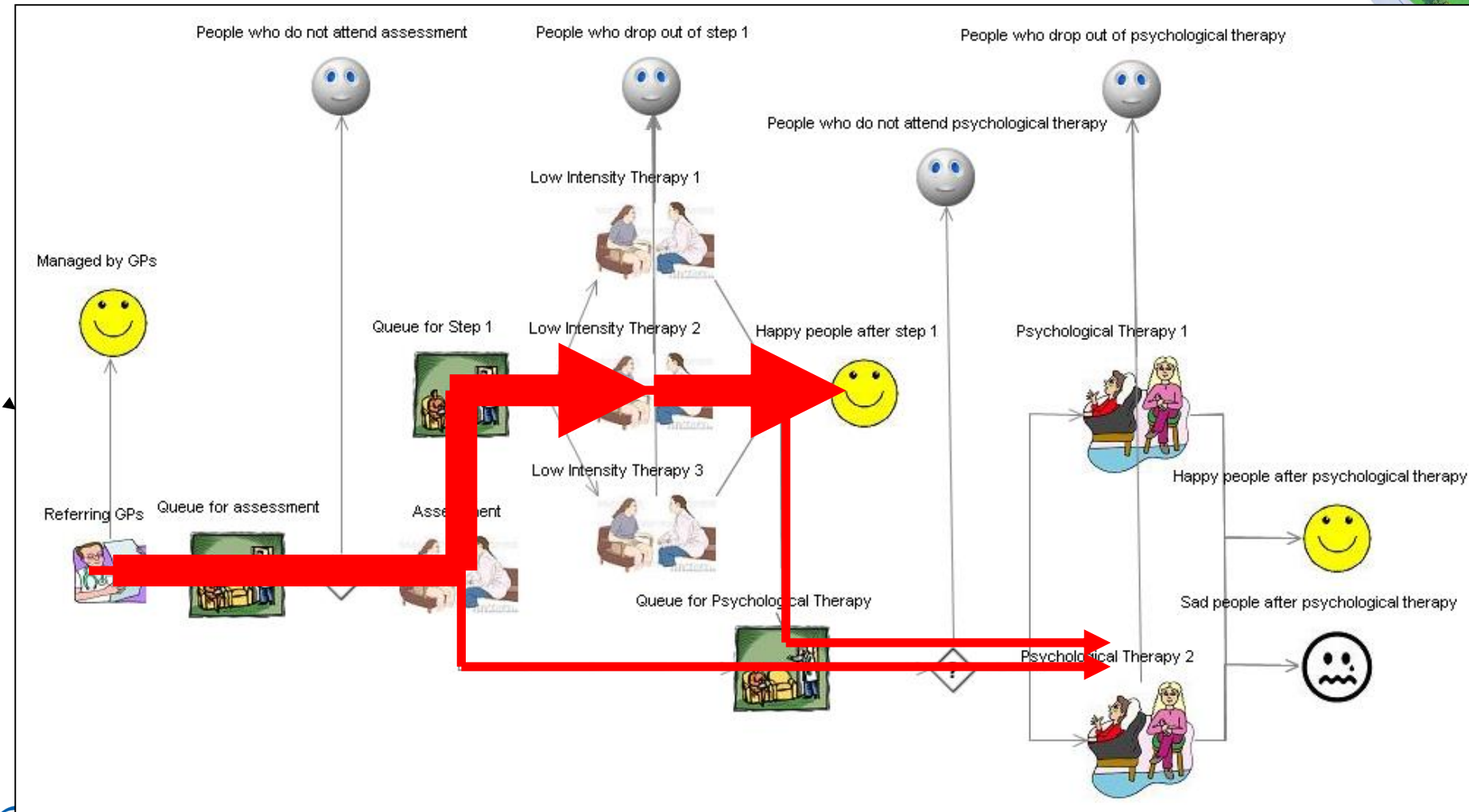




# Stepped Care: High-Intensity Path 2

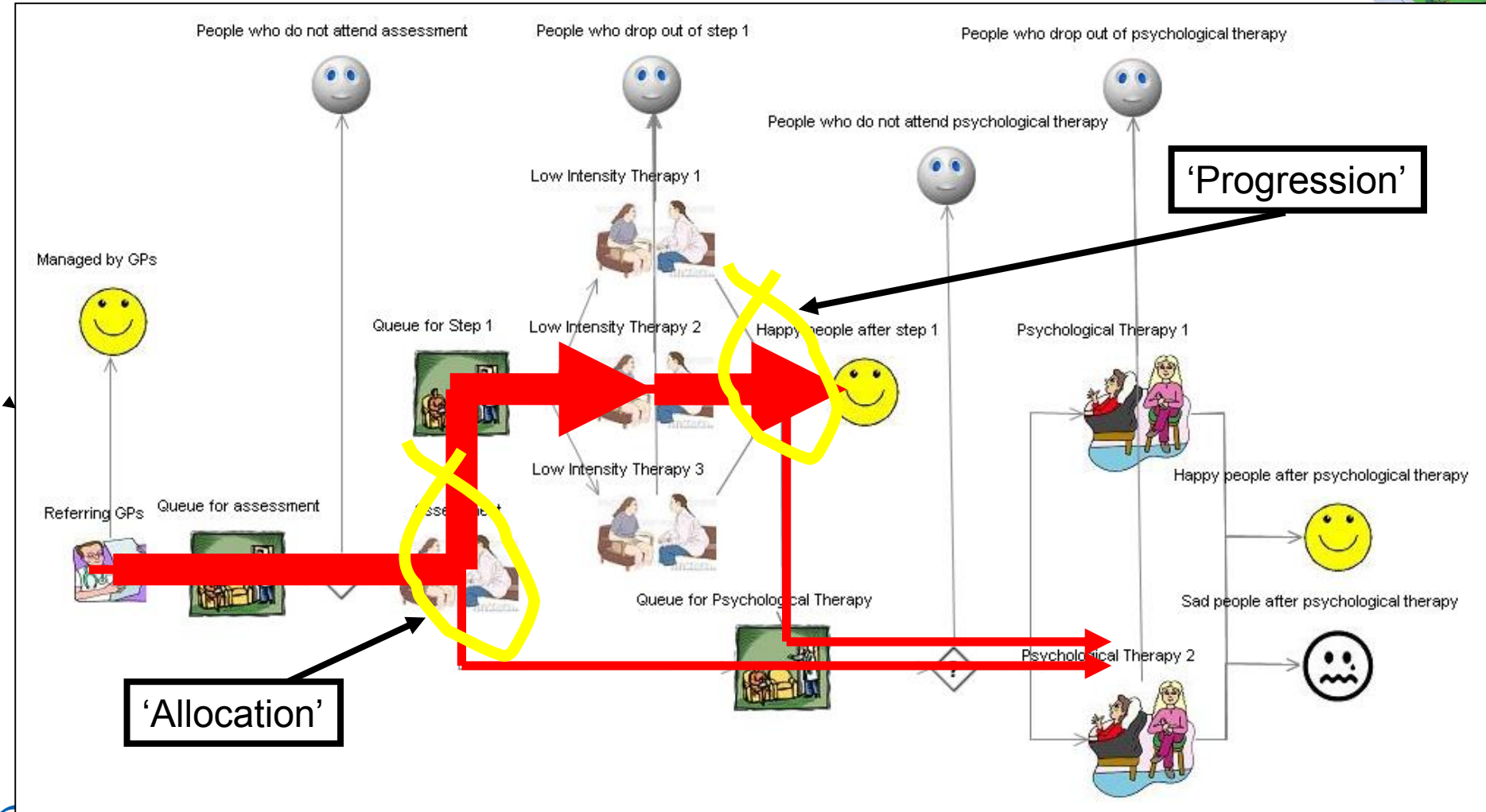


# Stepped Care: Ideal Balance





# Stepped Care: Decision Points



# Decision Points:

## Allocation, Progression or a Mixture?

- Allocation systems stratify patients and initially allocate or 'match' them to interventions in 'tiers' according to some supposed objective criteria
- Progression systems provide all patients with low-intensity treatments and organise progression according to some objective criteria

# Three Real Life Evidence-Based and Critical Features

- Trained para-professional workers
  - Focussed training of low-intensity workers
- Telephony contact as default (collaborative care case management)
  - Low-intensity treatment first
- Smart automated IT triggered supervision and patient management
  - Specialist clinical case management supervision from clinical experts

