Institution: The University of Manchester

Unit of Assessment: 3

Title of case study:
Increasing access to low intensity psychological intervention. (*ICS-09*)

1. Summary of the impact

Depression and anxiety are common, cause significant disability and are costly to the individual, the NHS and wider society. UK management of depression and anxiety has been revolutionised as a result of our research at the University of Manchester (UoM) on low intensity psychological interventions (cognitive behaviour therapy (CBT) based Guided Self-Help (GSH)) which is the primary form of care for hundreds of thousands of people with depression and anxiety disorders (including generalised anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder) through the "Improving Access to Psychological Therapies" (IAPT) scheme. Between 2009 and 2012 more than one million people used the new services, recovery rates are in excess of 45% and consequently 45,000 people have moved off benefits.

2. Underpinning research

See section 3 for references [1-6]; see section 5 for corroborating sources (S1-S9); UoM researchers are given in bold. In REF3a and REF5 this case study is referred to as ICS-09.

The impact is based on research that took place at the University of Manchester from 1998-2013.

Key Researchers

- **Karina Lovell** (Lecturer, 1998-2002; Senior Lecturer, 2002-2005; Professor, 2005-date)
- **David Richards** (Research Fellow, 1999-2002; Senior Lecturer, 2002-2004)
- **Penny Bee** (Research Associate, 2002-2007; Research Fellow, 2007-2008; Lecturer 2008-2012; Senior Lecturer 2012-date)
- **Peter Bower** (Research Fellow, 1995-2002; Senior Research Fellow, 2002-2007; Reader, 2007-2012; Professor of Health Services Research, 2012-date)
- **Judith Gellatly** (Research Associate, 2004-date)
- **Anne Rogers** (Senior Research Fellow, 1996-1999; Professorial Fellow, 1999-2012)
- **Chris Roberts** (Senior Research Fellow, 1997; Senior Lecturer, 1997-2004; Professor, 2004-date)

Our research showed that there was an urgent need, due to population demand, to deliver psychological interventions in a more time efficient and accessible manner [1]. In response to this we have developed and evaluated low intensity psychological interventions, namely CBT based Guided Self Help (GSH). We have also developed and evaluated delivery of CBT by telephone, an approach implemented nationally by the "Improving Access to Psychological Therapies" (IAPT) scheme.

We demonstrated that GSH is effective for both depression and anxiety [2]. We developed GSH and demonstrated its benefit in anxiety and depression via case studies, uncontrolled studies and RCTs [3] (**Lovell** et al., *BJGP* 2003 53:133-5, **Mead** et al., *Psychol Med* 2005 35:1-11, **Fletcher** et al., *Behav Cogn Psychoth* 2005 33:319-31). We also showed that guided self-help is acceptable to service users (**Rogers** et al., *Patient Educ Couns* 2004 *53, 41-46*, **MacDonald** et al., *Int J Soc Psychiat* 2007 53:23-35). We have developed culturally-sensitised GSH materials for the older person and black and minority ethnic (BME) groups (Dowrick et al. *Programme Grants Appl Res* 2013; 1(2)).

We demonstrated that the telephone can overcome many of the social, physical and economic barriers which prevent access to mental health services. Our research showed how remotely delivered therapy is effective [4]. We then established the clinical and cost effectiveness of telephone-delivered cognitive behaviour therapy (T-CBT) in a range of service users including

adults and young people with obsessive compulsive disorder (OCD) [5] *(*Turner et al., *Behav Cogn Psychoth* 2012 37:469-74). We showed that T-CBT leads to medium–large effects on clinical and work productivity outcomes (**Bee** et al., *Gen Hosp Psychiat* 2010 32:337-40). We demonstrated the clinical and cost effectiveness of T-CBT with people with chronic pain [6].

3. References to the research

The research has developed as a result of a number of successful, competitively awarded grants, including from the NIHR, MRC and ARC (now AR-UK). The papers are published in leading journals in their respective fields.

