Institution: University of Exeter

Unit of Assessment: UoA2 Public Health, Health Services and Primary Care

Title of case study: Improving Treatment Delivery for Depression

1. Summary of the impact (indicative maximum 100 words)

Depression is a major public health problem, producing substantial deterioration in health and well-being and costing the UK £billions annually. A programme of research at Exeter, led by Professor Richards, (trials and Phase IV implementation studies) has changed national policy on the treatment of depression (NICE guidelines). It has also underpinned the UK's Improving Access to Psychological Therapies (IAPT) programme which has been widely implemented, leading to new treatment for over 1 million people, with a recovery rate in excess of 45%, and over 45,000 people coming off sick pay and benefits. The research has also achieved International impact.

2. Underpinning research (indicative maximum 500 words)

As a frequent, recurrent condition, depression is a major public health problem causing reduced health and well-being and significant disability (and described by the WHO as a leading cause of disability in 2000), with large economic costs through lost productivity and health and welfare costs. A priority for the NHS and health systems internationally is maximizing the accessibility of evidence-based therapies and developing more effective treatment delivery models. Because of the limited availability of treatment for many depressed patients Richards' work (Professor of Health Services Research, Exeter, appointed 2008) has been to improve the evidence for and the accessibility of low-cost, evidence-based treatments. He and his team have also provided leadership in translational implementation programmes from this research, to train the next generation of NHS clinicians.

His studies have provided one crucial element of the empirical rationale for the £700m expansion of Improving Access to Psychological Therapies (IAPT) services throughout England. He developed the 'low-intensity' clinical methods and collaborative care organisational structures in a trial of collaborative care (Richards et al, 2008[1]) and then implemented these clinical and organisational procedures in one of the IAPT pilot sites (Clark et al, 2009; Richards and Suckling, 2009; Richards and Borglin, 2011 [2,3,4]). Data from 7859 consecutive patients treated by this service over two years demonstrated that combining low- and high-intensity treatments maximised treatment volumes whilst maintaining good clinical outcomes (Richards and Borglin, 2011[4]). Subsequently, he has led one of the largest trials (MRC/NIHR-EME) of collaborative care internationally (CADET), to directly address a NICE 2009 Depression Guideline research priority to improve depression treatment (Richards et al, 2013[5]). Results have removed the uncertainty about the effectiveness of Collaborative Care for depression in the UK, in that collaborative care had persistent positive effects, was cost effective within the NICE affordability threshold, and patients were more satisfied than in usual care.

Addressing a further NICE research recommendation, Richards is leading an on-going large-scale NIHR-HTA trial (COBRA) which is examining whether a simpler treatment – behavioural activation (Ekers et al, 2011[6]) – is as efficacious as CBT but potentially cheaper and more accessible through delivery by less expensive health-care professionals.

Externally funded grant support related to reported research

A Trial Platform of Enhanced Care for Depression in Primary Care. MRC £164,849. Chief Investigator Richards. With Bower, Gilbody, Lovell, Gask, Torgersen, Barkham and Rogers. ID: TP139 G0300677; start date 1st July 2004.

CADET: Multi-centre Randomised Controlled Trial of Collaborative Care for Depression. Medical Research Council. £2,287,916. Chief Investigator Richards. With Chew-Graham, Manning,

Kessler, Cape, Bower, Gilbody, Pilling, Lewis, Bland, Lovell, Gask, Barkham, Araya. Start date 1st September 2008.

COBRA: Cost and Outcome of BehaviouRal Activation: a Randomised Controlled Trial of Behavioural Activation versus Cognitive Behaviour Therapy for Depression. £1.9m. Chief Investigator Richards. With Gilbody, Kuyken, Taylor, O'Neill, Byford, Watkins, Wright, Ekers, McMillan, O'Mahen, Farrand. Four years. Start date: April 2012

3. References to the research (indicative maximum of six references)

Evidence for the quality of the research is apparent from the fact that each of the six references that follow is published is a high quality peer-review journal:

1. Clark, D.M., Layard, R., Smithies, R., Richards, D.A., Suckling, R., and Wright, B. (2009). Improving access to psychological therapy: initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47, 910-920.
2. Richards, D.A. and Suckling, R. (2009) Improving Access to Psychological Therapies (IAPT): Phase IV Prospective Cohort Study. *British Journal of Clinical Psychology,* 48, 377–396
3. Richards, D.A., & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study. *Journal of Affective Disorders, 133*, 51-60.
4. Richards D et al (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster-randomised controlled trial; BMJ, 347:f4913
5. Ekers, D., Richards, D.A., McMillan, D., Bland, J.M. & Gilbody, S. (2011). Behavioural Activation delivered by the non specialist: phase II randomised controlled trial. *British Journal of Psychiatry*, 198: 66-72.
6. Gask, L., Bower, P., Lovell, K., Escott, D., Archer, J., Gilbody, S., Lankshear, A., Simpson, A. & Richards, D.A. (2010). What work has to be done to implement collaborative care for depression? Process evaluation of a trial utilizing the Normalization Process Model. *Implementation Science*, 5, 15.

