

Talking Therapies and the Stepped Care Model

Implementation of the Stepped Care Model for the Delivery of Talking Therapies in Secondary Sector Adult Mental Health Services. A Waitemata DHB Mental Health Psychological Therapies Project

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Abstract

This paper discusses the adaptation and implementation of the Stepped Care Model to improve the Delivery of Psychological Therapies in a secondary sector DHB (the Waitemata District Health Board - WDHB) Mental Health Service.

The purpose of the Psychological Therapies Project in Waitemata District Mental Health is to increase access for clients to psychological therapies (talking therapies); and to increase resources (workforce) for the effective delivery of psychological therapies. Talking therapies are known to be an effective treatment; and there is increasing evidence of the effectiveness of some of these therapies. Furthermore, a WDHB needs assessment survey found that: consumers highlighted the need for greater access to talking therapies, and for a greater range of core therapies; there was a need for training of other allied professions and nurses to provide therapy; and outcome evaluation measures were needed to determine therapy effectiveness. A pilot project was commenced in an adult community mental health service to improve delivery of talking therapies using the Stepped Care Model.

Talking therapy is increasingly a keystone in the treatment of mental health disorders. International literature supports the need for increased and better access to talking therapies. (e.g., Rogan-Gibson & Earl, 2008).

Various international guideline groups advocate for talking therapies in the treatment of psychological distress. Within New Zealand, people who access mental health services and their family/whanau are now more aware of what interventions are available, and also of the effectiveness of psychological therapies (Peters, 2007). Cognitive behaviour therapies (CBTs) have

been found to be effective in the treatment of anxiety and depression, and some forms of CBT can be delivered by a range of health practitioners (Peters, 2009).

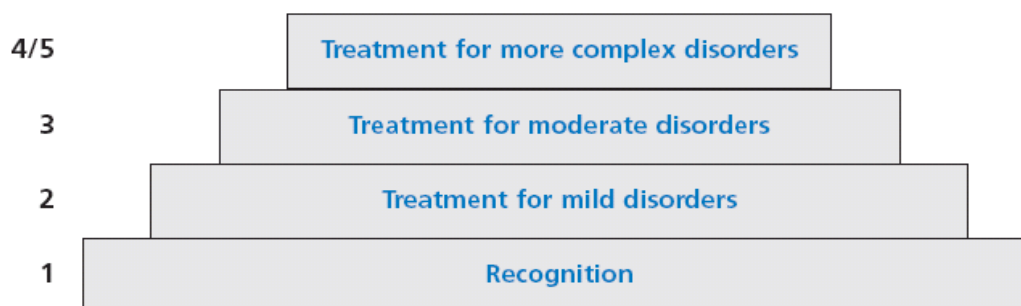
Stepped Care Model for Delivery of Psychological Therapies

Research supports the implementation of a *stepped care model*, or structure, for delivering psychological therapies in mental health (e.g., National Health Service, 2007).

This model has been used successfully across primary sector services (GPs, Primary Health Organisations - PHOs) and secondary sector services (community mental health and inpatient services).

National Institute for Health and Clinical Excellence (NICE).

Figure 1: The stepped care model



For different disorders, the interventions recommended by NICE can be found at <http://guidance.nice.org.uk/topic/behavioural>

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The National Health Service (NHS, 2007) states that in the stepped care model the idea is to provide patients with the most appropriate and cost-effective care in a non-invasive manner. Stepped care has two principles: Treatment is directed at the best chance of delivering a positive outcome while being least demanding, and treatment effectiveness is reviewed and stepped up or down as indicated. The provision of treatment is offered at increasing levels of intensity, and clients are matched with the level of treatment that will best meet their needs. The aim is to start with the least intensive level of intervention and step it up (or down) if needed.

The Psychological Therapies Project (PTP) in the District Mental Health Service (DMHS)

The project was instigated in Adult Community Mental Health. There was an opportunity for developing an effective delivery structure for therapies, along with workforce planning and a training framework to support psychological therapies. This was due to: increased consumer demand for talking therapies; a number of therapeutic models being utilised with no current strategy and co-ordination; many clinicians (both allied health and nursing) had trained in particular therapeutic models but application was unsystematic; training had been supported without accurate assessment of service user population requirements; and there was a lack of information around evidence of therapy application, evaluation, and effectiveness.

The aims of the PTP are to increase access for clients to therapies; to identify which psychological therapies are being used in the DMHS, and what is needed; to further develop a strategic workforce and training; and to prepare an implementation plan for the next 3 to 5 years for the delivery of therapy.

A needs assessment survey undertaken in 2008 had a number of components. There was consultation with consumers, which

revealed that the move to increase talking therapies was supported by consumers who needed greater access. A survey of clinicians showed that *all clinicians spent around 45% of their time applying talking therapies*. All professional groups had some degree of basic therapy knowledge, and some training, but there was a lack of formal training and supervision to deliver such therapies. A survey of the team managers found *all services spent over 40% of their time applying talking therapies*. Most were using mainly CBT and DBT, but other therapies such as motivational interviewing, trauma therapy, solution focused and/or problem solving therapy, and group therapy were needed. A more structured package of interventions was needed.

