Improving Access to Psychological Therapy

Expert Reference Group

Therapy or therapist:
Which or who contributes how much to patient outcome ?

Executive Summary

This paper responds to the three documents produced by CSIP, *Effective Psychological Treatments for Anxiety Disorders: A Report for the Department of Health in support of the submission to the Comprehensive Spending Review; Delivery Options for Evidence based Psychological Treatments: A Report for the Department of Health in support of the submission to the Comprehensive Spending Review;* and, *Cognitive Behavioural Therapy and the Effective Treatment of Depression: Report for the Department of Health in support of the submission to the Comprehensive Spending Review.*

This paper sets out to define **areas of agreement**, comments on the **current IAPT strategy and controversies** that this has raised, and makes **recommendations on an alternative strategy.**

The paper is limited to that part of the IAPT programme which delivers conventional low volume/high intensity brief therapy/counselling of the kind currently provided by about 260 existing primary care psychological therapy services. Our discussion of the relative contributions of therapy and therapist to patient outcome is limited to typical face-to-face service provision averaging a little over 5 x 50 minute sessions, because the evidence to which we refer is derived from that type of service. We recognise that this kind of "conventional" psychological therapy service provision in primary care forms only one, modest component in the overall IAPT programme

Our discussion and proposals do not apply to the very substantial part of the IAPT programme which is concerned with the provision of other new high volume/low intensity interventions as described in the stepped care guidelines and by Pilling & Burbeck (2007). We welcome the introduction of these new forms of intervention/treatment and accept that some of the interventions (such as guided self help or telephone support) are likely to be best supported by some form of written procedure or "manual". Without experience in the delivery of these new kinds of intervention we are not in a position to judge the extent to which the procedures or manuals should be CBT derived (though we would caution that the observations made later about the need to "fit" the patient's characteristics are likely to apply to these newer interventions as much as to existing conventional therapy).

It is our goal to see the existing primary care psychological therapy services built on and integrated into the much more ambitious service provision envisaged in the IAPT programme.

We propose that the IAPT programme should :-

- Acknowledge that a scientific controversy exists regarding the extent to which the form of therapy and the individual therapist effect patient outcome
- Recognise that the controversy is unlikely to be resolved for some years.
- In the light of that controversy, adopt a revised "safe" strategy focused on the employment of therapists with superior outcomes by :-
  - Routinely measuring the outcome for every patient seen by every therapist so that the effectiveness of every therapist can be measured.
  - Steering referrals towards effective therapists
  - Assisting less effective therapists to improve
  - Terminating the employment of low performing therapists who failed to improve to meet minimum standards of effectiveness
- Allow therapists working within the IAPT programme to choose the form(s) of therapy which they practice subject to them providing evidence that they are effective in their delivery of treatment
- Explicitly commit to building on existing primary care psychological therapy services subject to them providing evidence that they are effective in their delivery of treatment

It seems hardly rational for NHS management to lay down guidelines requiring that all psychological therapy services should use an outcome measure with all patients on a routine basis but then to ignore the evidence provided by these outcome measures.

The paper makes recommendations on a way forward that addresses the current research debate, considers the risks of continuing with the proposed strategy and proposes a low risk approach that addresses the mental health needs raised by Layard, while at the same time ensures that the Government does not take a decision that ignores other areas of Government policy and builds on existing psychological therapy services.

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1. Areas of Agreement

We would like to emphasise that we are in agreement with much of the IAPT programme.