4. Details of the impact (indicative maximum 750 words)

This research has had a far-reaching and significant impact on the lives of patients with depression. Other beneficiaries include health service commissioners and providers, mental health workers, and the wider populace through the economic benefits of increased productivity and reduced welfare costs (in 2007, depression's total annual costs in England were £7.5 billion, £1.7 billion health service costs, £5.8 billion lost earnings). Reflecting his expertise, Richards was a national advisor to the Department of Health (2008-2011) on the design and implementation of the nationwide IAPT initiative and the underpinning informatics systems.

The results of Richards' research are currently being implemented nationally and internationally, providing more treatment options for patients, and informing service and training provision. The research results provide the empirical bedrock for the low-intensity, high-volume component of the £700m implementation of IAPT services throughout England[1].

The IAPT programme has been described in a *Nature* editorial[2] on 27th September 2012 as "*a world-beating standard thanks to the scale of its implementation and the validation of its treatments by the UK National Institute for Health and Clinical Excellence*" (pp473–474). It continues to receive unanimous cross-parliamentary support in both houses of parliament, for example House of Lords Early Day Motion 1433; 09.02.2011 "*…welcomes the news that 3,660 new psychological therapists, trained under the Improving Access to Psychological Therapies programme, are in place as of January 2011; commends the current Government for its on-going commitment to invest in the IAPT programme; also commends the previous Government for starting the IAPT programme…*". The programme underpins the current coalition government's mental health '*No Health without Mental Health*' and talking therapies strategies.

Key successes of the programme in the first three full financial years from 2008 onwards, as documented by the Department of Health[3], include:

- Over 1 million people entering treatment
- 680,000 people completing treatment
- Recovery rates consistently in excess of 45%; 65% of people significantly improved
- Over 45,000 people moving off sick pay and benefits
- Nearly 4,000 new practitioners trained

The vast majority of these patients receive treatments established and delivered through Richards' research programme. These impressive implementation results have been underpinned by Richards' team in Exeter, and their academic and professional publications. They have created the IAPT para-professional 'Psychological Wellbeing Practitioner' (PWP) role and established it as a core component of the stepped care IAPT treatment delivery method. In addition to trial results, Richards et al's publications include the first major international edited textbook on low-intensity CBT (Bennett-Levy, Richards, Farrand, et al, 2010[4]); the national curriculum for IAPT low-intensity workers (Richards, Farrand and Chellingsworth, 2011[5]), and three sets of educational guidebooks for HEIs, low-intensity Psychological Wellbeing Practitioner (PWP) students and their supervisors (Richards and White 2010; 2009a; 2009b [6,7,8]). These materials are in use throughout the HEI sector and the NHS in England. Richards also worked closely with public and patient involvement representatives in his IAPT national advisor role and advised RETHINK, the national mental health charity, on their ultimately successful tenders for a number of IAPT services in England.

In addition, the recent (2009) NICE guidelines on depression[9] references the work of Richards' group, and particularly notes that the results of the recently published CADET trail (2013) *"should inform further updates of this guideline"*

Richards' research has prompted interventions to be implemented internationally: For example, he is an advisor to the 'Mindspot' Australian Federal Government service commission won by Macquarie University, Sydney, to implement low-intensity CBT throughout all states in Australia; he is also advisor to 'Beyond Blue' the national Australian Depression Initiative[10]. (Letters of engagement available for both examples).

5. Sources to corroborate the impact (indicative maximum of 10 references)

1. Department of Health (2011). *Talking Therapies: a four year plan of action*. London: Department of Health.
2. Editorial (2012). Therapy deficit: studies to enhance psychological treatments are scandalously under-supported. *Nature*, 489, 473–474 (27 September 2012)
3. Department of Health (2012). *IAPT three-year report. The first million patients.* London, Department of Health.
4. Bennett-Levy, J., Richards, D.A., Farrand, P., Christensen, H., Griffiths, K., Kavanagh, D., Klein, B., Lau, M., Proudfoot, J., White, J. and Williams, C. eds. (2010). *The Oxford Guide to Low Intensity CBT Interventions.* Oxford, Oxford University Press.
5. Richards, DA, Farrand, P, Chellingsworth, M (2011). *National curriculum for the education of psychological wellbeing practitioners (PWPs) (second edition, updated and revised, March 2011)*. Department of Health, London
6. Richards, D. and Whyte, M. (2010a). *Reach Out: National Programme Supervisor Materials to Support the Delivery of Training for Practitioners Delivering Low Intensity Interventions.* London: Rethink
7. Richards, D. and Whyte, M. (2009a). *Reach Out: National Programme Student Materials to Support the Delivery of Training for Practitioners Delivering Low Intensity Interventions 2nd Edition.* London: Rethink
8. Richards, D. and Whyte, M. (2009b). *Reach Out: National Programme Educator Materials to Support the Delivery of Training for Practitioners Delivering Low Intensity Interventions 2nd Edition.* London: Rethink
9. NICE Depression Guideline Group (2007-9) [CG90 Depression in adults: full guidance:

http://www.nice.org.uk/nicemedia/live/12329/45896/45896.pdf]
10. “Beyond Blue”, Melbourne Australia. Letter of Engagement, June 2013.