
Talking Therapies in Times of Change

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Abstract

The paper discusses the outcomes from research based on a pilot study to implement the stepped care model for the delivery of psychological (talking) therapies in an adult mental health service at Waitemata District Health Board (WDHB). The aim of the study was to determine if use of this model increased access to and effectiveness of talking therapies for the existing population. This research was a response to the outcome of an annual survey of mental health service users conducted by the consumer advisors on behalf of the Ministry of Health, which highlighted these questions. This paper also discusses the use of outcome measures Session Rating Scale (SRS) and Outcome Rating Scale (ORS) to evaluate effectiveness of therapy delivered. These therapy-specific measures are used to measure the quality of the therapeutic alliance with the service user relative to therapy progress. The benefit of the stepped care model is shown in an increase in access to therapies; an increase in the amount of therapy delivered; and an increase in the effectiveness of therapy for the service user. Implications for the use of this model are discussed in relation to community mental health in New Zealand.

This paper is a follow up to a previous paper: Earl, T. (2010). Talking therapies and the stepped care model. Journal of the New Zealand College of Clinical Psychologists, 20(2), 13–16.

Background

Demand for secondary mental health services in New Zealand continues to increase, and in order to respond to these challenges significant changes are needed in service delivery (Blueprint II, 2012). Some of the areas of challenge include variation in access to mental health and addiction services, especially for children, young people, and Māori populations; waiting times to access services; and gaps in service provision for coexisting problems related to

addictions, physical health, and disabilities. (Ministry of Health, 2012)

Blueprint II looks at an “across the life span” approach in the provision of mental health and addiction services. Main themes emphasize earlier and more effective responses by services, improved equity of outcomes for different populations, increased access to services, effective use of resources, and improved partnerships. The focus is to promote recovery, wellness and resilience

Research and development in talking therapies, is a focus for Te Pou, (the National Centre for Mental Health Research) and is aimed at supporting national strategies in mental health with the development of guidance and tools to assist practice. WDHB contributed to this work, in conjunction with Auckland University of Technology (AUT) by assessing the impact of talking therapies using a stepped care model on service provision in adult mental health.

The Stepped Care Model

The model was created in the UK by the National Institute for Clinical Excellence (NICE, 2009) to determine the level of care appropriate in the treatment of mental health problems and disorders. It recommends the use of evidence-based interventions at each level, delivered by competent workforce appropriately trained to the level required. In this model there are five steps, as it was created to cross both primary and secondary settings and the wide range of needs this represents.

Use of this model ensures that:

- Treatment is directed at the best chance of delivering a positive outcome.

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- The level of the disorder indicates the level of intervention.
- The aim is to start with the most effective level of intervention and on review, step it up (or down) if needed.

WDHB conducted the current research project to assess the implementation of the stepped care model for the delivery of talking (psychological) therapies in an adult mental health service. The aim of the study was to see if implementation of the stepped care model increases access to therapy, and increased the effectiveness of delivery of therapy. The stepped care model was condensed to three steps to reflect the needs

of WDHB secondary sector health population:

Level 1: Recognition, and supportive interventions.

Level 2: Low-intensity talking therapy interventions.

Level 3: High-intensity talking therapy interventions.

The stepped care model for talking therapies for this study describes the levels of mental health disorder, and the appropriate evidence based talking therapy intervention for that level (Figure 1).

**Level 3 Severe and complex disorders
 specialist high-intensity talking therapy**

Cognitive behavior therapy (CBT), dialectical behavior therapy (DBT), interpersonal therapy (IPT), family therapy, brief psycho-dynamic psychotherapy, and other specifically indicated therapies.

Delivered by psychologists, psychotherapists and those trained in specific talking therapies at this specialist level.

**Level 2 Moderate to severe disorders
 specialist low-intensity talking therapy**

Core CBT and DBT skills, solution focused therapy (SFT), motivational interviewing (MI), e-therapy, psycho-educational, and skills groups

Delivered by appropriately trained clinicians: Nurses, social workers, occupational therapists, doctors, psychologists, and psychotherapists.

