

Collaborative care and stepped care: innovations for common mental disorders

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Summary

Mental health problems such as anxiety and depression are highly prevalent and are a major burden on patients, families and health systems. Systems for the care of common mental health problems need to meet a number of aims: to provide rapid access to effective services in a way that is efficient, equitable and responsive to the needs and preferences of patients. A number of different models for the delivery of services for common mental problems have been described, but the current models fail to meet all these aims. Collaborative care and stepped care are innovations that should help to meet the demand for care for common mental disorders.

Competing demands in the management of common mental health problems

The individual and public health burden of mental ill health is dominated by 'common mental health problems' such as depression and anxiety. Prevalence estimates from around the globe suggest that around 16% of the adult population experience depression and anxiety in any one year, with common or 'high prevalence' mental health problems constituting 97% of the total population prevalence (Singleton *et al*, 2001; Andrews & Tolkein II Team, 2006). These problems cause such significant disability (World Health Organization, 2001) that in Australia it is estimated that at least 50% of days lost to disability through all types of mental illness are caused by the experience of depression or anxiety (Andrews *et al*, 2001). Many patients do not present for help; of those who do, as many as 50% will report purely physical symptoms and not be recognised as suffering from anxiety and depression. Even so, somewhere between 1% and 3.5% of the adult population are likely to be diagnosed with a common mental health

problem annually (National Institute for Health and Clinical Excellence, 2004a,b, 2005).

In the UK, the prevalence of these problems and the lack of effective services to deal with them have been blamed for a multi-billion pound cross-subsidy from the welfare budget. It has been estimated that the UK spends £7–£10 billion per year on benefit payments to support people with anxiety and depression through the payment of incapacity benefit to the long-term sick (Centre for Economic Performance, 2006). With more people on incapacity benefits owing to mental illness than unemployment benefit, mental health problems were cited as ‘the biggest causes of misery’ in Britain (Centre for Economic Performance, 2006).

Ameliorating the burden of common mental health problems presents a major challenge for primary care. The challenge is particularly significant because primary care services are expected to meet a number of goals:

- *Access.* Service provision should meet the need for services in the community. The right to obtain treatment should depend on need for services, not ability to pay or geographic location.
- *Effectiveness.* Mental health services should do what they are intended to do: improve health. Health may be defined in terms of health status, or broader definitions may involve wider function and quality of life.
- *Efficiency and equity.* Given that resources for any healthcare system are limited, they should be distributed in such a way as to maximise health gains to society, and should be distributed fairly across the population at large.
- *Patient-centred services.* Although the precise definition of patient-centredness varies, one definition is that patient-centred services are services ‘closely congruent with, and responsive to patients’ wants, needs and preferences’ (Laine & Davidoff, 1996).

Clearly, there are potential tensions between these goals. For example, prioritising access to care may improve equity but compromise efficiency. There may be clashes between patients’ preferences and evidence of effectiveness. Dealing with these multiple, competing demands has been a major challenge for those designing and delivering primary care mental health services.

Models of service delivery for common mental health problems

Clearly, there are many different ways of delivering services for common mental health problems to meet the goals outlined above, and making sense of them is a significant challenge. One method that can help is to describe ‘models’ of services. Models are abstract representations of complex areas, ‘inventions of the human mind to place facts, events and theories in an orderly manner’ (Siegler & Osmond, 1974). In the current context,

models represent broad descriptions of alternative approaches to service delivery, which vary in important ways and have different advantages and disadvantages.

The structure of mental healthcare in primary care is generally understood in terms of the 'pathways to care' model (Goldberg & Huxley, 1980), where accessing mental healthcare involves passing through a series of levels and filters between the community and specialist care (see Table 1.2, p. 10). The pathways model highlights the importance of the primary care professional, whose ability to detect disorder in presenting patients and refer them to specialist care appropriately represent key stages in the pathway.

