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

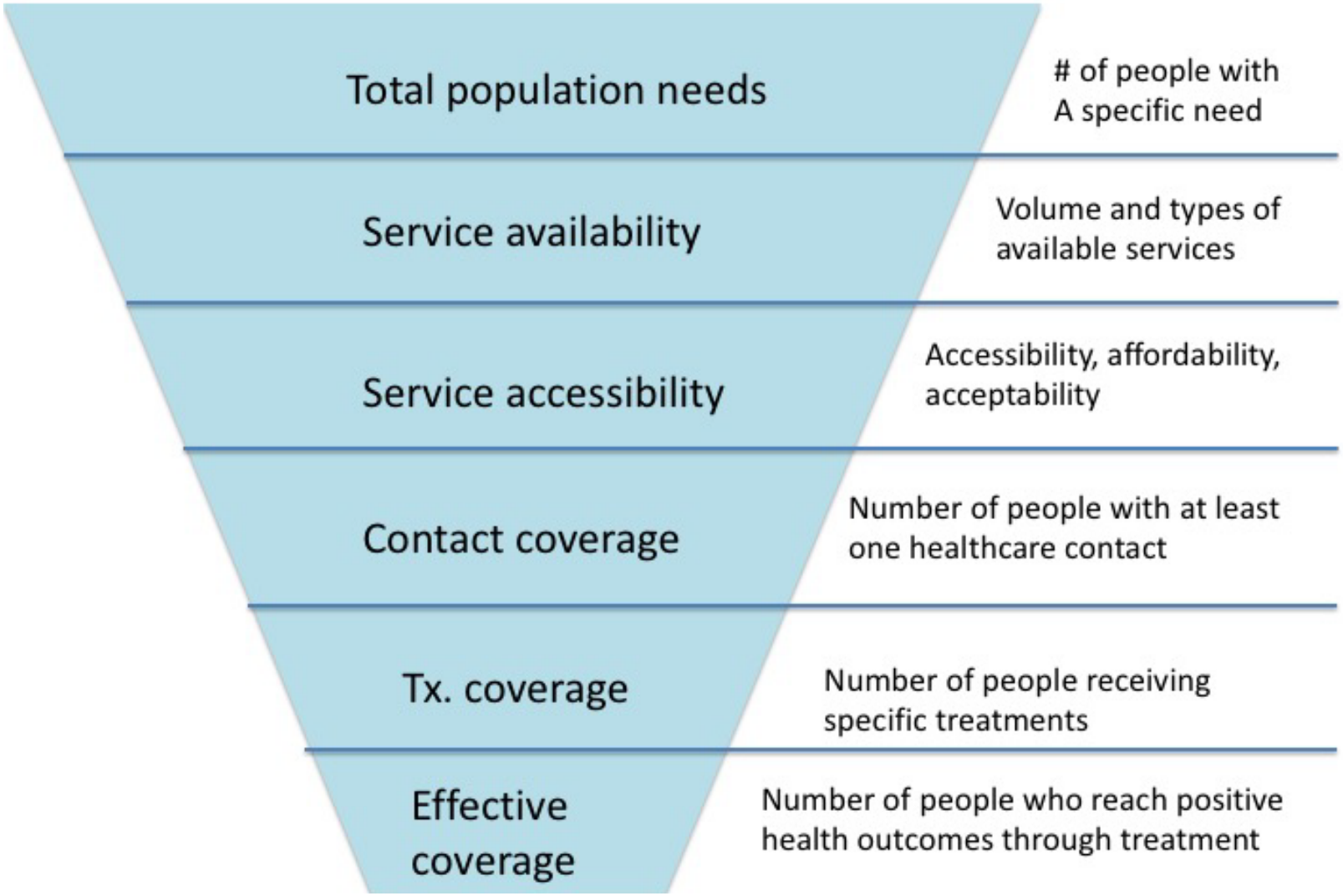
Stepped vs Stratified treatment

- **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?