**Level 1 Recognition and supportive intervention
 for presenting problem or disorder**

Promoting a culture of psychological mindedness by practitioners, with the aim of identifying and monitoring the service user's presentation of vulnerability.
Mental health and addiction screening / brief assessment may be indicated.

Wellbeing is supported through self-management and provision of: psycho-education; e-therapy recommendations; information and /or referral to support/self-help groups in the community; support to access community resources — financial, housing, social services, support via a whānau ora model where applicable.

This can be delivered by all practitioners and clinicians.

Figure 1. Stepped care model for talking therapies used in adult mental health service, WDHB.

As stated above, this study was a response to a survey of service users in adult mental health, which showed that they wanted greater access to talking therapy and more therapy options (WDHB, 2008). The authors piloted the implementation of the stepped care model in talking therapies for one year in 2011. The WDHB research study was done in collaboration with co-researchers from Auckland University of Technology (AUT). The pilot study aimed to determine if the use of the stepped care model would:

- Create an effective clinical pathway for service users to benefit from therapies.
- Increase access to therapy so that more service users could receive talking therapy.
- Increase the amount of therapy delivered, through upskilling the existing workforce.
- Increase the effectiveness of therapy through the use of evidence based therapies through the use of outcomes measures.

Participants, Service Users, and Therapists

The participants in the study were service users already accessing the clinical teams 1 and 2 in the Waitemata adult catchment area. The two teams were matched for similar numbers of service users receiving talking therapies at the beginning of the study, 1 November 2010. In experimental team 1 there were 4.7% of service users receiving therapy, and in control team 2 there were 3.4% of service users.

The therapists in the study were those clinicians who had already been trained at either level 2 or level 3 in at least one talking therapy. Their level of competency and expertise was determined by an interview with the manager and principal psychologist (see under “Identification of therapist competencies” below).

Research Design

The pilot study involved two teams of therapists delivering psychological therapies

from the adult community mental health service: The experimental group of therapists, Team 1; and the control group of therapists, Team 2. The two comparison groups were evenly matched for analysis. Training was provided to Team 1 on the stepped care model by the principal researchers, Earl and Lye. The training was on the stepped care model for delivery of talking therapies. The purpose of this was to increase the capacity of the existing team to provide therapy by using this different service delivery model. They were also trained in the use of the outcome measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS). Training was given to Team 2 only on the SRS and ORS so they could measure the delivery of therapy as usual, without the use of the stepped care model.

The study period ran from 1 November 2010 to 31 October 2011. Data was collected in a baseline phase from both teams for six months to use as a comparison for the experimental data. At the beginning of month 7 the stepped care model was implemented in Team 1 while Team 2 continued with therapy as usual, with both teams continuing to use the ORS and SRS. The data was compared over the first and second 6-month periods as the implementation was an incremental process over the year. It was analysed to provide the results discussed below (Bunting, 2011). At the end of month 12, a focus group was conducted with six clinicians from the experimental Team 1 to gain qualitative data about the project (Vinsen, 2011).

Process of the Stepped Care Pathway

- 1) Assessment of service user for therapy by multi-disciplinary team (MDT) with team psychologist or senior therapist present.
- 2) Allocation to a level of therapy by MDT in consultation with psychologist or therapist.
- 3) Therapy intervention at level 2 or level 3 (see stepped care diagram Figure 1)

4) Review of therapy progress for service user at week 8 (based on 1 session per week) using therapist assessment of progress and outcome information from the SRS and ORS.

5) Service user remains at same level, or is stepped up or down in therapy level, or discharged from therapy. The decision is made by MDT in consultation with therapist.