To meet the needs of patients with common mental health problems, four broad models have been described (Bower & Gilbody, 2005a; see also Box 25.1, p. 368). Although the models differ in important ways, a key issue is the degree to which the primary care professional takes the lead responsibility for the management of common mental health problems. Primary care professionals are at the forefront of care, and services which improve the quality of care at the primary care level have the greatest potential to increase access and equity, because such a large proportion of the population can access primary care with relative ease. The more that a service delivery model requires input from specialist mental health professionals, the more potential there is for problems with access, efficiency and equity, because specialists are relatively rare and expensive and their input cannot be easily made available for all patients.

Two of these models have received significant research attention. The first model (education and training) involves the provision of knowledge and skills concerning mental healthcare to primary care professionals (Kerwick & Jones, 1996). Generally, this has focused on improving recognition of common mental health problems and appropriate prescribing of medication. Training can involve widespread dissemination of guidelines, or more intensive practice-based education seminars (Gilbody *et al*, 2003) (see Chapters 24 and 29).

The second model (psychological therapy referral) is very different. In this model, primary responsibility for the management of the common mental health problems is passed to a psychological therapy practitioner (such as a counsellor or clinical psychologist). The workforce expansion of counsellors in UK primary care in the 1990s was a result of the enthusiastic adoption of this model (Mellor-Clark *et al*, 2001).

How do these models fare in terms of the goals of primary care? The education and training model scores highly on *access*, *efficiency* and *equity*, because changing the behaviour of primary care professionals has the potential to affect *all* patients with common mental health problems in primary care (Bower & Gilbody, 2005a). However, this model scores low on *effectiveness* and *patient-centredness*. Although there is good evidence that medication itself is effective, trials of interventions to change general practitioners' recognition and prescribing behaviour have generally failed (Thompson *et al*, 2000; Gilbody *et al*, 2003). Furthermore, patient attitudes

to medication are often negative (Priest *et al*, 1996; Khan *et al*, 2007), which means that their preferences are not being met.

In contrast, the psychological therapy referral model scores highly on effectiveness and patient-centredness. Psychological therapies such as cognitive-behavioural therapy (CBT) are effective (Churchill *et al*, 2002) and as effective as pharmacological agents in depression (National Institute for Health and Clinical Excellence, 2004b) and recommended over medication in most anxiety disorders (National Institute for Health and Clinical Excellence, 2004a, 2005). There is also evidence that many patients would like at least the choice of 'talking treatments' and a significant proportion have an outright preference for them (Bird, 2006). However, effectiveness and patient-centredness come at a price. The direct healthcare costs associated with employing a psychological therapist are potentially higher than a prescription for medication. Because of the prevalence of common mental health problems and the finite number of psychological therapists, demand far exceeds supply. Between 24% and 40% of people with common mental health problems worldwide receive any kind of treatment for their difficulties (Singleton *et al*, 2001; Andrews & Tolkein II Team, 2006). In the UK, a mere 9% receive any form of talking treatment, of which only 1% receive evidence-supported treatment such as CBT (Singleton *et al*, 2001). Therefore access is poor, efficiency may be compromised and equity is threatened.

This chapter deals with two major innovations that seek to overcome some of the limitations of these models to better fulfil the multiple and competing goals outlined above. These innovations are *collaborative care* and *stepped care*. Both were originally formulated in the USA and have attracted attention worldwide as both the evidence for their effect has accumulated and their inherent good sense has become apparent.

Collaborative care

One way of improving access to care while ensuring quality is through more effective use of specialist expertise to support primary care professionals. Originally, the model adopted to achieve this aim was 'consultation-liaison' (Gask *et al*, 1997; Bower & Gask, 2002). The premise behind consultation-liaison was that closer working between specialists and primary care professionals around the care of individual patients would improve the quality of their care, while ensuring that those benefits flowed through changes in the behaviour of primary care professionals and were thus able to benefit all patients accessing those services. Although used by a small number of enthusiasts (Strathdee & Williams, 1984), the consultation-liaison model was never adopted more widely in any primary healthcare setting internationally. However, consultation-liaison served as the basis for a US development known as 'collaborative care' (Bower & Gask, 2002).

