Stepped Care in Counseling Centers

Research evidence, legal and ethical issues
Objectives

- Identify 3 advantages of stepped care models.
- Describe legal and ethical concerns unique to delivering tele-behavioral health
- Describe 3 research based conclusions from studies of low intensity treatment models
- Describe 2 research based conclusions from studies of self-help interventions
Stepped vs Stratified treatment

**Stepped care**
- All or most begin at the least intensive level
- Assessment at regular intervals
- Movement up or down in intensity as needed

**Stratified care**
- Initial evaluation determines level of intensity
- Often less frequent movement up or down in intensity
Why stepped care?

• We have a world wide supply and demand problem
• Barriers such as cost, travel, childcare, time off of work prevent people from getting help
• Research evidence indicates stepped care is as effective or more effective than traditional therapy
Current system: scarcity, inequity, inefficiency

Adapted from World Health Organization
Model - Australia

STEPPED CARE MODEL & PRINCIPLES

- **Well Population**: Public information, Self-help strategies
- **At Risk Groups**: Public information, Self-help strategies, Digital mental health services
- **Mild Mental Illness**: Public information, Self-help strategies, Digital mental health services, Peer supports, GPs and allied health services for those who require them
- **Moderate Mental Illness**: Public information, Self-help strategies, Digital mental health services, Peer supports, Face-to-face primary care and clinician-assisted digital mental health, GPs and allied health
- **Severe Mental Illness**: Public information, Self-help strategies, Digital mental health services, Peer supports, Coordinated, multiagency, face-to-face clinical care including GPs, allied health professionals and mental health nurses

Health Promotion, Early Interventions, Low Intensity Services, Face-to-Face Services, Multiagency Care
Model - UK

Step 1: Primary Care / GPs
- Minimal symptoms of anxiety and/or low mood

Step 2: Psychological Wellbeing Practitioners
- Mild to moderate depression
- Mild to moderate anxiety disorders
- Sleep problems
- Social anxiety
- Generalised anxiety
- Panic disorder

Step 3: CBT Therapists / High Intensity Therapists
- Moderate to severe depression / anxiety disorders
- Obsessive compulsive disorder
- Social anxiety
- Specific phobias
- Generalised anxiety
- Panic disorder
- Post traumatic stress disorder

Step 4: Senior CBT Therapists / Counselling Psychologists / EMDR Therapy
- Severe and recurrent depression and anxiety disorders
- Complex trauma
- Personality disorders
- Where previous treatment has not been successful
Countries using stepped-care

- Netherlands
- UK
- Australia
- Canada
- New Zealand
- EU countries
Research on Stepped-Care

- Meta-analysis of RCT’s: stepped care vs. care as usual (CAU), self-help included
- Across studies stepped care had superior outcomes in treating anxiety
- Stepped-care and CAU had equal efficacy in treating depression, yet stepped-care was ½ the cost
- Canadian province implementing stepped-care reduced waiting by 25% in 6 months
Limitations to stepped-care

- No consensus on structure of model, levels, combinations, sequences, number of steps
- Local research needed on the most feasible model for any setting
  - Local needs
  - Local available resources
  - Multicultural factors
  - Criteria for self-correction
Considerations

• Cost effectiveness depends on stepping-up criteria
• Most effective criteria are sensitive enough to detect those who are not responding, yet maximize the proportion in lower intensity treatments
• Must rapidly identify those who need a higher step of care
Designing a Stepped-Care system

• Evidence-based instruments
• Evidence-based treatments
• Multi-culturally sensitive
• Identify intervals for self-correction
• Resources, content, duration, sequence, delivery method
• Evidence of effectiveness for anxiety, depression, substance use, eating disorders
Universities using Stepped-care

- Memorial University, New Foundland 9 steps, both population interventions and UCC steps. Individual therapy reserved for highly motivated and higher acuity
• Walk-in consultation, 9 possible steps
• **Georgia Tech U** 6 steps,
  – Assessment: appropriate vs referral
  – Consultant manages in <3 sessions
  – Self-help
  – Guided self-help
  – Psychoeducational seminars
  – Very brief counseling
Tele-behavioral Health

Rapidly changing acceptance!