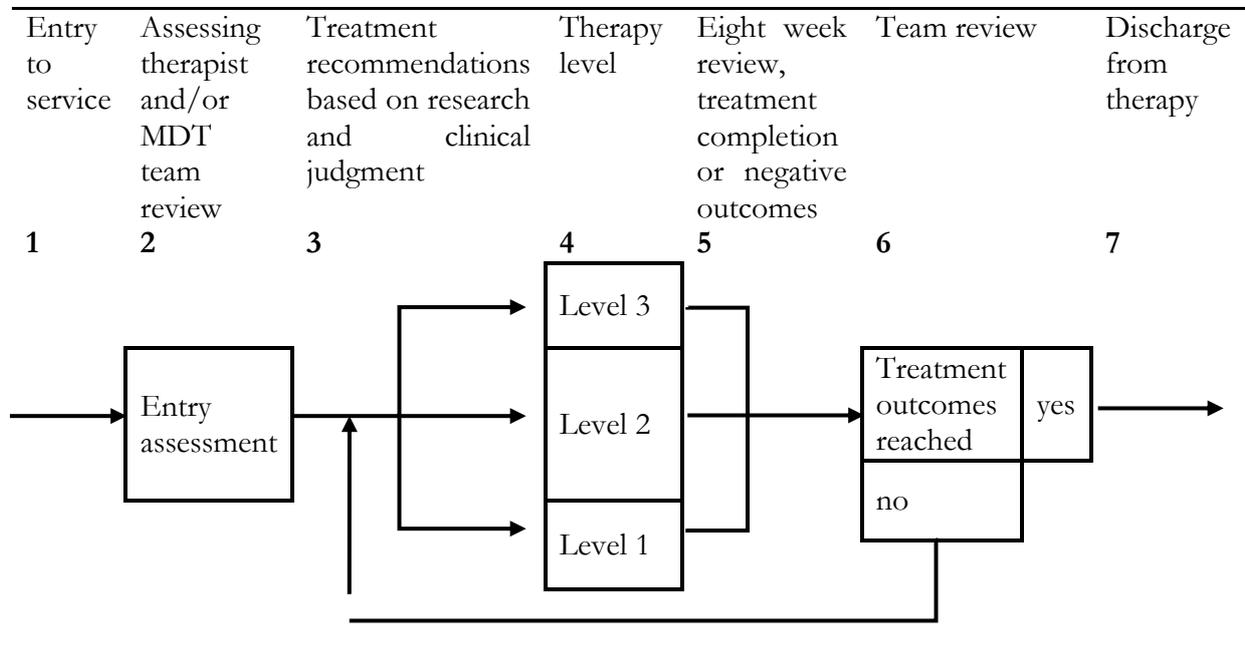


Figure 2. Stepped care pathway for talking therapy.

Identification of Therapist Competencies

Clinicians who were part of the experimental Team 1 were assessed, using a semi structured interview, by a senior therapist and the team manager, and allocated to a level of competency in their practice for each therapy modality, relating to levels 2 and 3 of the stepped care model. Level 1 clinicians were not practicing formal therapy interventions and were not assessed. Competencies were adapted from the IAPT guidelines (IAPT 2007) and the CORE (1999) competencies.

The clinicians were credentialed to provide therapy at either level 2 or 3. Where previously only psychologists and therapists had provided therapy, other clinicians such as nurses, social workers, and occupational therapists could now provide therapy if they had been suitably trained

Training

Clinicians who were recruited to deliver talking therapy were those that had previous training in:

- Level 2: Low-intensity therapies: CBT (cognitive behaviour) skills, DBT (dialectical behaviour) skills, SFT (solution-focused), MI (motivational interviewing).
- Level 3: High-intensity specialist therapies.

Training was given to the experimental Team 1 in the stepped care model and pathway, and how it could increase capacity for providing talking therapies. In both teams, clinicians were trained in the use of the outcome measures. Training sessions (two) were conducted in person to the groups of therapists in the teams, using power point presentation and written material, by the principal researchers Earl and Lye.

