

MULTIPLE ACCESS POINTS AND LEVELS OF ENTRY (MAPLE): ENSURING CHOICE, ACCESSIBILITY AND EQUITY FOR CBT SERVICES

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Abstract. Mental health problems contribute 23% to the global burden of disease in developed countries (WHO, 1999). In the U.K., recent legislation attempts to address this by modernizing mental health services so that they provide evidence based, accessible and non-discriminatory services for both serious and common mental health problems. Cognitive behaviour therapy (CBT) has a robust evidence base that fits very well with the thrust of policy. However, CBT's delivery systems are rooted in traditional service models, which pay little attention to the growing evidence base for brief and single-strand treatments over complex or multi-strand interventions. Services characterized by 9-5 working, hourly appointments and face-to-face therapy disenfranchise the majority of people who would benefit from CBT. In this paper we argue that the evidence exists for service protocols that promote equity, accessibility and choice and that CBT services should be organized around multiple levels of entry and service delivery rather than the more usual secondary care referral systems.

Keywords: Cognitive-behaviour therapy, brief treatments, service delivery, mental health, self-treatment.

Introduction

The efficacy of CBT

During the last 40 years behavioural and cognitive psychotherapies (referred to in this article by the common term Cognitive Behavioural Therapy – CBT) have made a huge impact in an increasingly diverse variety of fields, from mental health care and mental health promotion to physical care (Roth & Fonagy, 1996). In the U.K., the recent *National service framework (NSF) for mental health* (DoH, 1999) identifies CBT as a major component of primary and secondary mental health care services and proposes overall national standards guided by 10 principles, including service user involvement and evidence based interventions. CBT's collaborative nature and robust evidence base does at first glance appear to fit in very well with some of the NSF's guiding principles.

The efficacy of CBT and many of its component parts is well established. For example, cognitive and behavioural techniques alone or combined have demonstrated efficacy in the

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treatment of phobic disorders, obsessive-compulsive disorder, post-traumatic stress disorder, generalized anxiety, depression, panic disorder, somatic problems, eating disorders (Marks, 1987; Clark & Fairburn, 1997). More recently, increasingly complex CBT interventions have been developed, with some authors suggesting multi-strand approaches even where a single strand intervention has been shown to be previously effective. For example, a recent paper advocated the use of a CBT intervention for PTSD (Fecteau & Nicki, 1999). Included were a number of procedures i.e., education, relaxation, imaginal exposure, live exposure and cognitive appraisal of the trauma. A further example of a complex treatment for OCD is found in Wells, 1997. In the example treatment outline for OCD Wells argues that “the framework presented here working on the meta-cognitive appraisals and beliefs, and introducing alternative strategies for dealing with intrusions that disconfirm beliefs in thought-action fusion, and positive and negative beliefs about rituals.” (p. 263) In the outline itself a whole range of techniques are suggested, from detached mindfulness, controlled worry periods, verbal attribution, exposure and response prevention, and the modification of beliefs about the rituals.

Although these complex multi-strand treatments are increasingly advocated, we will argue later that there is little evidence that multi-strand therapy produces superior results to a single strand approach (Abramowitz, 1997; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Tarrier et al., 1999).

The demand for CBT

More than 25 years ago it was recognized that demand for CBT was likely to exceed supply. At this time, nurses became the first group outside the medical and psychology professions to receive systematic training in CBT. Fifteen years ago, following a controlled study of nurse therapists in primary care, Isaac Marks estimated that: “about 1800 nurse therapists might meet most needs of primary care patients in the United Kingdom for behavioural psychotherapy” (Marks, 1985, p. 84).

With the expansion of CBT into areas of mental health care other than anxiety disorders this estimation has been revised ever upwards. Goldberg and Gournay (1997) identify a range of disorders (ranging from severe disabling psychotic, depressive and anxiety disorders, through somatized presentations to mild and moderate disorders including disorders of appetite) for which there is fair to good evidence for the efficacy of CBT. Using point prevalence data on these disorders (for example, there are estimated to be 300,000 people with agoraphobia in the British population) and an estimation of the number of therapists currently available, they point to a severe shortfall in the provision of CBT therapists and consequently to the number of patients treated.