- November 2014—36% would consider virtual visits
- May 2015—55% would consider virtual visits

- Satisfaction with virtual visits—85%
- Tele-home health services expected to grow from 12% of the market in 2013 to 55% by 2019.
Ethical issues in online services

Self-help and web resources less of an issue, once you add interaction it becomes a factor to consider

Interactive questionnaire- are they anonymous? Do you know the students’ identities?

With professional interaction
You must consider
risk management
Ethical principles summary

• Clinical Training
• Patient education about the technology
• Informed consent and Legal Issues
• Assessing clients, appropriate screening, cultural issues
• Issues in direct care at a distance
Clinical training

• There are fundamental differences between face-to-face and online therapy.
• We must practice within our area of competence, so training is an ethical mandate.
• Training should include clinical practices online, crisis response, dealing with technology, creating policies and procedures, risk management, privacy and security, legal and jurisdictional issues.
Jurisdictional issues

• Therapy is taking place wherever the client is located
• You are responsible for complying with all laws regulating practice in the client's location.
  – Documentation
  – Abuse reporting
  – Tarasoff
Screening and education

• How are you going to screen clients?
• What cultural issues do you need to consider?
• What criteria will you use to select appropriate clients?
• How will you train clients to use the telehealth tools?
• What procedures are in place if there is a system failure?
Vetting vendors

- HIPAA, HITECH, EU-GDPR
- Encryption
- Do they have evidence of effectiveness?
- Business Associates Agreements?
- Is there a recovery plan if their system fails?
- What about firewalls?
- How do users sign-on? Passwords?
- Where is the data located?
- Who owns the data?
- What about risk management?
Low intensity treatments

• Includes group, self-help, apps
• iCBT most researched, mindfulness, treatments with a strong educational component easiest to adapt: BA, ACT, DBT, CPT
• Many studies, meta-analyses going back to the 90's have found iCBT effective
Evidence of effectiveness

• ICBT vs. Treatment as usual for anxiety—iCBT was superior (Benton, et al, 2016)
• ICBT vs Care as usual, metaanalysis of 20 studies for anxiety and depression, no difference in outcomes. Dropout was slightly lower for iCBT (Carlbring, et al, 2018)
• Meta-analysis of 64 studies, anxiety, depression, panic disorder, social anxiety disorder, iCBT was effective for every disorder
• Effect size of .80 (Cooper and Conklin, 2015)
Cost effectiveness

• Comparison of cost and effectiveness
• ICBT, pharmacological interventions, combined for anxiety
• 42 studies compared
• ICBT was as effective or more effective while also far more cost efficient (Donker et al, 2015)
Self-help vs. supported

- Outcomes consistently somewhat lower for self-help, higher drop-out rates (Carlbring et al 2018)
- Even minimal human guidance of 5 minutes weekly is effective (Carlbring et al, 2018)
- Self-help iCBT can be effective for insomnia, mild anxiety
Problems studied

- Supported ICBT shown to be effective even at 3 year follow-up for (Anderson et al 2017):
  - Social anxiety
  - Depression
  - Co-morbid GAD and MDD
  - OCD
  - Gambling
  - Chronic fatigue
  - Substance use
Tao as example

Four Ways to Deliver TAO Content

1. Individually Assigned by Clinician Enrollment Manager
   - Therapist Assisted

2. For out of jurisdiction students in a continuing therapeutic relationship (Summer break)
   - Internal Self-Help

3. Anonymous Campus Wide Self Help Curated by Groups Manager
   - Self-Enrolled Self-Help

4. Needs based Curated by Groups Manager Can be facilitated by Group Administrator
   - Custom Content Groups
Self-help

• Majority of apps have little or no evidence of efficacy

• Systematic review of 8 studies, compared with waitlist of control group, showed significant decrease in symptoms, only 2 of the products were commercially available (Donker et al, 2013)
Ethical risks with apps

• What data is collected and stored?
• What data is shared and with whom?
• Reliability? Updates?
• Privacy
• Theft of devices
• Evidence of efficacy- studies tend to be small, not randomized, non-controlled
• Many developed by software engineers with no involvement by mh professionals
Self-help can be effective; however supported programs have been consistently more effective. (Lewis et al 2012)

Self-help is more effective with internet self-selected participants than with clinical practice related participants (Coull & Morris 2011)

Adding a single training session or minimal supportive check in improves outcome (King et al, 2017)
Peer supported programs

- Peer supported programs structured with CBT can be effective.
- SAMHSA Core competencies for peer workers in Behavioral Health Services