Like consultation–liaison, collaborative care seeks to enhance relationships between primary care professionals and specialist staff. However, collaborative care is based on the principles of chronic disease management, and involves the addition of new staff ('case managers') who work with patients and liaise with primary care professionals and specialists in order to improve the quality of care (Katon *et al*, 2001). Case managers provide support, medication management and brief psychotherapies directly to patients, while liaising with the primary care professional and receiving support from a specialist. Collaborative care may also involve screening, patient education, changes to practice routines and developments in information technology (Gilbody *et al*, 2003).

How does collaborative care meet the goals outlined at the start of the chapter? The model attempts to overcome the lack of effectiveness of training and education by increasing the amount of specialist input to primary care professionals, and by employing case managers to work directly with patients and support practitioners in delivering care (e.g. supporting patients to adhere better with medication). It attempts to provide more patient-centred services, because case managers have a supportive role, and many collaborative care models also include brief psychotherapy. In addition, it attempts to preserve the advantages in terms of access, equity and efficiency by ensuring that this increased input of specialists is delivered as efficiently as possible.

Evidence for the effectiveness of collaborative care

The model has been the subject of a large number of trials. Most were conducted in the USA (many by the Seattle group, led by Wayne Katon) but a number have now been carried out in other countries, such as the UK (Chew-Graham *et al*, 2007; Richards *et al*, 2008) and Chile (Araya *et al*, 2003). These trials have been summarised in a number of systematic reviews, which all agree that the model has shown robust evidence of clinical effectiveness (Badamgarav *et al*, 2003; Gilbody *et al*, 2003; Vergouwen *et al*, 2003; Gilbody *et al*, 2006a; Kates & Mach, 2007; Williams *et al*, 2007). In one of the most recent reviews, 37 randomised studies, with 12 355 patients with depression in primary care, were analysed. Meta-analysis showed that depression outcomes were improved at 6 months and evidence of longer-term benefit was found for up to 5 years (Gilbody *et al*, 2006a). There is evidence that the model is associated with higher costs (Gilbody *et al*, 2006b), however, and it remains to be seen whether the benefits can be delivered effectively *and* efficiently.

Bower *et al* (2006b) explored factors in collaborative care treatments that were directly related to outcomes. Collaborative care models that improved medication compliance were more effective. The background of case managers was also important, with those studies using staff with a mental health background (e.g. psychologists or mental health nurses) more effective than those that used non-specialist staff (e.g. practice

nurses). Also, collaborative care was more effective when case managers were regularly supervised by specialists such as psychiatrists. However, the review did not find that the addition of brief psychotherapy substantially improved outcomes, nor did increased numbers of sessions (Bower *et al*, 2006b), although some individual trials did show benefits from adding brief psychotherapy (Wells *et al*, 2000). The optimal mix of ‘active ingredients’ in a collaborative care model remains of key interest among researchers and practitioners.

Service delivery issues in collaborative care

The key service delivery issues in collaborative care reflect the difficulties of achieving the optimum balance between access, efficiency and equity while delivering effectiveness and patient-centredness. For example, despite the thin evidence that psychological therapy improves outcomes in a collaborative care model, patient preferences for talking treatments (Bird, 2006) render it preferable to include a psychological therapy component within collaborative care. Unfortunately, this may reduce the optimal efficiency of collaborative care, since psychological treatments require both more time and a greater skill in delivery. If case managers are to function only at a basic level – coordinating rather than delivering care – then psychological therapists must be provided within the model, at greater direct cost. Alternatively, training case managers to deliver psychological therapy themselves increases the training costs of these workers.

The finding that scheduled supervision improves patient outcomes requires that case managers and specialists can access the same individual patient record in order to enhance their supervision and consequent decision-making. This is likely to require a shared patient record, something which services may struggle to achieve, particularly where primary care and specialist practitioners are operating different systems. Furthermore, sophisticated decision algorithms may be required to differentiate between patients who are progressing well, those who require additional input and those who can be expected to recover spontaneously. Routinely collected outcome measures, albeit not the only piece of information, are central to such decision-making (Bower *et al*, 2006a). Once again, this is a feature of clinical practice that may be hard to enforce comprehensively to ensure accurate and consistent decision-making.

