



Research report

Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study

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ABSTRACT

Introduction: Worldwide, health systems are improving access to empirically supported psychological therapies for anxiety and depression. Evaluations of this effort are limited by the cross sectional nature of studies, short implementation periods, poor data completeness rates and lack of clinically significant and reliable change metrics.

Objective: Assess the impact of implementing stepped care empirically supported psychological therapies by measuring the prospective outcomes of patients referred over a two year period to one Improving Access to Psychological Therapies service in the UK.

Method: We collected demographic, therapeutic and outcome data on depression (PHQ-9) and anxiety (GAD-7) from 7859 consecutive patients for 24 months between 1st July 2006 and 31st August 2008, following up these patients for a further one year.

Results: 4183 patients (53%) received two or more treatment sessions. Uncontrolled effect size for depression was 1.07 (95% CI: 0.88 to 1.29) and for anxiety was 1.04 (0.88 to 1.23). 55.4% of treated patients met reliable improvement or reliable and clinically significant change criteria for depression, 54.7% for anxiety. Patients received a mean of 5.5 sessions over 3.5 h, mainly low-intensity CBT and phone based case management. Attrition was high with 47% of referrals either not attending for an assessment or receiving an assessment only.

Conclusions: Recovery rates for patients receiving stepped care empirically supported treatments for anxiety and depression in routine practice are 40 to 46%. Only half of all patients referred go on to receive treatment. Further work is needed to improve routine engagement of patients with anxiety and depression.

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1. Introduction/background

Despite more than fifty years of research into, and development of, effective behavioural and cognitive-behavioural treatments (CBT) for depression and anxiety, the availability of such treatments worldwide remains poor (Andrews and Tolkein II Team, 2006; McManus et al., 2009). Although the evidence in support of CBT as an empirically supported therapy (Chambless

and Hollon, 1998) is strong, trained therapists are in short supply and the organisation of treatments in many countries remains at best *ad hoc*. Recently, established arguments for empirically supported psychological therapy have been strengthened by the increased prominence of the evidence based medicine movement in health care generally (Sackett et al., 1996). The concept that health care should be based on scientific evidence is now mainstream.

In many countries, practice is guided by clinical health care guidance, for example by the APA Task Force on Promotion and Dissemination of Psychological Procedures (1995) and the UK National Institute of Health and Clinical Excellence (NICE). NICE in particular has identified the important role that empirically supported psychological treatments, mainly CBT, should have

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in the treatment of depression (National Institute for Health and Clinical Excellence, 2009) and anxiety disorders (National Institute for Health and Clinical Excellence, 2005a, 2005b, 2007). Once guidance is issued, they highlight the inability of health care providers to deliver the treatments recommended in the guidelines. For example, in the UK, no more than 10% of people with anxiety or depression receive psychological treatments for their problems and only 5% of the total disorder prevalence had access to an evidence-based psychological treatment (McManus et al., 2009). Worldwide the economic burden of this untreated anxiety and depression to economies runs to hundreds of billions of dollars, estimated to be £19 billion in the UK alone (Layard, 2006).

Although increased investment is one solution to the lack of treatment availability, other organisational strategies have been proposed. Foremost amongst these is stepped care (Haaga, 2000), a system of delivering and monitoring treatments so that the most effective yet least resource-intensive treatment is delivered to patients first (Davison, 2000). Stepped care is included in Australian and NICE guidelines (Andrews and Tolkein II Team, 2006; National Institute for Health and Clinical Excellence, 2007, 2009) as the method by which treatments for depression and anxiety, including CBT, should be delivered.

In order to address the severe under-provision of treatments, the UK government has instigated a highly ambitious programme of Improving Access to Psychological Therapies (IAPT) in England by funding the implementation of NICE guidelines for people suffering from depression and anxiety disorders. The IAPT programme aims to address under-provision of these treatments by training 3600 new psychological therapists between 2008–2011 to enable 900,000 more people to access treatment, with half of those engaging in treatment moving to recovery and 25,000 fewer on sick pay and benefits by 2010/11.