# Supervision in Stepped Care

- Clinical data should be collected at every session in real time
- Clinical and process data should automatically trigger supervision alerts
- Supervisors and supervisees should be able to view the same electronic data
- The Electronic Health Record (EHR) should summarise and present data in a format to aid clinical decision making, not just to collect audit data

# Remember principles

- Low burden
  - Low-intensity treatments should be a major feature which are highly utilised
- Scheduled review
  - Objective criteria for measuring progress and acting on findings
- Balance allocation and progression
- Aim for high volume

# What do People think about Stepped Care?

- Clinicians, patients and managers report that **increased and timely access** to treatment is an advantage of this way of working.
  - *“I think loads of people are getting help that they didn’t used to get before. So that’s been good. Lots of people are getting more access to psychological therapies than they ever used to, and that’s and that’s a good thing.”* Clinician
  - *“I could actually get in contact with somebody swiftly, so there wasn’t going to be a huge waiting list, that he [the GP] felt it was appropriate, that he’d had good reports I think from, from other patients.”* Patient

# What do People think about Stepped Care?

- Managers regard stepped care as better meeting the **needs of commissioners and general practice** than traditional systems
  - *“It was empowering, it was useful, it was what primary care wanted. Certainly from a PCT commissioning point of view it was exactly what commissioners were wanting and it certainly was what GPs and primary care practitioners were wanting.”* Manager
  - *“It was wholly about increasing capacity and access in primary care.”* Manager
  - *“We spent an awful lot of time looking outside of traditional mental health services.”* Manager



# What do People think about Stepped Care?

- Patients, workers and GPs consider the **structure** of stepped care to be a major benefit
  - *“I think from my point of view as a clinician it’s a really good framework to operate within. It’s always very safe to deliver patient care in that way.”* Clinician
  - *“It’s sort of like a series of sieves where you know the idea is that you’re captured at an appropriate point in the treatment system.”* Patient
  - *“As far as this [GP] practice is concerned it feels like there’s a consistent pathway, there’s clarity about the pathway and people are following it and it works and its easy and people feel better afterwards, so you know.....tick, tick, ticks in all boxes.”* General Practitioner



# What do People think about Stepped Care?

- The provision of **low-intensity treatment** is regarded as an important new alternative for many patients
  - *“The good thing is that you do see people who otherwise would not have accessed the service and people who wouldn’t need more than a few sessions and it does work really well for them, they’re not being given more than they need and that’s really good.”* Clinician
  - *“I think it was just the job because a psychiatrist seemed a bit heavy. On the other hand if it had been less and I hadn’t had anybody to talk to at all, I just think I would have gone into depression and have got a lot worse.”* Patient

# Pitfalls...

- Stepped care is much more than the provision of a new set of low-intensity alternative treatments
  - *“So, yes it is stepped care. It is very stepped. It is a big bloody leap in between teams. Instead of it being fluid and flowing and connected, there is no connection.”*  
Clinician
  - *“We’re still holding people, we’ve still got the six month waiting list and that block [at Step 4] seems to be, for me, feels like its jeopardising the whole project.”*  
Clinician

# Pitfalls...

- Preparation and training of staff
  - *“Most of the problems have been lack of explanation of what the project actually entailed... to be honest, it wasn’t very clear at the outset.”* Clinician
  - *“There was no induction for us as a team. We left one job on the Friday and started in this job on the Monday and started running with very, very little management supervision or input and just being told to get on with it.”* Clinician
  - *“I don’t really feel I’ve got the competence to do Step 2 work because we’ve had no training in it. Maybe there’s an expectation that because you’ve got a certain level of training then you can just move across [to Step 2 work]. But it’s very different.”* Clinician