Indeed, in comparison to these enormous morbidity levels – running into several hundred thousands of people suffering from most of the major disorders for which CBT has been shown to be effective – there are precious few therapists. For example, the 250 clinically active CBT nurse therapists are unlikely to treat more than 15,000 patients in total annually. Unfortunately, whilst there is no equivalent systematic data on the clinical behaviour of the 3,000 clinical psychologists (although many do not work in routine clinical environments), even if 2,000 clinical psychologists were to complete 50 courses of treatment per year (a very generous assumption), the levels of service delivery would do no more than scratch the surface of the population’s need for CBT. In fact, Gournay (personal communication)

has suggested that the total figure for CBT treatments completed by all qualified therapists is much lower, more likely in the region of 70,000 per year.

With such a huge disparity between need and provision, many services have both lengthy waiting lists and waiting times, with a 6–12 month wait for treatment not unusual. This is, however, only the tip of the iceberg since lengthy waiting lists actually serve as proxies for rationing systems by increasing the reluctance of other health professionals to refer clients to such services. Epidemiological estimates suggest that only a small proportion of people either present for or are referred to traditional treatment services (Goldberg & Gournay, 1997). There is also a huge unmet need in primary care from people with “sub-threshold” anxiety and depressive disorders who might benefit from brief CBT-structured advice and guidance but are not referred to secondary services on the basis of “lack of problem severity”.

The delivery of CBT

The usual method of accessing CBT for clients is based on a traditional delivery system of outpatient appointments. Therapists work from offices and clinics in secondary care or primary care settings. Patients are usually allocated 45–60 minutes per session and receive therapy on a weekly basis for 6–12 sessions in total. Treatment is usually face-to-face, individually based and requires the client to engage in a collaborative therapeutic relationship with the therapist. In order to receive therapy, clients usually have to travel to the therapist’s office and to do so between the hours of 9.00 a.m.–5.00 p.m. To gain access to the therapists’ waiting list in the first place clients will have had to consult either their GP or a secondary mental health care professional.

Although the above may be something of a caricature, and whilst it is true that some examples of self-referral, out of hours, domiciliary, group or self-help services exist, the traditional outpatient model remains the major route of access for most clients into CBT. Unfortunately, this traditional based service is potentially very inefficient for a number of reasons. Three of the most pressing are outlined below.

1. Much time is wasted through clients not attending traditionally structured clinics. DNAs (did not attend) are common in mental health clinics, with up to 25% of clients not attending initial appointments (Zegleman, 1988).
2. The usual session duration between 45–60 minutes for CBT is based on tradition and therapist convenience rather than evidence. We do not know if this is an optimum session’s time for therapeutic efficacy.
3. Studies have also demonstrated a negatively accelerated dose-effect curve for psychological treatments in general (Howard, Kopta, Krause, & Orlinsky, 1986), in part accounted for by the fact that people improve at different rates, with large numbers of people substantially improving in the early stages of therapy. This has also been confirmed by more recent analysis that includes CBT treatments (Barkham et al., 1996). In particular, Barkham et al. (1996) demonstrated that patients improved more quickly when limits on the number of sessions were imposed. Whilst patients who received 16 sessions ultimately improved more than those who received 8 sessions, the difference was small in comparison to the extra effort from both therapist and client.

Table 1. Traditional CBT services and national service framework guiding principles

Services should:	CBT services likely adherence to principle
Involve service users and their carers in planning and delivery of care	Maybe
Deliver high quality treatment and care that is known to be effective and acceptable	Likely
Be well suited to those who use them and non-discriminatory	Maybe
Be accessible so that help can be obtained when and where it is needed	Unlikely
Promote their safety and that of their carers, staff and the wider public	Maybe
Offer choices that promote independence	Unlikely
Be well co-ordinated between all staff and agencies	Unlikely
Deliver continuity of care for as long as this is needed	Unlikely
Empower and support their staff	Likely
Be properly accountable to the public, service users and carers	Maybe

In Table 1 we have mapped “traditional” outpatient, appointment-based and face-to-face CBT service models against the NSF’s 10 guiding principles. We have given each principle a rating of likely/maybe/unlikely which is our estimate of the probability with which traditional CBT service models currently adhere to these principles.

In our view, the traditional CBT service model probably scores only two “likely” ratings (for the evidence base and empowerment of staff), four “maybe” ratings (for service user involvement, suitability of therapy, safety and accountability) and four “unlikely” ratings (for accessibility, choice, co-ordination and continuity of care). Whilst this is our personal opinion, we invite CBT therapists to critically assess their own services against these 10 guiding principles using the same rating scale. This should provide a baseline for measuring the effectiveness of service configuration changes.