Stepped care

Whereas the collaborative care model is an attempt to increase the effectiveness and acceptability of the training and education model, stepped care is an attempt to modify the psychological therapy referral model in such a way that the benefits (i.e. effectiveness and patient-centredness) are maintained, while its problems (i.e. access and efficiency) are minimised. Worldwide, guidelines for depression and anxiety recommend that stepped

care should be the mechanism whereby treatments for depression and most anxiety disorders are organised (National Institute for Health and Clinical Excellence, 2004a,b; Andrews & Tolkein II Team, 2006).

Stepped care is based around two fundamental concepts. The first principle is that of 'least burden'. That is, interventions received by a patient should always be those which deliver good outcomes, while burdening the patient and the healthcare system as little as possible (Sobell & Sobell, 2000). Such a principle underpins most other healthcare interventions; for example, a non-invasive diagnostic or therapeutic procedure may be preferred by patients and healthcare providers alike over more invasive alternatives. In the case of common mental health problems, such interventions are often described as 'self-help' or 'minimal interventions' to contrast them with conventional psychological therapy interventions (such as 6- to 12-hour sessions of CBT). 'Minimal interventions' are designed to provide effective care while reducing the need for input from specialist therapists. Interventions without therapist contact (so-called 'pure self-help') are potentially the most efficient and could have the biggest impact on access, but these may not be optimally effective with depressed and anxious patients, who could lack motivation and confidence. Interventions with a small amount of therapist contact beyond an initial assessment are often called guided self-help, and might include supplying an initial therapeutic rationale or ongoing assessment of progress (Newman *et al*, 2003).

Can minimal interventions maintain the effectiveness of psychological therapies while doing so in a manner that is more efficient, thus increasing access and equity? There is a developing evidence base concerning effectiveness (McKendree-Smith *et al*, 2003; Den Boer *et al*, 2004; Anderson *et al*, 2005; Hirai & Clum, 2006; Gellatly *et al*, 2007). Studies reviewed by the National Institute for Health and Clinical Excellence (2004b) for the depression guidelines and other reviews suggest that guided self-help is effective, although there have been difficulties in replicating some of these results in the UK context of the National Health Service (Richards *et al*, 2003; Mead *et al*, 2005; Salkovskis *et al*, 2006).

The second principle is that of 'self-correction' (Newman, 2000). Here, the idea is that if minimal interventions such as guided self-help are not working, there must be a system in place to detect this, which in turn leads to alternative, more intensive treatments being offered (such as conventional psychological therapy). The decision to step up (or otherwise) requires sound information and systems of clinical review which are far from *ad hoc*. Programmed review at clinically relevant intervals requires the regular and systematic collection of outcome measures and clinical information.

In psychological therapies, these two principles are often interpreted as the provision of minimal interventions, such as guided self-help with 'scheduled reviews' of clinical outcomes in place to detect treatment response. Lack of improvement then leads to a 'step up' to more intensive treatment, such as conventional CBT. A narrative review of stepped care

concluded that while such systems offer the potential for greater efficiency, the optimal configuration of system elements is unknown. The authors note that the benefits of stepped care are unlikely to be fully realised if significant resources are expended on complex assessments and if a large proportion of patients are allocated to conventional interventions (Bower & Gilbody, 2005b).

Service delivery issues in stepped care

Although stepped care is of inherently good sense, there is a lack of specific empirical evidence for this system when used with high-prevalence disorders (Andrews & Tolkein II Team, 2006). This causes difficulty when implementing stepped care, since the two principles of least burden and self-correction may be interpreted and implemented in more than one way. If a stepped approach is prioritised, all patients should be offered a minimal intervention as the initial step in a treatment programme. Interventions of greater intensity are reserved for those patients who do not benefit from the initial minimal intervention. In contrast, a stratified approach assesses patients and allocates some to either minimal or conventional interventions. Such allocation requires some judgement to be made as to the likely response patients will make to the treatments available at different steps – so-called ‘aptitude treatment interaction’ (Sobell & Sobell, 2000).