Outcome Measures

In order to assess progress in therapy the experimental and control teams were trained in the use of outcomes measures. The SRS (Duncan, et al., 2003) measures the quality of the within session therapeutic alliance between service user and therapist. The ORS (Miller et al., 2003) measures the progress in therapy over time. These are client-driven therapy progress measures that are completed by the service user. Miller and Duncan's research has found that the quality of the therapeutic alliance is one of the best predictors of effective therapy outcomes. It is the rating by the service user, and their feedback about the therapy relationship, that is found to enhance the effectiveness of therapy progress and outcomes.

Results

Focus Group

The focus group was conducted with the therapists in the experimental Team 1 by the AUT student researcher. The main outcomes from the group as documented by

the researcher were that the resources which are available for therapists to apply the model showed to impact on the service user's access to talking therapies. The more resources that were available the greater the ability there was to provide more service user's with therapy. Evaluating the outcome of therapy was considered an important aspect of service user therapy. Team culture seemed to have an overarching effect on all the themes, in that individual's attitudes towards the model influenced the way therapists viewed and adopted the new practices. (Vinsen, 2011)

Comments from the group were also recorded to illustrate the positive experience of the use of the stepped care model for the delivery of talking therapies. "... it was great because way more people were able to receive therapy, at the intensity they needed" (Vinsen, 2011, p.68) "...so this is one of the advantages of stepped care model is that we have ongoing assessment of what is going on." (Vinson, 2011, p.67).

Increased access to Talking Therapy

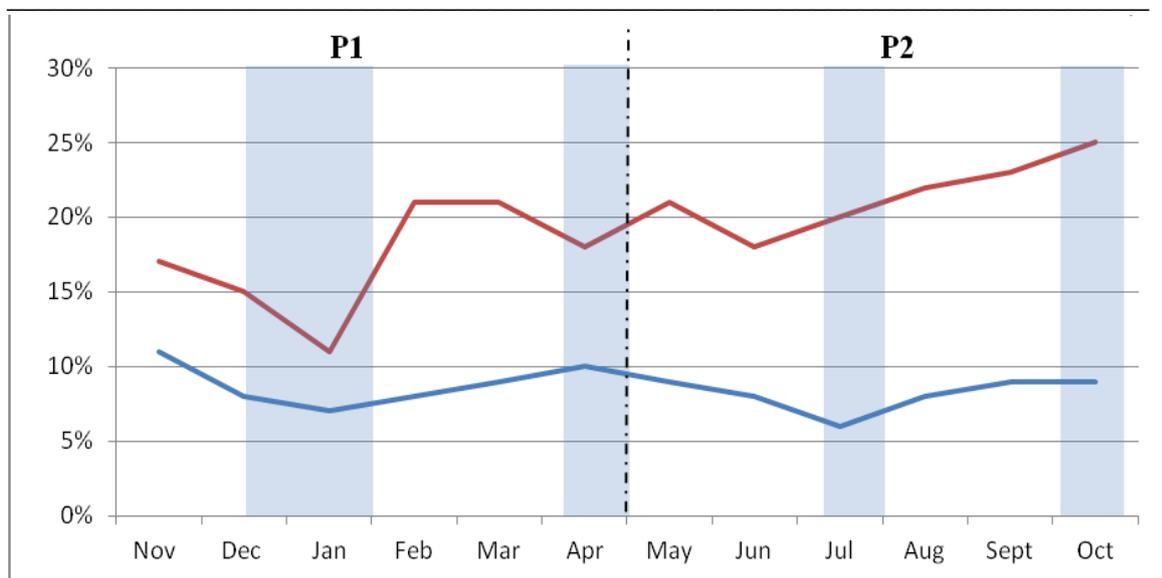


Figure 3. Increased access to therapy: Team 1 experimental is the red line, and Team 2 control is the blue line.

- Talking therapy service users as a percentage of the total number of service users accessing the service are recorded.