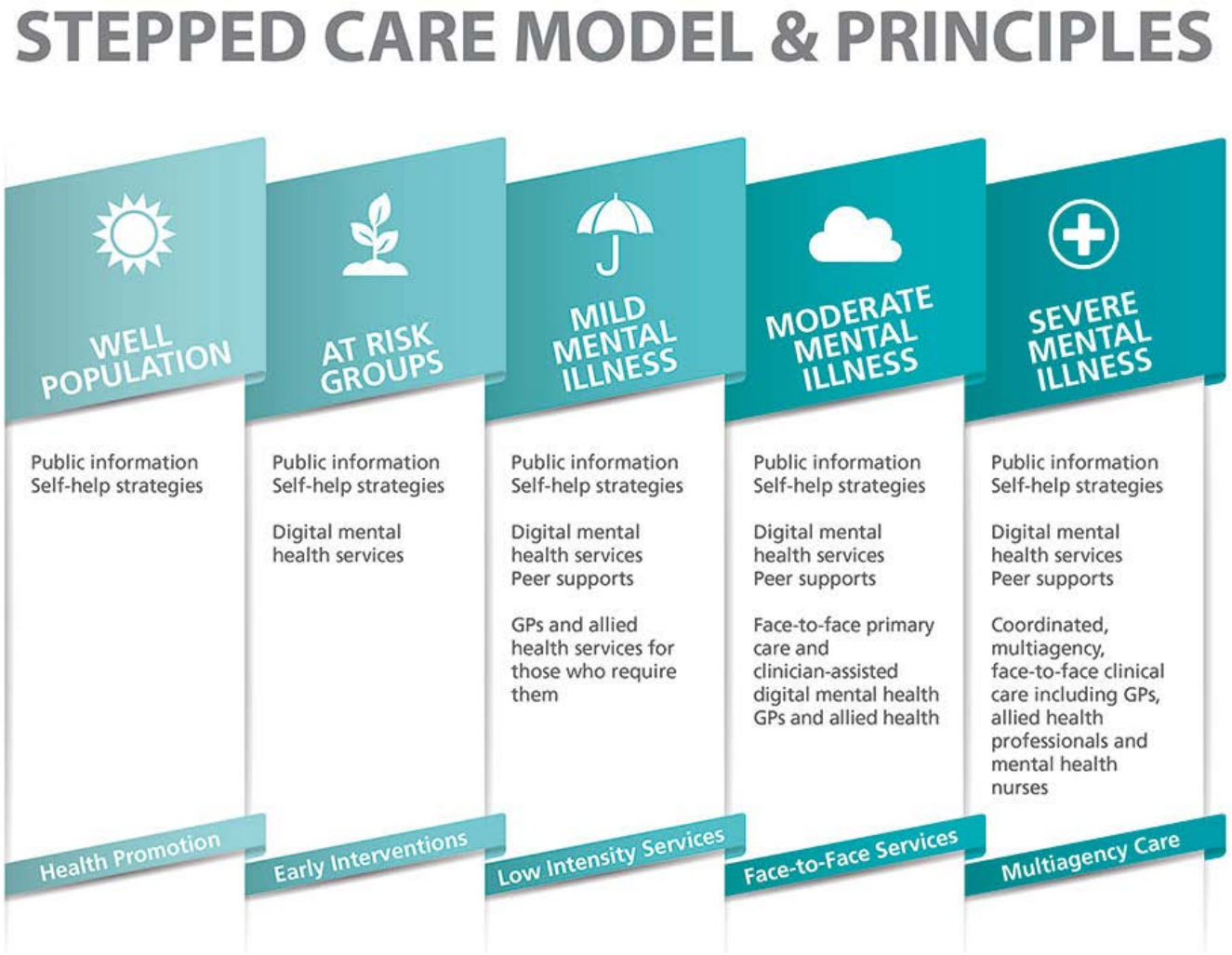
- We have a world wide supply and demand problem
- Barriers such as cost, travel, childcare, time off of work prevent people from getting help
- Research evidence indicates stepped care is as effective or more effective than traditional therapy