# Pitfalls...

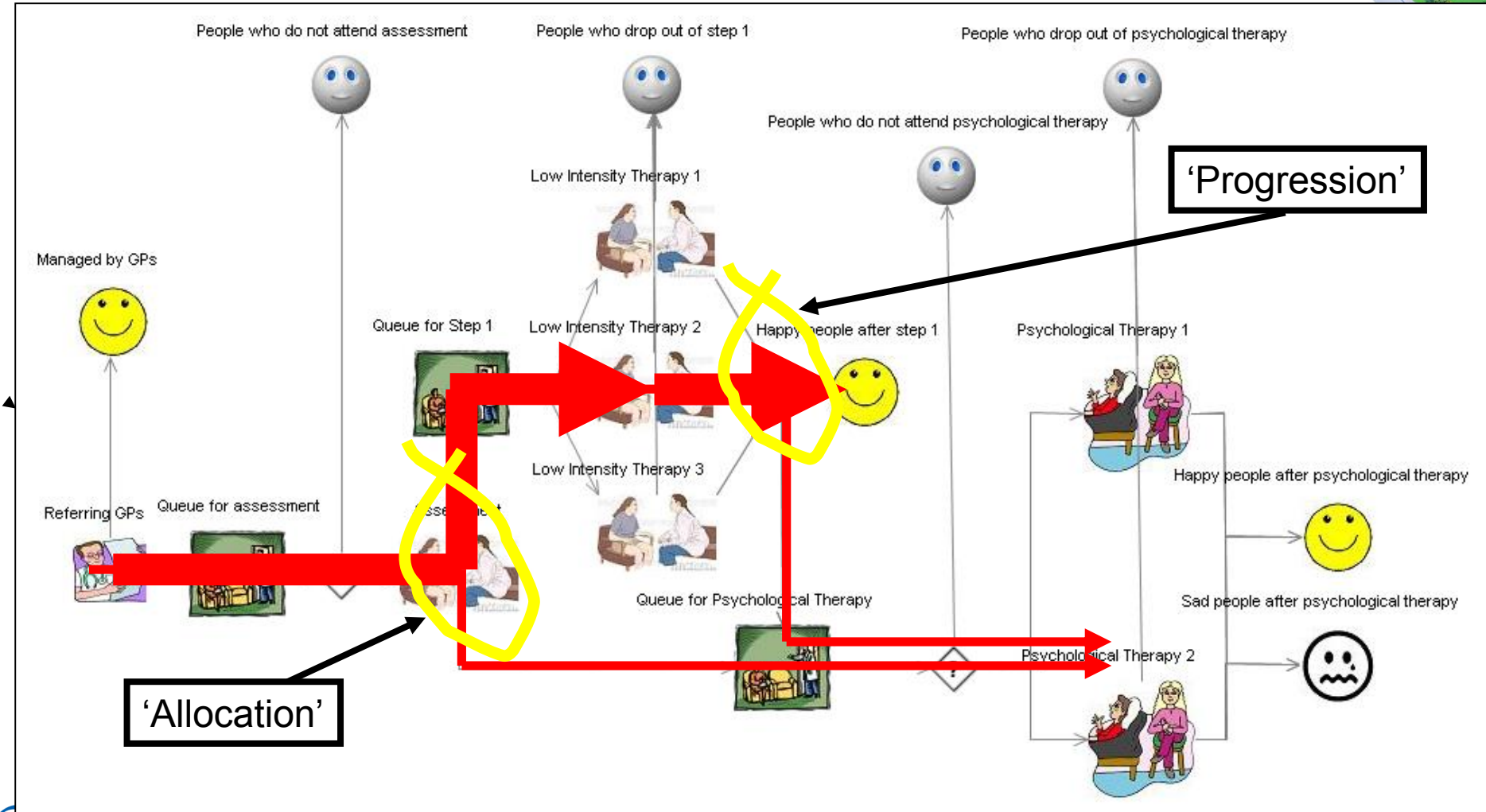
## ■ Staff resistance to change

- *“They wanted me to do [CBT training]. I’m really sorry, I refused. I refused point blank.”* Clinician
- *“I trained to do mental health interventions. It suits me. I’ve invested a lot of time in training and yet I’m being asked to spend a large part of my time doing step 2 work and I suppose I have resisted that, for personal reasons.”* Clinician