- We agree that the prevalence of depression has become a serious problem - for those who suffer from it; for their families and friends; for society which carries a heavy cost both directly in funding treatment and benefits and indirectly in terms of the economic contribution lost when people are too depressed to work.
- We agree that there are large numbers of sufferers from depression who would both prefer and would benefit from "talking treatment" (Lord Layard's analysis suggests 800,000 people per annum requiring treatment and the figures put forward in the Pilling & Burbeck report suggest a still larger number).
- We agree that there is a serious under-provision of psychological therapy services within the NHS. The fact that the average waiting time for primary care psychological therapy is 72 days (Trusler et al. 2006) and for secondary services is commonly 1-2 years are evidence of this under-provision.
- We are supportive of plans to improve the availability of psychological therapy by introducing and expanding the provision of high volume/low intensity interventions within the stepped care model. (Although we disagree with the statement by Clark & Richards that *"The non-CBT treatments that receive support in NICE guidelines have not developed reduced therapy time options".* Most existing primary care psychological therapy services encourage therapists to provide a "single session" when appropriate and increasingly services encourage therapists to terminate therapy ahead of the planned number of sessions when the patient is seen as having recovered).
- We agree with the need to run trials to establish the effectiveness in routine clinical practice of high volume/low intensity stepped care interventions such as bibliotherapy, guided self help, collaborative care using case managers, telephone support, etc.

2. Current IAPT Strategy and areas of concern

As we understand it, one strand of the current IAPT strategy is that the form of therapy offered within the programme should be restricted to solely to CBT. We have been informed by the co-convenor of the Workforce Planning Group that therapists without CBT training will not be eligible for employment within the IAPT programme. The three papers submitted to the January 07 meeting of the ERG (Clark. 2007; Clark & Richards. 2007; Pilling & Burbeck. 2007) all clearly share the common proposition that the form of therapy offered within the IAPT programme will be restricted solely to CBT.

2.1. Key Assumption Underlying the "CBT Only" Strategy

The proposition that only CBT therapy should be offered within the IAPT programme is based on an underlying key assumption that it is primarily the <u>form</u> of therapy (CBT, IPT, psychodynamic, person centered, etc) which primarily determines whether the patient recovers/improves.

It is fairly easy to see how this assumption arose given the obvious parallel between psychological therapy treatment and pharmaceutical treatment particularly given that a high proportion of the therapy trials involved comparing the effectiveness of therapy with medication. In drug treatment trials it is invariably assumed it is the drug not the doctor which is responsible for patient recovery/improvement. As Shapiro & Shapiro (1997) point out, the double–blind design in drug trials reduces the physician's role to an interchangeable constant because they are unaware of whether they are providing a medication or a placebo.

So in designing an RCT for therapy it has been natural to design the trial around therapists selected to conform to uniform criteria who are assumed to contribute nothing to the outcome of treatment other than administering a "pill" in the form of therapeutic treatment which had been reduced to a strict procedure described in a "manual" - what Norcross (2002) describes as *"disembodied therapists performing procedures"*.

2.2 Questioning the Assumption

The assumption that it is the <u>form</u> of treatment which is critical in determining patient outcome began to be questioned in the late 70's, mainly because of the number of RCT's with patients with depressive illness, which seemed to show equivalence of effectiveness between different forms of therapy. This led to a further questioning of what Kiesler described as the 'myth' of therapist uniformity in therapy.

Research has advanced to the point today where a significant proportion of the research community (at least in the US) take the view that, to quote Wampold (2001), *"A preponderance of evidence indicates that there are large therapist effects……and that the effects greatly exceed treatment effects"*.

The evidence for this position is best summarised in :-

- "Psychotherapy Relationships That Work" (Norcross. 2002) which documents the results of a three year study carried out by Division 29 of the American Psychological Association involving over 50 distinguished US researchers in the therapy field
- The Great Psychotherapy Debate: Models, Methods and Findings (Wampold 2001) which deals with the hard statistical evidence derived from meta-analyses of RCT's
- The Heart and Soul of Change: What Works in Therapy (Hubble, Duncan & Miller. 1999).