- The baseline period P1 was from 1 November 2010 to 30 April 2011. The experimental period P2 is the introduction of stepped care which was incremental from 31 April to 31 October 2011.
 - The intake number of service users in both teams was similar.
 - In the experimental Team 1, there was an increase in the percentage of service users accessing talking therapies under stepped care.
 - In the control team there was no increase in the percentage of service users accessing talking therapy.
- (Note that the light blue columns indicate school holiday periods with drop in service users referred through to therapy intervention.).

Increase in Talking Therapy Contacts

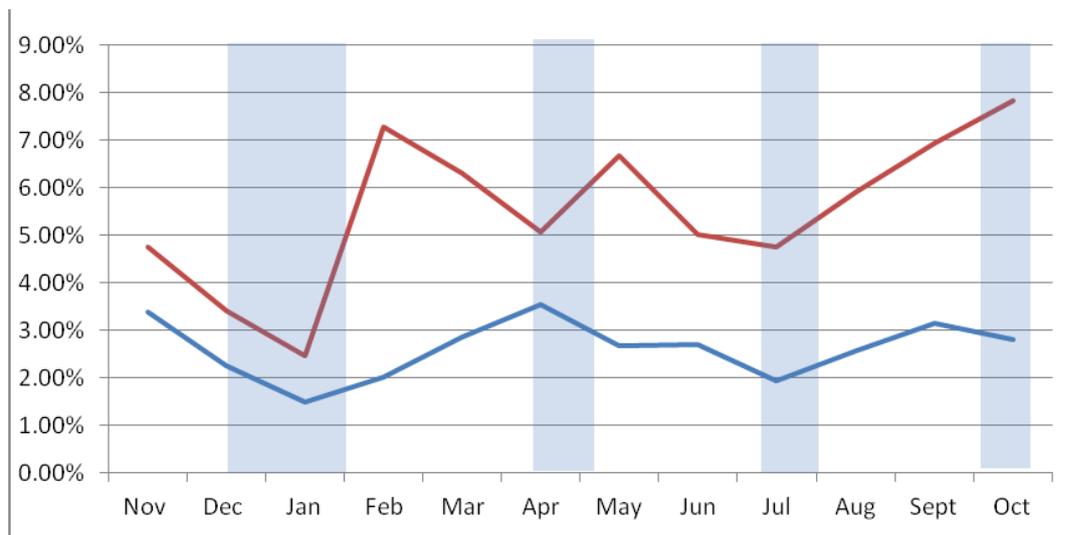


Figure 4. Increase in talking therapy contacts: Team 1 experimental is the red line, and Team 2 control is the blue line.

- The number of talking therapy contacts as a percentage of total contacts increased in the experimental Team 1 from 31 April to October 31.
- There was no significant increase for control Team 2 for this period.
- This indicated an increase in the number to talking therapy sessions provided by clinicians.
- No extra “talking therapy” clinicians were employed over this time.