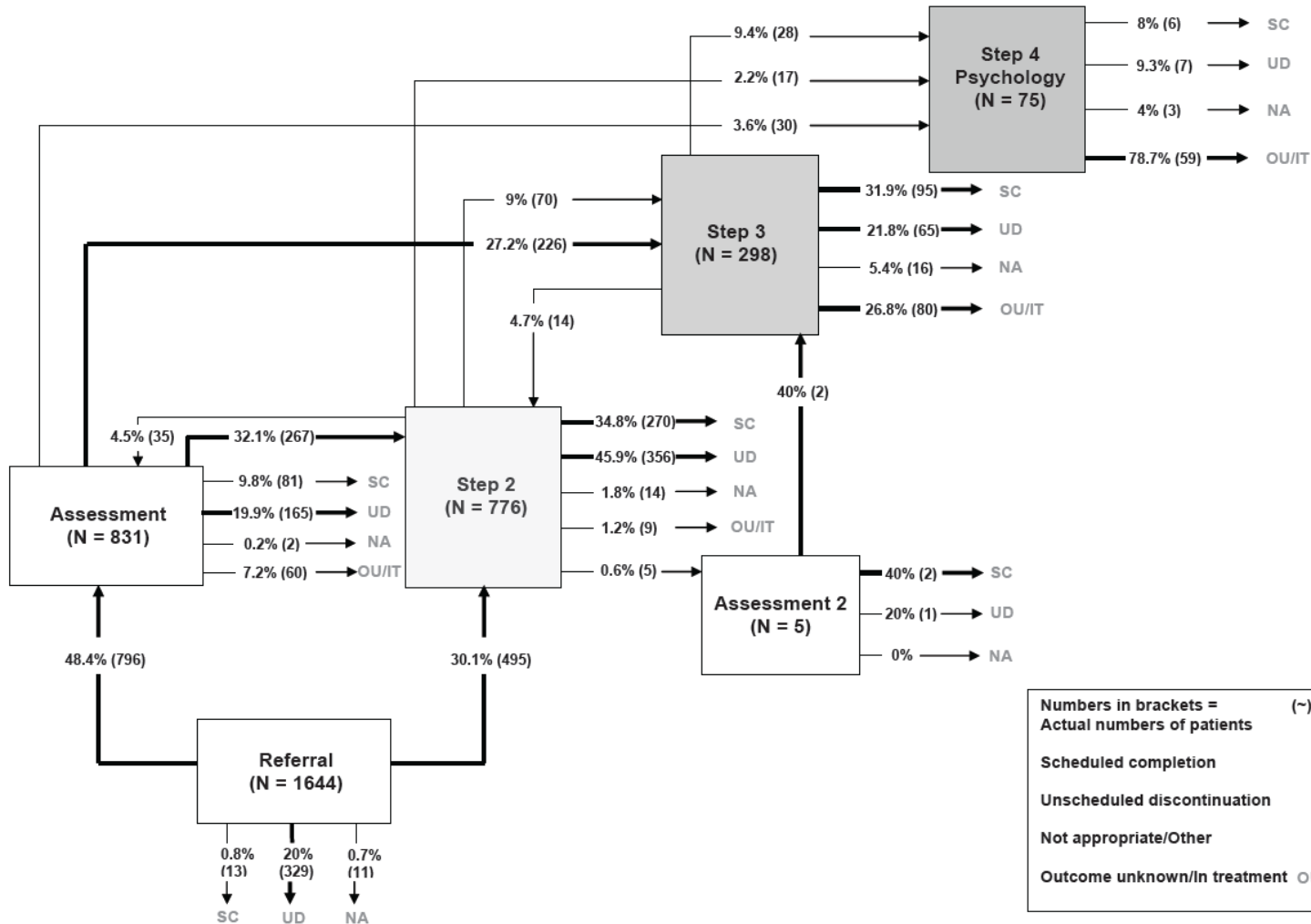
# Pitfalls...

- Inconsistent adherence to the model
  - *“My understanding of stepped care is that it should be the least intervention offered first, to be stepped up appropriately. Now, again we’ve got this big bottleneck at step three of face-to-face clients and I would suggest that’s because the stepped care model isn’t being used as it should.”* Clinician

# Stepped Care: Decision Points



# Stepped care...



Numbers in brackets = Actual numbers of patients (~)