We will not attempt to re-summarise the evidence here and would rather focus on the naturalistic evidence held within the view that the therapist has more effect on outcome than the therapy. This has been strengthened in recent years by the evidence emerging from large scale routine clinical practice ("naturalistic") databases. The largest of these (we believe currently approaching 100,000 patients) is that created by PacfiCare Behavioural Healthcare in the US. Among the conclusions emerging from analyses of that data are :

"There are large and stable differences in the effectiveness of clinicians and outcomes can be improved by referring patients to effective clinicians" (Brown & Jones. 2005) and

"Behavioural health outcomes for a large system of care could be significantly improved by measuring clinical outcomes and referring patients to therapists with superior outcomes" (Brown, Lambert, Jones & Minami. 2005)

The evidence emerging from the CORE National Research Database (covering 12,000 patients across 34 services and 600 therapists) in this country is similarly that there are very substantial differences between the effectiveness of individual therapists and almost no detectable differences in the effectiveness of different forms of therapy.

Evidence derived from naturalistic databases can, of course, be criticised when compared with the "gold standard" of evidence derived from RCTs because it suffers from attrition, lacks a control group, randomisation, patient homogeneity and rigorous design. However, there are equally questions over the degree to which RCT results transfer to routine clinical practice and as we discuss later the most recent analyses suggest that almost all RCTs have involved too few therapists to reliably distinguish therapist effects from therapy affects.

It's sufficient to say that the evidence so far emerging from the rather few naturalistic databases which have been created to date for very large numbers of patients and therapists points uniformly in the direction of therapist effect being much more important than therapy effects.

2. 3 The Scientific Controversy

The situation today is therefore that we face a scientific controversy which is not actually discussed in Clark (2007), Clark & Richards (2007) or Pilling & Burbeck (2007). On the one side there are experts who conclude that it is the effectiveness of the particular form of therapy which largely determines patient outcome. On the other side there are the experts who conclude that it is the effectiveness of the therapist which largely determines patient outcome.

Scientific controversy is no bad thing – indeed it is the hall mark of a healthy science which is making progress – but how and when might this particular controversy be resolved? And how does it affect the choice of an IAPT strategy whilst it is unresolved?

2.4 How the Controversy Arises

The controversy stems from :-

- The first group of researchers assume that the performance of therapists is uniform in carrying out their statistical analyses of individual RCT's.

  The results of the analyses are open to question because the assumption that the performance of therapists is uniform means that treatment effects are over-estimated - because the expected variance among treatments also contains the expected variance among therapists (Wampold & Serlin. 2000; Kenny & Judd. 1986; Kirk. 1995; Serlin et al. 2003).

- The second group of researchers assume that variance in outcome might be due to either therapist or therapy in carrying out statistical meta-analyses of multiple RCT's.

  The results of the meta-analyses are open to question because, as Elkin et al (2006a) point out, there are limitations in them due to the small numbers of therapists involved, therapist rated measures were sometimes used to rate outcome, there was sometimes a failure to test for therapist effects and treatment was sometimes not included as a variable in the analysis of therapist effects.

It is clear that the scientific controversy will only be resolved by adopting more sophisticated methods of statistical analysis (notably multi-level modelling) which explicitly recognise that variance in outcome may be due to either therapy or therapist or an interaction of the two.

3. Recommendations

We have proposed three main recommendations, the first of which looks at multi-level modelling and is designed to address the concerns raised within the current research debate; the second area considers the risks involved in the current IAPT strategy, and the final area makes recommendations on an alternative strategy.

3.1 Addressing the concerns of the current research debate

3.1.1 Multilevel modelling

To get some idea of how multi-level modelling might resolve the controversy it is instructive to look at the recent retrospective analyses of one of the largest scale RCTs carried out in the US (the National Institute of Mental Health Treatment of Depression Collaborative Research Program or TDCRP).

Briefly, the original analyses of the TRCRP data – which assumed uniformity in effectiveness between therapists - concluded that there was little or no difference in effectiveness between the two forms of therapy (CBT and Interpersonal Therapy) which had formed the therapy arms of the trial.