Therapy Effectiveness Increased

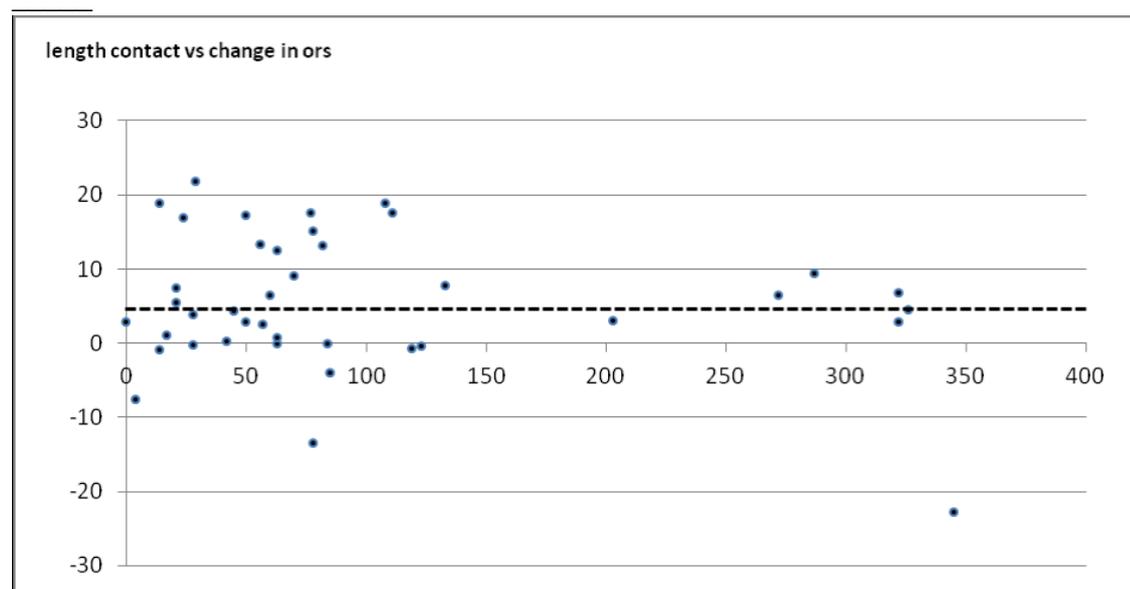


Figure 5. ORS scores over time in Experimental Team 1. Vertical axis = ORS score. Horizontal axis = days in therapy.

- Each dot represents a service user in experimental Team 1. Therapy sessions were given at one session per week. The increase (or decrease) in scores between start and completion of therapy for a service user was recorded.
- Above the zero line indicates positive change.
- Above the dotted line indicates significant change of 5 points or more on the ORS.
- Therapy was shown to be effective at 8-10 weeks, equal to 8-10 sessions, which is 56 to 70 days on the graph.
- There was a total of 40 service user's data recorded. Of those 30 service users who made gains in therapy, 18 recorded positive change at completion of therapy at 10 sessions or under. Of these, 10 made significant gain. An increased duration spent in therapy did not always result in improved outcome.
- Of a total of 40 services users, three made no change and seven made negative changes. A review at eight weeks captures those not making progress, indicating that a change to therapy is needed.
- Data collection was not able to gain information as to what percentage of service users were stepped up a level in therapy.

Discussion

The stepped care pathway enhanced the provision of talking therapies in the adult mental health service. It enabled an increase in service users accessing therapy, and also enabled earlier referral and intervention with therapy. This supports best practice recommendations for treatment of many disorders. The service user had appropriate access to the level of intervention needed

and the type of therapy needed. The model increased the efficiency with which the service user moved through the service. It therefore could be seen to increase productivity of the service, in meeting the increased demand for therapy.

Enhanced provision of talking therapy was likely due to more service users being referred through to therapy and earlier, due

to clinicians being aware of a clear clinical therapy pathway in place. Using a pathway also made movement through the service more efficient. With a review point at eight weeks/sessions, service users were not delayed or lost in the system. The service also had more therapy resource to offer, more clinicians from professions other than psychologists and psychotherapists were enabled to provide therapy, specifically at level 2 low-intensity therapy in a stepped care model. Over the time of the study no new therapist clinicians were employed.

The service users themselves will gain from ongoing review of therapy. The use of the SRS enabled the therapist to adjust the therapy relationship. To ensure that the intervention was what the service user needed and wanted, they gave feedback to the therapist regarding the therapy session. Research has found that the quality of the therapeutic alliance is one of the best predictors of effective therapy outcomes, if rated by the service user, and feedback is likely to enhance the effectiveness of therapy (Miller et al., 2006; Lambert, 2001). A review at eight sessions aims to ensure that the therapy is effective for them. If no progress has been made, the therapist and team can explore why not and change the level and type of evidence-based therapy intervention. The right evidence-based therapy at the right time and at the right intensity is sought for that service user. Historically therapy practice has not been consistently assessed on a routine basis. For the system to be self-correcting the service needs to have agreed outcomes for the service user against which to measure health gain or improvement. The actual extent to which movement between the levels occurred was not able to be assessed in this pilot study, but it is an integral part of the stepped care model.