Evidence for alternative delivery models

In order to provide CBT services (whether primary or secondary care based) that are not only evidence based but also accessible, innovative and cost effective, the use of alternative treatment delivery models needs to be examined more closely. In particular, providing briefer treatments can lead to overall increases in service delivery and more cost-effective services. The evidence for brief treatments comes from two broad areas: first, those studies that have dismantled particular ingredients of therapies and, second, those that have compared multi-strand or intensive treatment with single strand or brief treatments.

Dismantling studies

A number of studies have attempted to look at the active ingredients of particular CBT therapies. Dismantling studies are used to find out which therapeutic ingredients are important and which are redundant. Some of these studies compare more traditional and arguably simpler behavioural techniques with more complex cognitive techniques. Others compare

complex ‘‘multi-strand’’ treatments, which contain techniques drawn from both behavioural and cognitive models, with simpler ‘‘single-strand’’ treatments drawn from one or other model alone.

Jacobson et al. (1996) conducted an impressive study investigating the elements of CBT for depression. One hundred and fifty outpatients with major depression were randomly allocated to one of three groups, either: (1) Behavioural activation only (BA); (2) Behavioural activation plus activation and modification of dysfunctional thoughts (AT); (3) Cognitive therapy in its complete form with behavioural activation, activation and modification of dysfunctional thoughts plus schema focused work (CT). This study can be seen, therefore, as a comparison between one single-strand treatment and two multi-strand treatments, CT being the most multiply complex experimental condition.

Results found that all three groups improved. Importantly, the CT condition was not superior to either of the other conditions at post-treatment or at 6-month follow-up. Of key importance is that single-strand BA was as effective as the increasingly complex AT and CT conditions in altering negative thinking and dysfunctional attributional style – specific target symptoms for both AT and CT.

Other studies looking at dismantling CBT have also found little superiority for one treatment over another and no superiority for multi-strand over single-strand approaches. For example, in posttraumatic stress disorder no differences emerged between exposure and cognitive therapy (Tarrier et al., 1999). A multi-strand exposure therapy plus cognitive restructuring condition was not superior to either exposure or cognitive treatment delivered as single-strand treatment alone (Marks et al., 1998). In social phobia a meta analysis found that multi-strand CBT was not superior to single-strand exposure alone (Feske & Chambless, 1995). Although a further review claimed that combined CBT for social phobia was superior to exposure alone (Taylor, 1996), this review has been criticized by the Cochrane Collaboration on methodological grounds (Centre for Reviews and Dissemination, 1999).

In agoraphobia, a detailed review (Chambless & Gillis, 1993) found that multi-strand CBT was no more effective than single-strand exposure techniques alone. Furthermore, in a study comparing exposure and cognitive therapy in agoraphobia no difference was found at post-treatment between the two treatments (Bouchard et al., 1996). In a review of the literature by Abramowitz (1997) cognitive therapy and exposure therapy were found to be equally effective in obsessive-compulsive disorder. In the treatment of panic disorder, no differences were found in outcome between interoceptive exposure and cognitive restructuring (Hecker, Fink, Vogeltanz, Thorpe, & Sigmon, 1998).

Increasingly, therefore, studies are suggesting that there is little difference between simpler behavioural and more complex cognitive treatments in a range of disorders. Furthermore, multi-strand treatments seem not to confer any benefit over single-strand treatments.

Efficacy of brief vs. intensive therapy

Studies have also investigated reducing therapist time either by offering brief therapies, such as bibliotherapy, and/or by increasing accessibility through alternative service delivery systems.

There are many examples of uncontrolled work and now some controlled studies, which have compared brief therapist intervention with placebo, no treatment or non-CBT treatment. Self-help reading materials (whose delivery nearly always also includes some reduced ther-

apist assistance) has shown promising results. Such CBT focused bibliotherapy has been examined among a range of mental health problems, for example: chronic fatigue (Chalder, Wallace, & Wessely, 1997), agoraphobia (Matthews, Teasdale, Munby, Johnston, & Shaw, 1977), OCD (Fritzler, Hecker, & Loose, 1997), panic (Gould, Clum, & Shapiro, 1993; Gould & Clum, 1995), binge eating (Carter & Fairburn, 1998), anxiety disorders (White, 1998), specific phobia (Hellstrom & Ost, 1995), depression (Bowman, Scogin, & Brenda, 1996) and recurrent deliberate self-harm (Evans et al., 1999).