However, the successful implementation of results of randomised clinical trials into routine clinical practice is not a foregone conclusion (Bero et al., 1998; Glasgow et al., 2003; NHS Centre for Reviews and Dissemination, 1999). Treatments developed in trials may not translate into situations of contextual heterogeneity (Medical Research Council, 2008). Add to this factor, the nuances of training and delivery of apparently standardised treatments by many hundreds or thousands of individual therapists, and one typically finds far greater variation in outcomes than the original trials results (Lambert et al., 2010). Indeed, although Stewart and Chambless (2009) report that for anxiety disorders, data from routine practice may closely approximate outcomes seen in trials, they call for more observational cohort studies of routine clinical populations, echoing the UK Medical Research Council's (MRC) position that the least well performed element of the research–practice cycle is implementation (Medical Research Council, 2000, 2008). Long-term surveillance is recommended in the form of uncontrolled, longitudinal observational cohort studies to measure the extent to which the effects of treatment evidence gathered in RCTs is effectively translated into routine practice.

Therefore, aside from the evidence marshalled by NICE for the effectiveness of psychological treatments for depression and anxiety, the IAPT has been underpinned by the results of two 'demonstration sites' which acted as pilot test beds

during 2006/7. In one of these sites, psychological therapies were delivered using a stepped care organisational protocol (Richards and Suckling, 2008) whereby the majority of patients received a low-intensity form of CBT such as guided self-help (Gellatly et al., 2007; Hirai and Clum, 2006). This site treated around five times more patients than an alternative where many more patients were allocated to 'high-intensity' i.e. standard face to face, CBT (Clark et al., 2009; Richards and Suckling, 2009), although the focus in the second site included more patients with those anxiety disorders for which there is no good evidence for low-intensity CBT, particularly PTSD. Nonetheless, these results showed that the routine implementation of stepped care psychological therapies, primarily CBT, could deliver recovery rates of 55–56%, broadly in line with that predicted from RCTs of the constituent psychological treatments.

Although this data (Clark et al., 2009; Richards and Suckling, 2009) were a significant advance on other evaluations of routine psychological therapies practice, which have managed to collect data on no more than 33–38% of clinical outcomes for all patients (Stiles et al., 2006, 2008), it was limited by the cross sectional nature of the study. A significant proportion of our patients were still 'in treatment' so that in the stepped care site pre-post outcome data were only available on 46% of the 2795 patients who were assessed during the first year of operation. At that point it was, therefore, unknown as to how many of the patients still 'in the system' would complete treatment and meet criteria for recovery after they ceased contact. It might be the case that a large proportion of those patients completing contact within the first year were more likely to recover, thereby leading to inflated effect sizes. Further, although we were able to report effect sizes and recovery rates, we did not analyse the data using reliable and clinically significant change criteria (Jacobson and Truax, 1991; McMillan et al., 2010). These criteria may be a better representation of patient recovery than other less sophisticated methods which rely on patients falling below a cut point on a clinical outcome measure, no matter what their pre-treatment starting point. Finally, one might also argue that the intense scrutiny placed upon the site during the first year of operation might question the extent to which our previous data could be said to be 'routine'.

To remedy these limitations we conducted a prospective study of all patients entering the pilot site until the point that they exited the system. Our objective was to determine the clinical impact of providing evidence-based psychological treatment in a complete cohort of patients with anxiety and depression treated at the site. This remedies the major limitation in our previous cross-sectional analysis (Richards and Suckling, 2009) in which a large number of patients who had not completed their contacts with the service had unknown outcomes. Our prospective method adopts a procedure analogous to an intention to treat analysis in clinical trials, but for observational data, where rigorous efforts are made to ensure outcomes for all patients are collected. We set a census date three years after the site commenced operations, 12 months after referral data on all patients in our cohort had been logged at the site, to maximise the chances that all patients would have completed contact. We analysed outcome data conventionally as well as

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