In the retrospective re-analyses, as summarised by Hill (2006), two groups of researchers independently carried out multi-level modelling (or hierarchical linear modelling) analyses of the data, two experts were asked to comment on the results and then the original researchers were asked to respond.

One group of researchers (Elkin et al. 2006a) concluded that there was no evidence of therapist effect on outcome.

The other group of researchers (Kim et al 2006) found that about 8% of the variance in outcomes was attributable to the therapist (out of a total of 13% attributable to no-patient variables) and 0% was attributable to form of treatment.

In the discussion of this intriguing result by Soldz (2006), Crits-Christoph & Gallop (2006), Elkin et al (2006b) and Wampold & Bolt (2006) two themes emerge.

3.1.2 Learning to Build a Robust Model

The first theme, is succinctly stated by Soldz (2006) - *"the difference in results between the two studies resides in the choice of model".* Both groups provide rational explanations for the assumptions made in constructing their model but we are left with the problem that their respective models fall short of de Leeuw's criterion, quoted by Soldz, that *"a good, robust statistical model should…..when doing different analyses and using different assumptions come to similar conclusions".*

As Soldz points out, psychotherapy research has largely avoided the complexities of statistical modelling and he goes on to comment that *"use of data analytic techniques such as multilevel models requires us to understand a range of issues of which most of us psychotherapy researchers have remained blissfully unaware".* (The range of references quoted by Soldz in this context illustrates how much further ahead econometric modelling is in dealing with the complexities of statistical modelling).

It seems likely that it will take some years for psychotherapy researchers to gain both the required level of expertise in multi-level modelling and to produce generally agreed models which meet the criteria for robustness and which allow an answer to be given on the relative contribution of therapy or therapist to patient outcome.

3.1.3 The Need for Much Larger Databases

The second theme emerging from the discussion is that all the four groups of experts involved were in agreement that the TDCRP dataset, despite being one of the larger psychotherapy RCT research datasets ever collected (with 205 patients seen by 17 therapists) was too small to adequately support multi-level analysis. As Soldz points out *"In using a small number of therapists and a smaller number of patients per therapist, the analyses….violated the recommendations of many authors on multilevel analysis regarding minimal sample size …..These recommendations suggest for a two-level model a minimum of 30 groups; some suggest 30 observations per group".* This would suggest that to run a minimal (2 level) multi-level analysis capable of reliably identifying therapist effects versus therapy effects would actually require a minimum of 900 patients spread evenly across 30 therapists.

The upshot of this is that everyone involved agreed that the controversy would not be resolved until much larger databases are available for analysis :-

Elkin et al *"we will probably learn more about the presence of therapist effects, and be better able to demonstrate the significance of these effects, by carrying out studies of large data bases, collected for example, in the context of managed care or other large practice networks. In these settings, there would*

be access to large numbers of therapists and relatively large numbers of patients per therapist. Significant variability among therapists is also more likely to be found in usual practice (ie not using manualised treatments nor carefully selected therapist samples)"

Crits-Christoph & Gallop *"the question of the impact of the therapist on outcome is better evaluated in the context of naturalistic studies rather than manual-based trials".*

Soldz *"progress in this area will require large datasets with many hundreds if not thousands of cases such as those available to managed care companies, state mental health and substance abuse systems and those engaged in developing or implementing outcomes monitoring systems".*

With this level of unanimity it seems clear the controversy over whether it is the therapy or the therapist that largely contributes to patient outcome will not be resolved until datasets are available for analysis which cover much larger numbers of both therapists and patients than have been seen in any RCT to date. It seems very unlikely that the necessary funding to carry out RCT's on this scale will be made available whether in this country or the US.

As a consequence, the controversy looks likely to be resolved by carrying out multi-level analyses on large naturalistic databases (of the type built by PacifiCare in the US or CORE in this country) which contain very large numbers of patients and therapists.