There are advantages and disadvantages to both systems of implementation. A stratified model requires an ability to predict the likely benefit for an individual patient of different types of interventions. While factors such as severity of disorder, chronicity and disability have predictive power at a population level, they are unreliable indicators of individual patient response to treatment. Workers familiar with operating conventional services may err on the side of caution and favour more intensive treatment without attempting to deliver a minimal intervention first. Such a risk-averse approach could negate the potential efficiencies of the system as a whole.

In contrast, a stepped model runs the risk of prolonging waits for higher-intensity treatments by requiring all patients to spend some time first trying a minimal intervention. If patients who would benefit from a more intensive therapy are not recognised, they may be inappropriately treated. Paradoxically, this may inappropriately extend the duration of their contact with services, once again compromising system efficiency. It may even deter some patients from seeking further treatment (through their experience of treatment failure), although some studies suggest that experience of minimal interventions actually whet patients’ appetite for further treatment (MacDonald *et al*, 2007).

The degree of emphasis on stepped or stratified care will have a major influence on system performance. However, whatever the balance between these two approaches, the vital importance accorded to the principle of clinical review cannot be overstated. Unless health and social outcomes

are recorded accurately, regularly and frequently for each patient, stepped care cannot be self-correcting. Despite valiant attempts to set up routine outcome measures as standard in the UK and elsewhere (Barkham *et al*, 1999; Margison *et al*, 2000), outcomes of therapy are often recorded subjectively, irregularly and infrequently. Algorithms which take severity, chronicity and disability into account in a systematic and objective manner are rarely used in clinical decision-making. Furthermore, the availability of different treatments in the stepped care model will affect system performance. There is little point in a review indicating that another treatment is required if this merely leads to a step up to a long wait for such therapy. Stepped care systems need to ensure a smooth transition between steps, so that patient experience is not disjointed.

A UK case study: the Newham and Doncaster demonstration sites

This case study, undertaken in the UK, is a reflection of worldwide concern to improve access to mental health services (Horton, 2007; Thornicroft, 2007) and reduce the disability caused by disorders such as depression and anxiety (Andrews & Titov, 2007). Two clinical 'demonstration sites' were set up to test the hypothesis that investing in psychological therapies will increase patients' well-being and decrease their reliance on state benefits (Layard, 2006). Doncaster chose a model of care which could be broadly categorised as a stepped model and Newham (a London borough) a stratified model. Many operational lessons have been learned through these sites.

In Newham it was found that the allocation model was not able to deliver the volume of psychological therapy anticipated. Newham was heavily resourced, with experienced and highly trained therapists (mostly clinical psychologists) providing conventional psychological therapy and working in a traditional fashion (one-to-one appointments each lasting about 1 hour). Although minimal interventions were available, these were found to be underresourced. As a consequence, within a year of operation, the management in Newham recruited a significant number of workers to deliver minimal interventions at a lower step. In the first year, assessments were conducted by the therapists providing conventional treatments. It was found, though, that when patients were allocated to a minimal intervention after this initial assessment they became dissatisfied. Assessment is itself an engaging experience for patients and they felt let down by the experience of being handed on to another worker whom they might have perceived as being less 'expert'. Therefore, different, less-qualified workers, albeit specifically trained in low-intensity psychological interventions, were directed to undertake the triage function, directing patients to low- or high-intensity steps, with low-intensity treatment being the default preferred option.