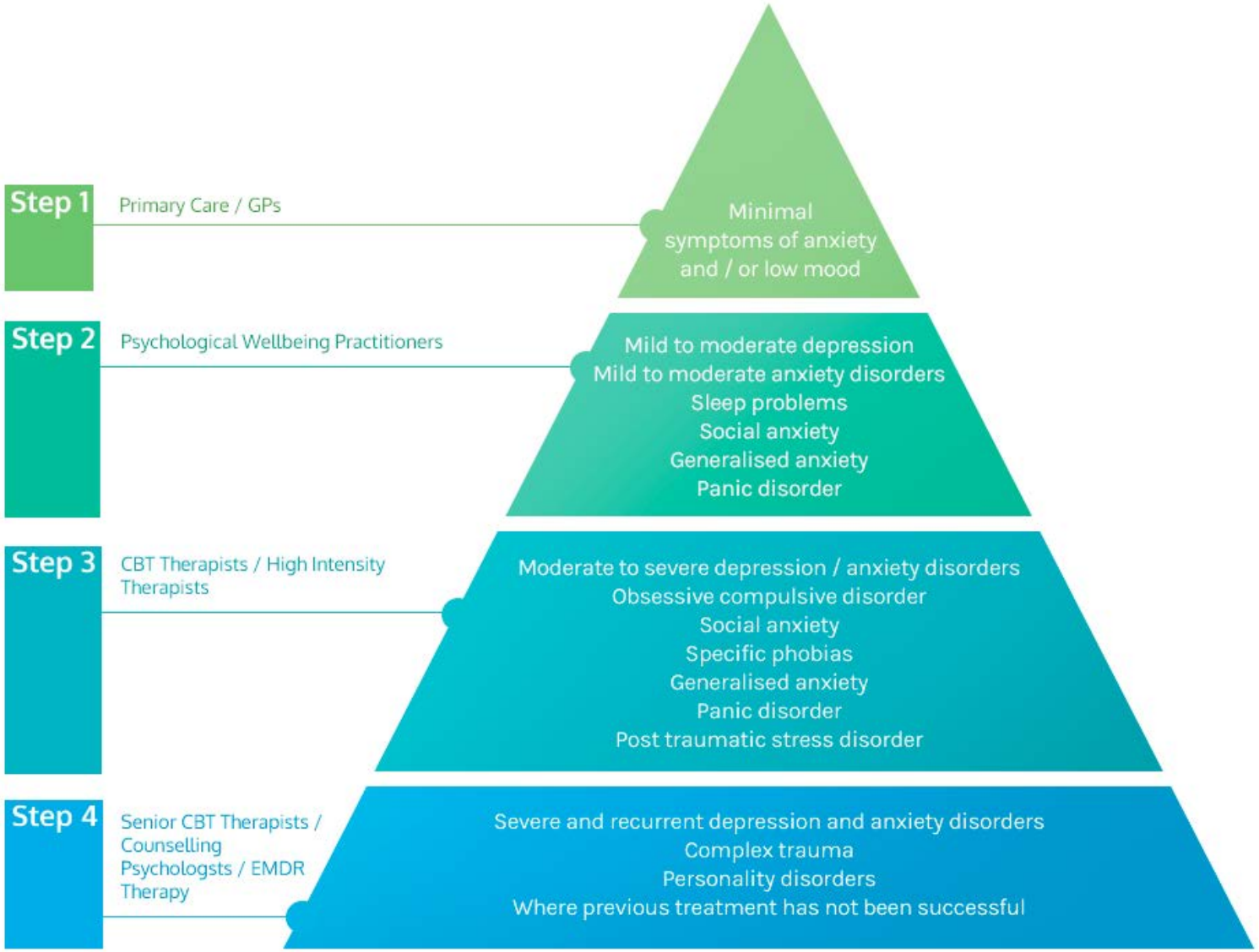
Current system: scarcity, inequity, inefficiency

Adapted from World Health Organization

Model- Australia



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 Psychologsts / 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 concensus 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