Many clinicians had training in a talking therapy but could not practice therapy, and others were keen to be trained. This can be facilitated by service planning to determine capability and capacity of therapy service

provision. A review of the service user population and disorders will determine the need for therapies in that service area. Strengths and gaps in therapy resources and service provision can be assessed through a team skill mix review, which will determine training needs to fill the gaps. Providing more therapy showed that an increase in workforce was not needed, but rather, diversity and flexibility of clinician's roles and practice were promoted. Implementation of an effective stepped care model for the delivery of talking therapies requires comprehensive service planning, which is based on service user needs and wants, and the provision of talking therapies by a skilled workforce.

From this study the conclusions of the research project therefore recommended that this stepped care model for the delivery of talking therapies be rolled out to other WDHB adult mental health services.

Issues Arising

There were significant issues arising that need to be addressed in order to enhance change, and maximize the gain from using a stepped care model for the delivery of talking therapies. The change indicated is one of moving from a long term therapy intervention, to shorter term strategic and specialist therapy interventions. Facilitation of easy access to and from a service can allow the service user to be discharged earlier, but then return for a top up of therapy if required. To achieve this, systems changes may be necessary within the wider service to implement the model. Changes to practice have both positive and challenging aspects, so provision of support to clinicians through management, and supervision is required.

The study found that the following tools are desirable to support the implementation of the model. A toolkit would include:

- Stepped care pathway that is “crisp” and adhered to in order to gain the most effectiveness.

- “Stock take” measure to determine the current therapy skill mix in a team, gaps, and needs for training in therapies.
- Guidelines for allocation to a therapy level, review of therapy progress, and criteria for changing levels.
- Selected training in evidence-based therapies, and resources to support this.
- Supervision resources and time, to ensure that practice is supported.
- Competencies for practicing at each therapy mode, and at each level of stepped care.
- A consistently used outcome measure to demonstrate progress such as the ORS and SRS that captures the service user’s perspective on treatment.
- A review process, to ensure therapy progress is discussed and changes made where appropriate for the service user; and preferably implemented reliably at an eight-session interval.

Recommendations to generally enhance the future development of talking therapies in a mental health service may also include:

- A flexible workforce to embrace change to enhance therapy service provision.
- Determination of what it will look like for clinicians to work at the “top of their scope”, and robust discussion about the balance of generic (such as key working) and intervention-specific work.
- Better inclusion of e-therapies in therapy provision, particularly outside the standard working week.
- Closer collaboration around the impact of coexisting problems specifically addictions and physical health, on therapy treatment planning.
- Better use of clinical pathways in talking therapies, and their wider application, such as with sensory modulation
- Sensitivity to cultural and spiritual needs, and its implications for talking therapy delivery.
- Closer integration with primary care to promote a collaborative approach:

For example, a stepped care pathway across all five steps; including clear treatment recommendations; and use of the same outcomes evaluation tools.

In summary, the health sector is functioning in a time when mental health services are expected to meet an increase in mental health issues in our population; but do this with limited resources. The stepped care model has been shown to assist by increasing access to psychological therapies for service users. It also improved the efficiency of therapy delivery, and increased the effectiveness of talking therapy intervention with the service user. Keeping the service user needs and choice at the heart of mental health service delivery was the starting point of this project, and as such, needs to remain the focus of mental health intervention in talking therapies to provide the most benefit to their recovery, wellness and resilience.

Te Pou will soon be publishing guidance and tools to support the implementation of programmes in services, for the delivery of Talking Therapies in a Stepped Care model. Please refer to Te Pou Talking Therapies web page at - www.tepou.nz/improving-services/talking-therapies

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