Recommendations of the PTP

1) Stepped Care Model for delivery of psychological therapies. The model below was adapted and implemented for use just within a secondary sector adult mental health service. In WDHB Mental Health, the approach supports service user involvement, fits well with the recovery approach, and also with the concept of integrated care pathways (ICPs).

Level 3 Severe and Complex disorders HIGH Intensity Therapy

Specialist therapies such as CBT, IPT, DBT, family therapy, trauma therapy and other specific indicated therapies.
For complex, severe, co-morbid, Axis II presentations, for clients not responding to treatment, and for mild to moderate specific presentations as indicated.

Applies to psychologists, psychotherapists and clinicians trained in specific talking therapies.

Level 2 Moderate to Severe Disorders LOW Intensity Therapy

Strategic and core interventions involving: basic CBT and DBT therapy, guided self help, psycho-education groups, skills groups, problem solving therapy, solution focused therapy, behavioural activation, motivational interviewing, and e-therapy

Applies to **clinicians** appropriately trained in a therapeutic intervention from MDT, crisis services, inpatient clinicians (nurses, social workers, occupational therapists, medical doctors, psychologists, and psychotherapists)

Level 1 Recognition, Assessment & support

Having a culture of psychological mindedness – to engage the client and establish a therapeutic alliance to support clients in their recovery.

Emphasizes the use of basic knowledge and skills in communication and interaction with clients, such as Real skills, Real skills Plus, Care Coordinator training.

Applies to all clinical staff.

2) Increase the availability of evidence based therapies at Level 2 (Low Intensity therapies) that are effective in treating moderate disorders, and to recommend the most appropriate evidence based therapies for the adult service. Different treatments suit different people and different health conditions.

3) Ensure training of all clinicians in Level 1, and appropriately train clinicians in Level 2 low intensity therapies and Level 3 high intensity therapies. It was also recommended to increase therapy resources by training allied health clinicians and nurses to deliver therapies at the low intensity or core therapy level. The recommended ratio of high to low intensity therapists per recovery team is in the vicinity of 6 (high intensity) to 4 (low intensity) (Department of Health, 2008); or 5:5 ratio (Centre for Economic Performance's Mental Health Policy Group, 2006).

4) To ensure therapy competency and supervision. It was recommended that therapies were delivered to an appropriate standard of practice.

5) To implement outcome evaluation of therapy, utilizing tools developed by Scott Miller to improve service users' experience of and benefit from therapy; and to improve the quality of clinicians' interventions. These tools included the Session Rating Scale (SRS; Duncan et al., 2003) to measure the therapeutic alliance, a main factor in determining therapy effectiveness session by session; and the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) to measure therapy

effectiveness (e.g., reduction in level of distress) over time. Other measures were also to be used as appropriate, including diagnostic criteria, goal setting, visual analogue scales, and psychometric measures.

6) Evaluation of the project via combined WDHB and Auckland University of Technology research outcome evaluation of firstly, a 1 year pilot study with the Rodney Adult Mental Health Service (RAMHS), and then of further roll out to other teams.

RAMHS Pilot Project

The RAMHS Pilot project commenced at the beginning of 2010. The pathway using the Stepped Care Model is as follows:

Allocation of therapy level

After the client has been accepted into the service and completed the initial interview, a diagnosis is made or confirmed, and therapy is recommended as a treatment option. A case discussion is held with the multi-disciplinary team (MDT)/recovery team, at which a senior psychologist or therapist is present. The level and type of therapy is recommended. (This is supported with guidelines for therapy triage in the Pilot Project handbook.) Where recommendations cannot be clearly made, the client has a further assessment with a psychologist and recommendations are made to the team. A referral is then made to the appropriate therapist.

Treatment

The client receives therapy for a recommended number of sessions. This is also supported by the use of outcome evaluation tools (the SRS and ORS), and any other specified measures as noted before.

Review

At the completion of eight weeks, the client is reviewed by the MDT/recovery team, with the therapist's report and outcomes from the evaluation tools that have been administered. Progress is expected to be seen at eight weeks. Therapy is then either continued at the same level, stepped up or

down, or the client is discharged from therapy if therapy is complete. If the therapy is found to be ineffective, a change of therapy or therapist may be indicated. Continuation in the face of no progress (by doing more and harder) is not appropriate. Clinical judgement may be needed when working with clients with personality disorders and with some forms of psychotherapy. A further therapy review date is set as appropriate.

The clinical pathway has the following supports:

- A clinician handbook has been compiled;
- Clinician competencies are being assessed;
- Training is being implemented at Level 2 - training is in core CBT and DBT skills, motivational interviewing, solution focused or problem solving therapy;
- Staff are being trained in the stepped care model;
- A therapy supervision data base is being constructed;
- There is training in the use of the evaluation measures described above;
- The research project with AUT has commenced, with the experimental design beginning in September 2010.

Future directions

All teams in DMHS have had a briefing and their data about current therapy provision has been reviewed. The model will be rolled out to other teams (specifically- North and West Adult Community Mental Health teams) following the conclusion of the Pilot project. All teams are keen to adopt the model, and supportive of opening up access to therapies, and also opening up therapy provision by other professions in a structured and supported way.

Progress reports will be published with ongoing results discussed. Results will also be published at the conclusion of the WDHB/AUT research project.

Further information related to material presented in this article can be obtained from the author.

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