In contrast, Doncaster's stepped care model was combined with telephone-based case management inspired by the collaborative care

approach (Richards & Suckling, 2008a,b). Case managers were recruited from community members and educated specifically to support minimal interventions such as computerised CBT and guided self-help, with rigorous and scheduled supervision from mental health specialists. This model was able to deliver the required volume but Doncaster's inability to recruit sufficient conventional therapists limited the ability to deliver a seamless stepped care service. Although less than 5% of patients were 'stepped up', waiting lists still developed at the higher-intensity steps. Importantly, although the proportion of patients receiving conventional treatment was much smaller in Doncaster than in Newham, the overall treatment effect sizes were identical. This was not explained by differences in the initial severity of disorder, which was similar. Although Doncaster treated more recent-onset cases (patients with disorder duration of less than 6 months), outcomes were equivalent for both recent-onset and chronic cases. The two sites were resourced equivalently, but Doncaster treated four times as many patients as Newham in the 1 year of operation. These volumes and outcomes led to the UK Secretary of State for Health announcing an additional £300 million investment for psychological therapy services for 2008–11. This figure represented sufficient funds to treat almost 1 million additional patients with anxiety and depression.

Both demonstration sites found, therefore, that stepped care was more efficient when a greater proportion of patients received minimal interventions. Patient preference could be significantly influenced by the person conducting an initial assessment, but outcomes appeared to be just as good when the default treatment was mainly a minimal intervention, rather than a predominance of conventional psychological therapy. Some of the latter is definitely required, however, and services must be careful to ensure that sufficient is available to prevent waiting lists building up between steps.

In Doncaster, telephone-based collaborative care case management was an effective way of delivering the majority of minimal interventions for both depression and anxiety. While collaborative care is not an essential component of stepped care, it can be used to enhance efficiency (telephone contacts were typically 40–50% shorter than face-to-face appointments) and maintain contact with reluctant attenders for appointments. Providing case managers are adequately trained, providing they receive full case-load supervision from mental health experts and providing evidence-based minimal interventions exist, case managers can support and effectively treat the majority of patients with common mental health problems in stepped care.

Conclusion

Organising and delivering primary care mental health services in a way that meets the goals of access, effectiveness, efficiency and patient-centredness

remains a key challenge for the future. Dissatisfaction with conventional models of delivery has led to the development of innovative new models which may be better suited to meet the multiple goals of primary care mental health. However, delivering these innovations in practice remains a challenge, and researchers and managers are only beginning to develop an understanding of how collaborative care and stepped care can function in routine practice. Future developments may see these two models being integrated further, to provide a more seamless and integrated approach to delivery. The results of ongoing evaluations of these services are eagerly awaited.

Key points

- This chapter describes two innovative models which may significantly improve the quality of services for common mental health problems: collaborative care and stepped care.
- Collaborative care is based on chronic disease management principles, and involves the addition of case managers, who work with patients and primary care and specialist professionals to improve quality of care.
- Stepped care is designed to increase the efficiency of service delivery. In this model, patients initially receive 'self-help' or 'minimal interventions'. Patients are subsequently assessed, and only those patients who fail to benefit are then 'stepped up' to more intensive treatments.
- The evidence base concerning both of these models is accumulating, and case studies of the models in action illustrate important service delivery issues.

Further reading and e-resources

Centre for Economic Performance, <http://cep.lse.ac.uk/research/mentalhealth/default.asp>. This site features influential reports on the economic issues in mental healthcare and the need for investment in psychological therapy.

The chronic care model, http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2. This site describes the model that underlies collaborative care models in mental health

Clinical Research Unit for Anxiety and Depression (CRUFAD), <http://www.crufad.org>. This is a site describing the work of CRUFAD in Australia, including relevant self-help resources.

Improving access to psychological therapies, <http://www.iapt.nhs.uk>. This is a site describing the Improving Access to Psychological Therapies programme in the UK.

Improving access to psychological therapies research project, University of Sheffield, <http://www.iapt.group.shef.ac.uk>. This site describes a project (funded by the UK Service Delivery and Organisation programme) evaluating new models for the delivery of psychological therapy in the UK.

UK Care Services Improvement Partnership, *Primary Care Services for Depression*, <http://kc.csip.org.uk/viewdocument.php?action=viewdox&pid=0&doc=35064&grp=1>. This is a guide that outlines possible stepped care models for depression.

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