The use of naturalistic data to carry out the multi-level analyses required to establish the extent to which therapy and therapist contribute to patient outcome will raise all the problems of attrition, spontaneous recovery rates, lack of a control, non-randomisation, non-homogeneity of patients, issues which Stiles et al (2006) raise in the discussion of their results. Not all of these problems can be overcome because of the nature of naturalistic data. Thus a final resolution to the controversy seems likely only when a number of independent multi-level analyses have been carried out several naturalistic databases – and then only if the conclusions of those analyses converge.

The CORE user network are anticipating that the CORE National Research Database is likely to approach 100,000 patients in Spring 2007. We are less clear over the extent to which analyses of US databases will be published because there are hints that the insurance companies and HMO's are increasingly seeing the information as proprietary. We believe it likely that there will be a move towards building one or more large databases in Holland in 2007 because of changes to the legislation concerning re-imbursement of therapist fees.

3.2 Risks of the current IAPT strategy

The current IAPT programme accepts the view of those experts who consider that it is the <u>therapy</u> which largely determines patient outcome and that CBT is superior to all other forms of treatment.

The strategy is fairly high risk for a number of reasons :-

- On the basis of the National Primary Care Research & Development Centre's 2001 tracker survey we estimate that there are about 260 existing primary care psychological therapy services employing between 3,500 and 5000 staff. A survey of a sample of those services suggests that in total they provide treatment to about 250,000 patients per year. The best evidence that we have (Mullin et al 2006), based on 34 services and almost 12,000 patients, indicates that 72% of patients treated by these services achieve reliable improvement and 55% achieve full recovery.

  Less than half of the staff are CBT trained and the services do not meet the current IAPT criteria that they should offer only CBT. Thus in all probability all the existing services would be closed down and replaced by new IAPT services. (In principle, an existing primary care psychological therapy service could run in parallel alongside an IAPT within a PCT. But the IAPT proposes a single consolidated service approach, the CSIP "Improving Primary Care Mental Health Services" guidelines adopt a similar mantra and the budgetary problems common to most PCT's are bound to influence them against what might seem to be duplicated services). It seems inevitable that the asset of these existing services, successfully treating 250,000 patients pa, would be thrown away.

- Over half of the 3,500 to 5,000 staff in existing primary care psychological therapy services will either have to be re-trained in CBT – at a cost of several million pounds or they will be made redundant (again at a cost of some millions).

- There is an existing pool of perhaps another 20,000 trained and experienced therapist/counsellors who are not currently working in the NHS, only a small percentage of whom are CBT trained. In expanding the IAPT workforce this pool cannot be drawn on without investing some millions in training them in CBT.

- The closing down of existing primary care psychological therapy services (for which we already have some evidence) accompanied by creation of new services based on high volume/low intensity treatments will make it hard to avoid the IAPT programme being seen

as replacing existing (successful) services with lower cost (unproven) services using less skilled and experienced staff. Rather than expanding the provision of psychological therapy the image of the IAPT programme may become one of simple cost cutting in existing services.

- If the scientific controversy finally settles in favour of the form of therapy contributing little to patient outcome then the existing primary care psychological therapy services will have been replaced – at considerable cost – by services which actually deliver lower levels of successfully treated patients.
- A "CBT only" policy will drive the NHS towards a therapeutic mono-culture. If the scientific controversy finally settles in favour of the form of therapy contributing little to patient outcome then a large number of successful therapists will have been lost and we will have lost the variety in therapeutic training which has contributed towards the development of successful therapists.
- Very few 3rd sector providers exist who can provide a "CBT only" service so that the goals set out in the "Our Health, Our Care, Our Say" White Paper will be impossible to meet in this service sector.

Possibly the most important impact however lies in the loss a crucial kind of patient choice, because whilst patients will have a greater choice in the sense of being offered a wider range of high volume/low intensity treatments, the only form of treatment offered will be CBT.