Other promising results have been found in both uncontrolled and controlled studies that have investigated alternative access systems in the delivery of treatments and compared them with no treatment or placebo controls. For example, telephone treatment has been shown to be effective for agoraphobia (McNamee, O'Sullivan, Lelliott, & Marks, 1989), OCD (Lovell, Fullalove, Garvey, & Brooker, 2000) and binge eating (Wells, Garvin, Dohm, & Striegel-Moore, 1997). Postal self-help books improved outcomes for nightmares (Burgess, Gill, & Marks, 1998). Computer delivered therapy performed well in phobias (Liness, Kenwright, & Shaw, 1999) and computer conducted telephone treatment was effective in OCD (Bachofen et al., 1999). Another form of delivery that provides an alternative to traditional service models is the use of self-help clinics for anxiety disorders (Liness et al., 1999) or a self-help room for anxiety and depression (Whitfield, Williams, & Shapiro, 1999). Although these remain at the pilot stage, encouraging results have been found.

However, for the relative efficacy of single vs. multi-strand CBT treatments to be determined, systematic studies need to be conducted that compare single-strand or brief treatments with multi-strand or intensive treatments (often traditionally delivered CBT "treatment as usual"). A number of studies have already been conducted (Table 2).

Treasure et al. (1996) compared 110 clients with bulimia nervosa by treating them with either (a) 8 weeks of a self-help manual followed by up to 8 weeks of intensive CBT treatment with a therapist or (b) 16 weeks of intensive therapist based CBT treatment. Results found that both groups improved and no difference was found between groups at post-treatment or at 18-month follow-up. Of the clients in treatment group (a), 35% made sufficient recovery in the self-help phase that they did not need any of the intensive intervention.

In agoraphobia, Ghosh and Marks (1987) randomized 40 clients with agoraphobia to either exposure by a psychiatrist, self-help book or by computer. Results found all groups improved equally at post-treatment and at 6-month follow-up.

In a small randomized study of panic disorder, Newman, Kenardy, Herman and Barr Taylor (1997) found that palmtop computer assisted brief CBT was as effective as a longer intensive CBT treatment. In panic disorder, a recent study by Clark et al. (1999) found a brief five-session programme as effective as an intensive twelve-session CBT treatment programme.

In a large randomized study by Marks, Griest, Baer, Kobak and Hirsch (1999), 200 clients with OCD were allocated to behavioural treatment (exposure and response prevention) delivered by (a) a computerized telephone system or (b) a therapist and compared to (c) relaxation. Results found that exposure and response prevention was superior to relaxation, and that when delivered by therapist was only slightly superior to the computer telephone-conducted delivery. Of particular importance was that effect sizes for both active treatments was similar to that found in meta-analysis for studies with exposure and response prevention

Table 2. Studies comparing single-strand or brief treatments with multi-strand or intensive treatments and the brevity and accessibility of the intervention

Study	Disorder	Brevity	Accessi- bility	Method of delivery	Therapist time	Results
Treasure et al. (1996)	Bulimia nervosa	✓	X	CBT either (a) 8 sessions of self-help followed by 8 therapist sessions (b) 16 sessions of therapist	(a) not available (b) not available	Both groups improved equally at post-treatment and 18 month follow-up
Newman et al. (1997)	Panic disorder	✓	X	CBT either (a) 4 session CBT (computer assisted) (b) 12 sessions	(a) 6 hours (b) 12 hours	Both groups improved but b > to a on some measures post-treatment but equal at follow-up
Clark et al. (1999)	Panic disorder	✓	X	CBT either (a) 12 sessions + 2 booster (b) 5 sessions + 2 booster (c) wait list control	(a) 11.9 hours (b) 6.5 hours	a and b > to c, but equal effectiveness of a and b at post-treatment and at 12 month follow-up
Selmi et al. (1990)	Depression	✓	X	CBT either (a) computer administered (b) therapist administered (c) wait list	(a) 20 mins per week (b) unavailable	a & b > c, but no difference between a & b at post-treatment or at 2 month follow-up
Ghosh & Marks (1987)	Agoraphobia	✓	✓	Exposure by (a) self-help book (b) computer (c) psychiatrist	(a) 1.2 hours (b) 0 hours (c) 3.1 hours	No difference between a, b, or c
Marks et al. (1999)	OCD	✓	✓	(a) exposure and response prevention by computer conducted telephone (b) exposure and response prevention guided by therapist (c) relaxation	Not reported	a & b > to c, b superior to a on patient global improvement and 1 measure on social functioning

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in OCD. Finally, in depression, CBT was found to be equivalently effective whether a computer or a therapist delivered it (Selmi, Klein, Griest, Sorrell, & Erdman, 1990).