Key Publications

1. **Lovell K, Richards D** (2000). Multiple Access Points and Levels of Entry (MAPLE): Ensuring choice, accessibility and equity for CBT Services: *Behavioural and Cognitive Psychotherapy,* 28, 379-391. URL: http://journals.cambridge.org/action/displayFulltext?type=1&fid=63912&jid=BCP&volumeId=28&issueId=04&aid=63911
   Available from UoM on request.

2. **Gellatly J, Bower P**, Hennessy S, **Richards D**, **Lovell K** (2007). What Makes Self Help Interventions Effective in the Management of Depressive Symptoms? Meta-analysis and Meta-regression. *Psychological Medicine* 37, 1217-1228 DOI: 10.1017/S0033291707000062

3. **Lovell K, Bower P, Richards D**, Barkham M, **Sibbald B**, **Roberts *C***, **Davies L**, **Rogers A**, **Gellatly J**, Hennessy S. (2008) Developing Guided Self Help for Depression using the Medical Research Council Complex Interventions Framework: a description of the modelling phase and results of an exploratory randomised controlled trial: *BMC Psychiatry*, 2008, 8, 91 DOI: 10.1186/1471-244X-8-91

4. **Bee P**, **Bower P, Lovell K**, Gilbody S, **Richards D**, **Gask L**, **Roach P.** (2008). Psychotherapy mediated by Remote Communication Technologies: a meta-analytic review: *BMC Psychiatry*, 2008, 8, 60. DOI: 10.1186/1471-244X-8-60

5. **Lovell K**, Cox D, **Haddock G**, Raines D, Garvey R, **Roberts C,** Hadley S. (2006). Telephone Administered Cognitive Behaviour Therapy for Treatment of Obsessive Compulsive Disorder: A randomised controlled non-inferiority trial: *British Medical Journal*, 333, 883 DOI: 10.1136/bmj.38940.355602.80

6. **McBeth J**, Prescott G, Scotland G, **Lovell K**, **Keeley P**, Hannaford P, McNamee P, **Symmons DPM, Woby S**, Gkazinou C, Beasley M, **Macfarlane GJ** (2012). Cognitive Behaviour Therapy, Exercise or Both for Chronic Widespread Pain. *Archives of Internal Medicine*, 2012; 172:48–57. DOI: http://dx.doi.org/10.1001/archinternmed.2011.555

4. Details of the impact

See section 5 for numbered corroborating sources (S1-S9).

<u>Pathways to impact</u>

Our work on developing accessible, acceptable and evidence-based low intensity interventions began in 1998, prior to IAPT, through strong collaborations with researchers at the National Primary Care Research and Development Centre at UoM. We have conducted systematic reviews, uncontrolled studies, RCTs and qualitative work to establish the evidence base and acceptability to both users and those delivering services. We established the first Guided Self Help Clinics across 36 GP practices in a then Primary Care Trust. **Lovell** has trained in excess of 2,000 UK Psychological Well-being Practitioners, Cognitive Behaviour Therapists and other mental health practitioners to deliver GSH both face to face and via the telephone. Once we had shown that low intensity interventions are effective and acceptable to service users we adapted these interventions for 'hard to reach' groups, e.g., BME and older people.

One of our guided self-help books, based on our research, 'A Recovery Programme for Depression' (**Lovell** and **Richards,** London: Rethink Mental Illness 2012) was used as the principal self-help material for the national IAPT NHS demonstration site (Doncaster) and was used by more than 6,000 patients. **Lovell** has led the development of a range of other GSH books for specific difficulties including agoraphobia, OCD, chronic pain, chronic oro-facial pain, irritable bowel syndrome. Our more recent work has focussed on developing and delivering low intensity interventions for people with depression and long term conditions including diabetes, coronary heart disease, chronic widespread pain and chronic oro-facial pain.

Reach and significance of the impact

Impact on practice

The findings of our research on low intensity interventions have been widely implemented and have led to significant benefits for people with common mental health problems. Telephone-delivered psychological interventions have proved a significant benefit for those who are unable (or who prefer not to) attend scheduled face-to-face appointments and we have shown that it is highly cost effective. Our work with BT plc tested the use of telephone-CBT and GSH (**Bee** et al., *Gen Hosp Psychiat* 2010 32:337-40), demonstrating effects on clinical and work productivity outcomes. Based on these findings telephone-CBT and GSH have been implemented across the company (approx. 73,500 employees). Since the inception of the service there have been 1530 referrals, as confirmed by the BT Group Wellbeing Adviser (S1).