Scheduled completion SC

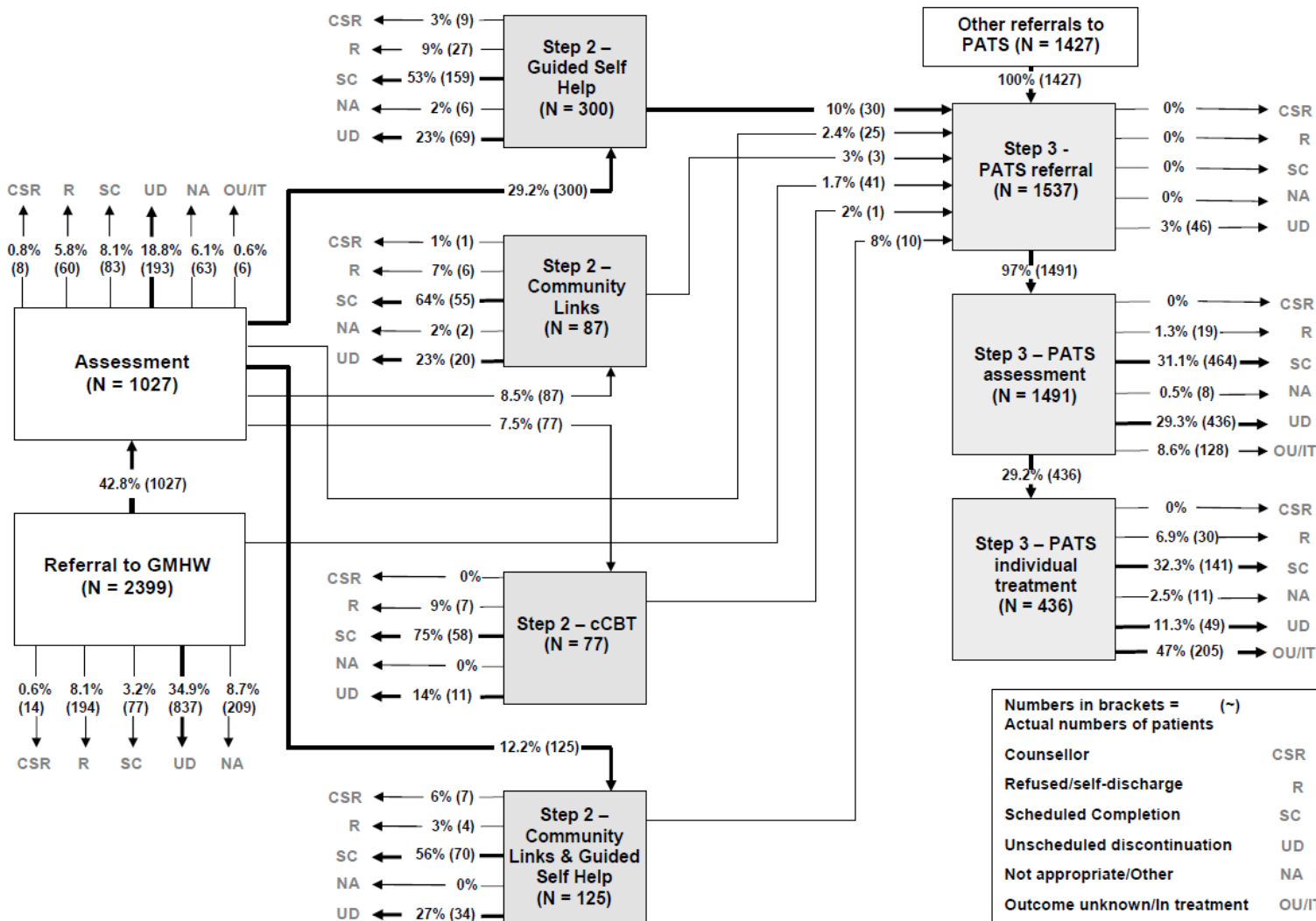
Unscheduled discontinuation UD

Not appropriate/Other NA

Outcome unknown/In treatment OU/IT



# ...or a wiring diagram!





# Implications for the Design of Stepped Care Systems 1

- In order to implement a stepped care service there are a number of critical decisions to be taken
  - decide where the specific system model sits in terms of the continuum between stratified and stepped decision making
  - decide which treatments will be provided and at which step they will be delivered
  - understand how patients will access the stepped care service
  - decide who will screen, assess and treat patients at each step

# Implications for the Design of Stepped Care Systems 2

- ❑ design systems that manage the interface between steps, particularly where treatments are delivered by different provider organisations or clinicians
- ❑ prepare, train and supervise staff for the new system
- ❑ put in place a system to audit the treatments being delivered.
- ❑ inform GPs, other referrers and other members of the health and social care community, including potential patients, about the new system



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# Questions and Discussion

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