There appears, therefore, to be an increasingly persuasive evidence base for brief CBT interventions, accessed through alternative delivery systems, having a powerful effect on a wide range of disorders that traditionally would have been treated using frequent and prolonged therapist-assisted face-to-face sessions.

MAPLE – Multiple Access Points and Levels of Entry for CBT services

Given the literature reviewed above, it can be argued that whilst the clinical elements of CBT are evidence based, the organization of services – characterized by a traditional outpatient, therapist intensive model, delivering multi-strand CBT – is not. As well as clinical protocols, service protocols need to be developed that *routinely* provide client choice in entry levels to CBT. These entry levels should be flexible and therefore accessible to a far more inclusive range of people with both common and serious mental health problems. The very broad range of structured, evidence-based options available through CBT should be organized so that clients can access them in a systematic manner. Clients should neither have to wait for vast lengths of time nor be denied even a referral just because service design pays no attention to the known evidence base on brief therapies and alternative delivery systems. We propose a service model called MAPLE – Multiple Access Points and Levels of Entry, which provides at least three broad levels of entry to CBT.

First, where promising evidence exists, less therapist intensive treatments should be the *first* choice for the majority of clients. In most cases therapy should be routinely initiated by the provision of brief therapies such as self-help materials and guidance – delivered through accessible alternative channels such as bibliotherapy or telephone advice lines. These services should be accessed by potential clients without reference to complex referral systems and artificial gateways. In the U.K., integration of CBT services with *NHS Direct* advice lines could provide a broad entry gate for this level of treatment. Practice nurses in GP surgeries could also deliver assisted self-help packages to many clients. Service user driven self-help groups such as *TOPS (Triumph Over Phobia)* could also deliver this level of treatment.

Second, in circumstances where a patient is deemed to be at serious risk, or for individuals with more complex needs, or for those who have been unsuccessful in following a brief treatment regime, more intensive therapist guided and therapist aided packages of care should be provided. Unless robust evidence (preferably a systematic review or at least one randomized controlled trial of adequate power) shows that multi-strand or complex therapeutic techniques are more effective, these second level packages should be simple or single-strand treatments. Whilst some of these packages may need to be delivered in specialist centres, it is likely that other people, such as primary care counsellors, could be re-trained to deliver such treatments (Goldberg & Gournay, 1997).

Third, therapist assisted multi-strand and/or complex therapies should be used where the previous stages have been unsuccessful or where clients with a previous history of treatment failure present for assistance. Traditional service models may be most suitable for this level of treatment that should in essence be a “treatment failure” service only. Level three should only be utilized where there is clear evidence that clients and service users have been unable to benefit from simple, single-strand treatment packages.

MAPLE and OCD

To illustrate our overall argument, obsessive-compulsive disorder (OCD) will be taken as a case example. The treatment of OCD has advanced over time as CBT researchers and clinicians have learnt from the research findings. This passage over time can be simplified as:

- No known effective treatment
- Hospitalization with therapist aided exposure
- Outpatient treatment with therapist aided exposure
- Outpatient treatment with self-directed exposure

Despite this, when a very useful experts consensus guide on OCD was produced recently (Allen, Docherty, Kahn, & David, 1997), briefer strategies were not mentioned and the guide recommended weekly office appointments of between 13–20 sessions as the appropriate number of CBT sessions for a typical patient with OCD. This expert opinion on the management of OCD seems not to have considered the need to promote appropriately targeted management, including self-help approaches, given the insufficiency of therapy available and the requirement for equitable access in modern mental health services (DoH, 1997). Some of this work has now been undertaken. For example, in the recently reported study described earlier, Marks et al. (1999) found that the treatment effect size of exposure and response prevention delivered by either computer conducted telephone in OCD were similar to that found in meta analysis studies of OCD. Fritzier et al.'s (1997) study found that a third of clients with OCD made clinically significant improvement after using a self-help manual with minimal therapist contact. In another pilot study, Lovell et al. (2000) examined the delivery of exposure by telephone where consecutive cases of OCD from a traditional service waiting list were given a brief assessment, one treatment session explaining the rationale, and then eight weekly telephone appointments of 15 minutes each. Three of the four clients improved at post-treatment and gains were maintained at follow-up.