Repeated surveys have shown that the majority of therapists have completed two or more kinds of training and describe themselves as eclectic or integrative. The competent therapist chooses a form of therapy(s) from their repertoire which best fits the patient - as Frank & Frank (1991) put it *"therapists should select for each patient the therapy that accords with the patient's personal characteristics and view of the problem".* Or as Norcross (2002) puts it *"As every clinician knows, different types of patients respond better to different types of treatment and relationships. Different folks do require different strokes. A clinician will strive to offer or select a therapy that fits the patient's personal characteristics, proclivities and world views – in addition to suiting the diagnosis".* Each of the 600 therapists in the CORE National Research Database, for example, will generally choose from a range of therapies in which they are competent and will invariably combine 2 or 3 therapies in order to best fit the specific patient.

The provision of therapy in solely one form – CBT – will rob the therapist of the ability to choose a form(s) of therapy which best fits the patient characteristics and the loss of patient choice will become only too real.

3.3 An Alternative IAPT Strategy

An alternative strategy for the IAPT programme would recognise that a scientific controversy exists and take a low risk approach by delaying any final commitment to one view or the other until it is resolved.

It would not exclude CBT but would allow therapists to choose the form(s) of therapy which they practice subject to them providing evidence that they are effective in their delivery of treatment. It would explicitly build on existing primary care psychological therapy services provided that they could produce evidence demonstrating their effectiveness.

It would focus on the employment of therapists with superior outcomes by :-

- Routinely measuring the outcome for every patient, seen by every therapist, so that the effectiveness of every therapist can be measured.
- Steering referrals towards effective therapists
- Assisting less effective therapists to improve
- Terminating the employment of low performing therapists who failed to improve to meet minimum standards of effectiveness

The policies described above have already been adopted by many primary care psychological therapy services who are using the CORE System. The risk in this approach is low because if it emerged in (1) that therapists practicing CBT were consistently the most effective then services would steadily shift towards becoming largely or wholly CBT services.

The existing primary care psychological therapy services could be built on (subject to them providing evidence that they are effective in their delivery of treatment) rather than being replaced, and the overall numbers of staff needing to be recruited and trained would be reduced by 3,500 – 5,000. The existing pool of 20,000 trained and experienced counsellors/therapists could be drawn on without investment in additional training and most importantly, patient choice will be maintained.

3.3.1 Adopting Both Strategies Simultaneously

It might be argued that it would be possible to get the best of both worlds by training up all staff within the IAPT programme in CBT and focusing on the employment of therapists with superior outcomes by :-

- Routinely measuring the outcome for every patient, seen by every therapist, so that the effectiveness of every therapist can be measured - as recommended by Clark & Richards (2007)
- Steering referrals towards effective therapists
- Assisting less effective therapists to improve
- Terminating the employment of low performing therapists who failed to improve to meet minimum standards of effectiveness

This strategy would still mean that :-

- In all probability all the existing primary care psychological therapy services would be closed down and replaced by new IAPT services. The asset of those existing services, successfully treating 250,000 patients pa, would be thrown away.
- Over half of the 3,500 to 5,000 staff in existing primary care psychological therapy services will either have to be re-trained in CBT – at a cost of several million pounds or they will be made redundant (again at a cost of some millions).
- The pool of 20,000 trained and experienced therapist/counsellors would not be drawn on without investing some millions in training them in CBT.
- If the scientific controversy finally settles in favour of the form of therapy contributing little to patient outcome then the existing primary care psychological therapy services will have been replaced – at considerable cost – by services which actually deliver lower levels of successfully treated patients.
- A "CBT only" policy will drive the NHS towards a therapeutic mono-culture. If the scientific controversy finally settles in favour of the form of therapy contributing little to patient outcome then a large number of successful therapists will have been lost and we will have lost the variety in therapeutic training which has contributed towards the development of successful therapists.
- Very few 3rd sector providers exist who can provide a "CBT only" service so that the goals set out in the "Our Health, Our Care, Our Say" White Paper will be impossible to meet in this service sector.

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