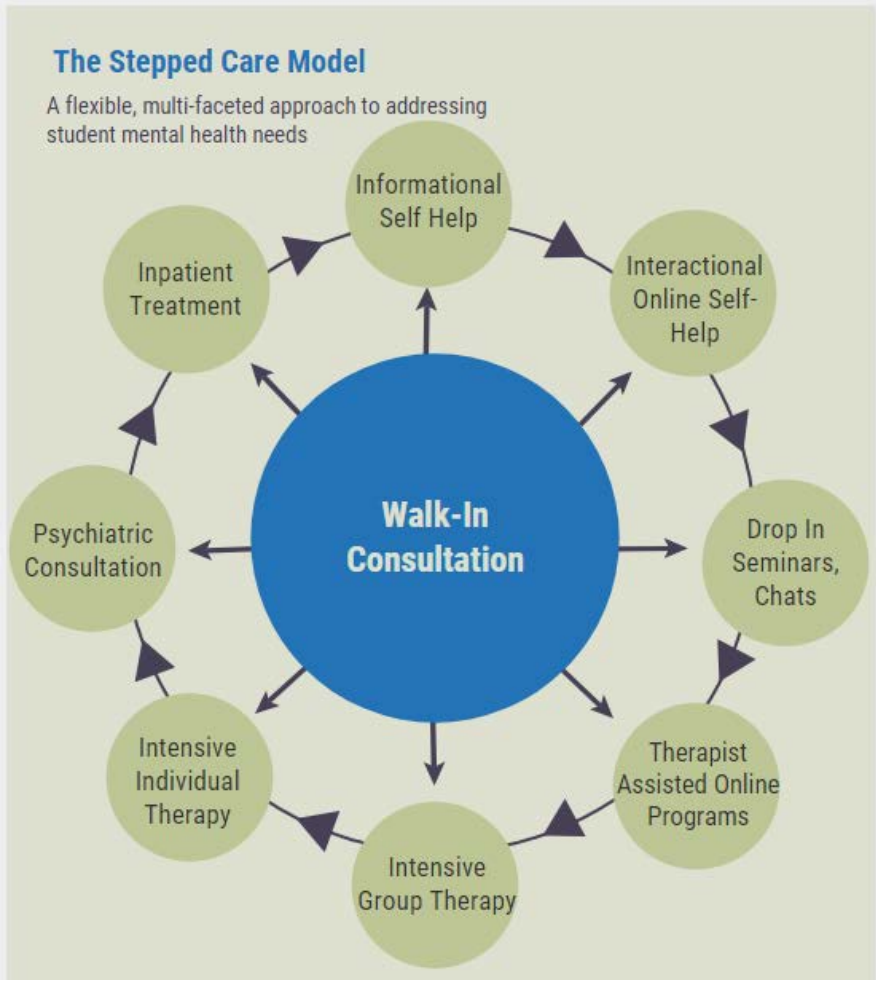
- Evidence-based instruments
- Evidence-based treatments
- Multi-culturally sensitive
- Identify intervals for self-correction
- Resources, content, duration, sequence, delivery method
- Evidence of effectiveness for anxiety, depression, substance use, eating disorders

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

George Washington U

- Walk-in consultation, 9 possible steps



Georgia Tech U

- 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

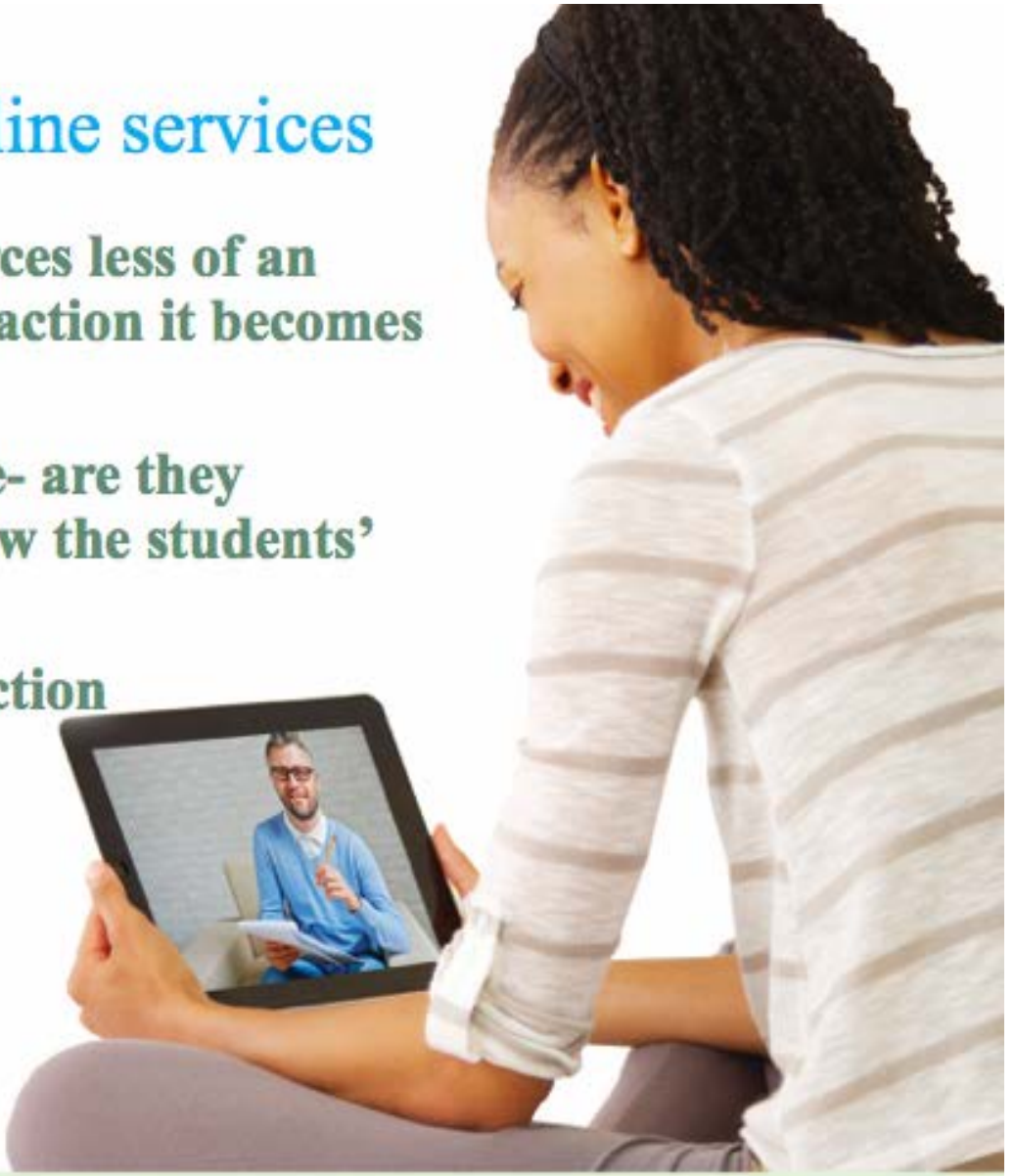
Self-help and web resources less of an issue, once you add interaction it becomes a factor to consider