Of particular note was that all clients requested phone calls between 6–8 p.m. This probably reflects the fact that for those people in paid employment, having access to a service after their working hours was preferable to the disruption caused by taking time off work. For others, not working, the need to disrupt domestic arrangements is no longer present, supporting the frequent pleas from user advocates for services that are more flexible in their hours of operation.

Figure 1 demonstrates how service delivery could be organized with OCD, commencing with self-help via single-strand treatment and only moving to multi-strand treatment in those individuals who fail to improve.

Conclusion

Despite the evidence for clinical effectiveness, on which CBT services score highly, the usual method of delivery both ignores a significant proportion of the evidence base on brief and/or single-strand treatment modalities and pays insufficient attention to important policy developments regarding access, availability and choice of mental health care. Effective and

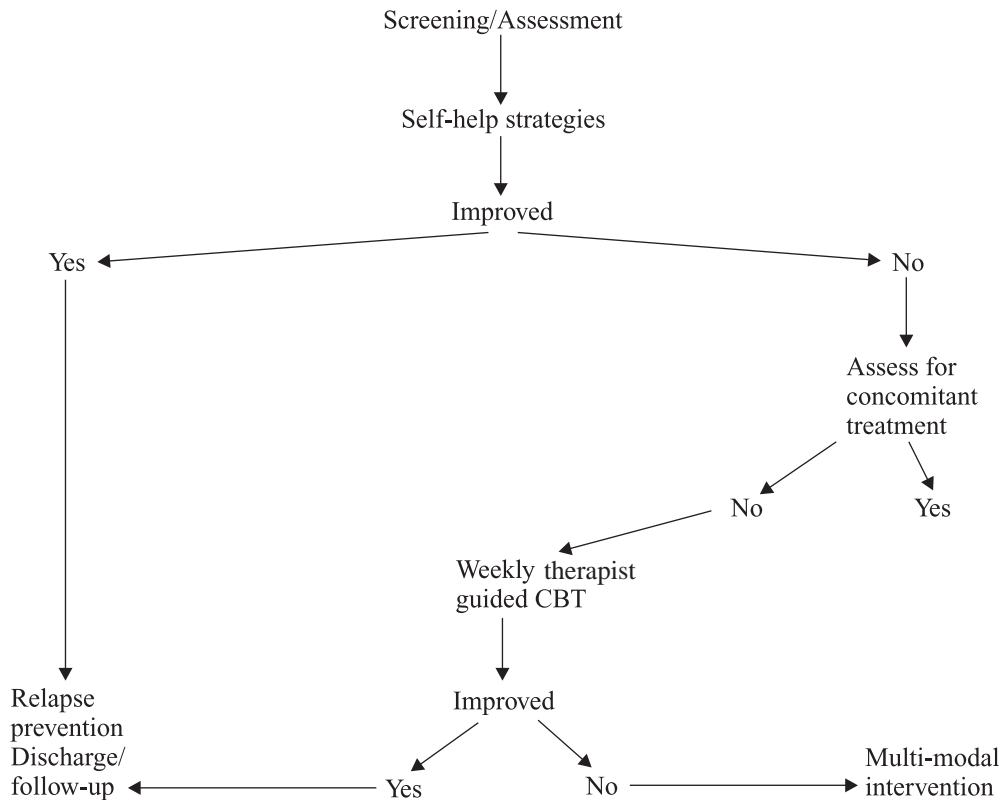


Figure 1. Levels of entry for OCD

equitable CBT treatments can only be delivered if systems are put in place that maximize client access, minimize initial therapist contact and abandon an exclusive reliance on traditional delivery systems.

This can only occur if therapists abandon their current traditional emphasis on 9–5 working, face-to-face sessions, hourly appointments and appointment systems run through outpatient waiting lists. Currently, the entry level to CBT is set far too high; artificial service and referral barriers disenfranchise many people who would clearly benefit from effective therapy.

The evidence is there and so is the challenge. Current policy clearly places CBT at the forefront of modern mental health services, particularly in the U.K. through the reforming zeal of the current government and its publication of *Modernising mental health services* (DoH, 1997) and the *National service framework for mental health* (DoH, 1999). For a movement that prides itself on its scientific credentials and its multi-professional democracy, it is incumbent upon us to turn our service delivery systems into truly accessible, equitable and evidence based operations. The current systems just will not do.

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