Our recovery book 'A Recovery Programme for Depression' is used in IAPT services across the UK and has been endorsed by Rethink (a large national user charity), which has the licence to publish the book on a not-for-profit basis (S2). Between 11,000 and 13,000 manuals are sold each year.

We have recently released the licence for our self-help manual for chronic widespread pain and we have received requests to use the manual from St Bartholomew's Hospital (UK) and the Mayo clinic (US). We have recently given '*beyondblue' (an Australian* national initiative to create a community response to depression) permission to print the materials in Australia for clinical, research and teaching purposes.

A large naturalistic observational study, not involving us but based on our work, of 7 IAPT services which included more than 7,000 patients in the East of England evaluated face-to-face and telephone-based psychological interventions (S3). This evaluation found that the clinical effectiveness of low intensity CBT-based interventions delivered by telephone was as good as face-to-face CBT except for people with more severe illness and cost 36% less per session than face to face CBT. (Hammond GC et al., *PLoS ONE* 2012 7(9): e42916)

In 2002, in partnership with Anxiety UK, a large national user charity which has supported more than a million people with anxiety, we developed and implemented a T-CBT and more recently Skype service for people unable to access face to face therapy. The service has seen a year on year increase in referrals for telephone-CBT and currently receives in excess of 400 referrals per year (S4). **Lovell** has provided written guidelines for telephone-CBT and provided regular training to volunteers and therapists. Anxiety UK also distributes **Lovell**'**s** self-help manuals on agoraphobia and obsessive compulsive disorder freely to their members. Feedback from users has found that these self-help manuals are regularly downloaded from their website and acceptable to members (S5).

Impact on policy

National (UK) policy increasingly advocates the use of the telephone to deliver psychological interventions, based on our work. Our work is cited in the national IAPT National Programme Educator Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions (S6). **Lovell** has also contributed to the national IAPT 'Good practice guidance on the use of self-help materials within IAPT services' (S6).

Lovell and **Bower** were co-investigators in the national external evaluation of IAPT implementation at demonstrator sites, funded by the NIHR Service Delivery and Organisation programme (S7).

Our research has contributed to treatment recommendations influencing current clinical practice in the following NICE guidelines: Post-Traumatic Stress Disorder (CG26); Depression (CG23, update CG90); OCD (CG31) and OCD Evidence Update (2013) (S8).

Lovell has been a member of the NICE guideline development group for both OCD (CG31), which recommend telephone delivered low intensity interventions for OCD, and the updated Anxiety guidelines (CG113) (S9). She developed implementation tools for the clinical case scenarios, the evidence update for generalised anxiety and the NICE pathway for OCD (S9).

5. Sources to corroborate the impact

S1. Corroborating email from BT Group Wellbeing Adviser.
S2. http://www.rethink.org
S3. Corroborating email from Professor of Psychiatry, University of Cambridge.
S4. http://www.anxietyuk.org.uk
S5. Letter from CEO, Anxiety UK.
S6. http://www.iapt.nhs.uk/silo/files/reach-out-educator-manual.pdf
http://www.iapt.nhs.uk/silo/files/good-practice-guidance-on-the-use-of-selfhelp-materials-within-iapt-services.pdf
S7. www.nets.nihr.ac.uk/projects/hsdr/081610154
S8. See:

- www.nice.org.uk/CG26
- www.nice.org.uk/CG23
- www.nice.org.uk/CG90
- www.nice.org.uk/cg031
- www.evidence.nhs.uk/evidence-update-47

S9. See:

- www.nice.org.uk/CG113
- http://guidance.nice.org.uk/CG113/ClinicalScenarios
- www.evidence.nhs.uk/evidence-update-22
- http://pathways.nice.org.uk/pathways/obsessive-compulsive-disorder