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, ansiety, depression, panic disorder, social anxiety disorder, iCBT was effective for everydisorder
- 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

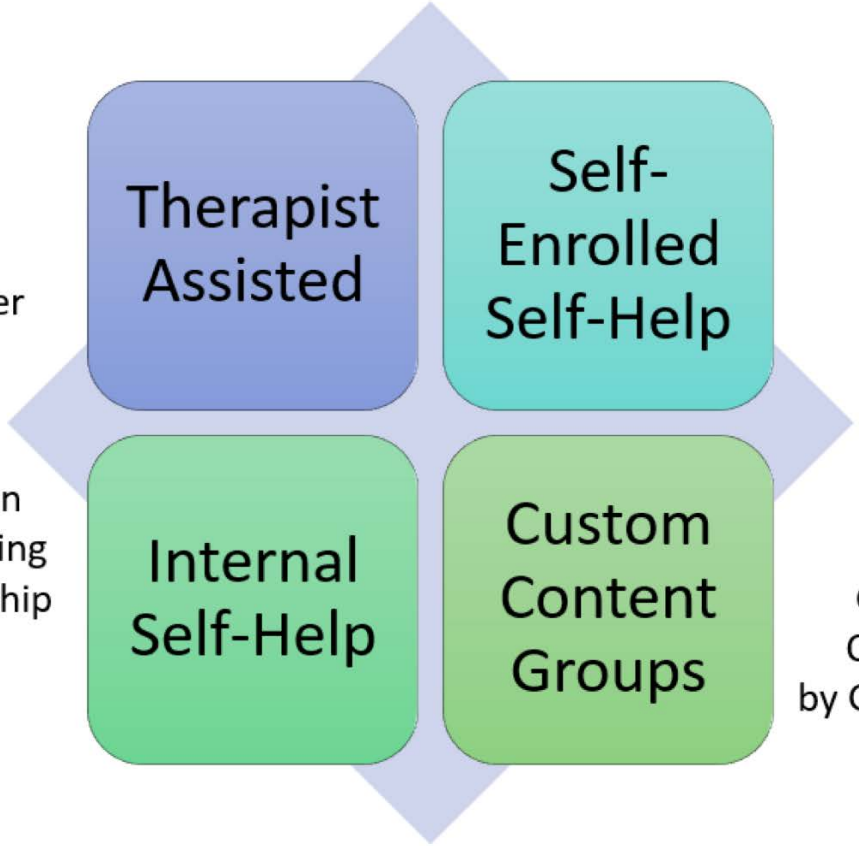
- Outcomes consistently somewhat lower for self-help, higher drop-out rates (Carlbring et al 2018
- Even minimal human guidance of 5 minutes weekly is effective (Carlbring et al, 2018)
- Self-help iCBT can be effective for insomnia, mild anxiety

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



Individually Assigned by Clinician Enrollment Manager

Anonymous Campus Wide Self Help Curated by Groups Manager

For out of jurisdiction students in a continuing therapeutic relationship (Summer break)

Needs based Curated by Groups Manager Can be facilitated by Group Administrator

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

- 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 structired with CBT can be effective.
- SAMHSA Core competencies for peer workiers in Behavioral Health Services
- https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf