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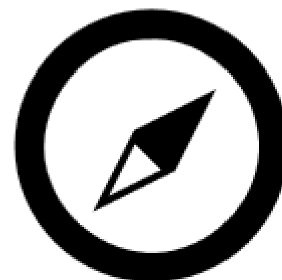

Summary Report

Is stepped care an effective model for the delivery of treatment for depression and anxiety?

Summary of the Rapid Evidence Assessment

September 2014

Australian Government
Department of Veterans' Affairs

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Executive Summary

- Depression and anxiety disorders are highly prevalent in the general community. While a number of efficacious treatments exist, their delivery and uptake are sub-optimal.
- Stepped care is a health care delivery model that aims to maximise efficiency of resource allocation. In stepped care, less intensive treatments are offered first, with more intensive treatments reserved for people who do not benefit from initial treatments. Stepped care is self-correcting, with variations to treatment based on regular assessments of patients' changing needs and responses to treatment.
- The aim of this review was to examine the efficacy of stepped care for the treatment of adults with depression or anxiety disorders. Stepped care interventions were defined as those comprising at least two psychological treatments of different intensities *or* at least two treatment modalities, one of which was psychological. Decisions about stepping up had to be based on an evaluation or assessment, done at a pre-specified time interval and with the aim of determining the next step.
- This literature review utilised a rapid evidence assessment (REA) methodology. A search was conducted for systematic reviews and/or meta-analyses of the efficacy of stepped care for the treatment of depressive or anxiety disorders or symptoms. The search identified a systematic review and meta-analysis of the efficacy of stepped care for the treatment of depression by Van Straten and colleagues, published in 2014[1]. As this systematic review included studies up until 2012, an additional literature search covering the period 2012 to 2014 was conducted with respect to depressive disorders and/or symptoms. As no systematic review or meta-analysis of the efficacy of stepped care for anxiety disorders or symptoms was identified, a literature search covering the period 2004 to 2014 was conducted with respect to these.
- Only randomised controlled trials (RCTs) or pseudo-RCTs were eligible for inclusion, reflecting the gold standard of clinical research. Taken together, the findings of the systematic review and meta-analysis by Van Straten and colleagues and the newly identified studies were assessed for strength of the evidence, consistency of evidence, applicability and generalisability to the population of interest.
- These assessments were collated to determine an overall ranking of level of support for stepped care in the treatment of (i) depressive disorders and/or symptoms (ii) anxiety disorders and/or symptoms, and (iii) specific anxiety disorders depending on the evidence available, in this case posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD). The ranking categories were 'Supported' – clear, consistent evidence of beneficial effect; 'Promising' – evidence suggestive of

beneficial effect but further research required; 'Unknown' – insufficient evidence of beneficial effect; 'Not supported' – Clear, consistent evidence of no effect or negative/harmful effect.

- The search identified one additional RCT of a stepped care intervention for depressive disorders or symptoms, and eight RCTs of stepped care interventions for anxiety disorders or symptoms. Of the latter, one was an RCT of a stepped care intervention for OCD, two were RCTs of stepped care interventions for PTSD or PTSD symptoms, and five were RCTs of stepped care interventions for anxiety disorders or symptoms.
- The key findings were that:
  - The majority of studies, including those in the meta-analysis by Van Straten and colleagues found stepped care to be an effective delivery model. Van Straten also found that stepped care had a moderate effect size on improving depression symptoms/disorder. Taken together, the evidence for the use of stepped care in the treatment of depressive disorders or symptoms received a 'Supported' ranking in this REA.
  - Stepped care for the treatment of anxiety disorders or symptoms received an 'Unknown' rating. While the studies were generally of good quality and tested interventions that would be applicable in an Australian context, results were inconsistent and difficult to generalise.
  - Stepped care for the treatment of PTSD or PTSD symptoms received a 'Promising' ranking. These studies were of high quality, consistency and applicability, but further research is required to determine the efficacy of the intervention tested in alternative samples and contexts.
  - Stepped care for the treatment of OCD received an 'Unknown' ranking, as only one study which had high risk of bias was identified.
- The existing stepped care literature was limited by a range of shortcomings, such as the heterogeneity of stepped care interventions tested, the failure to compare stepped care to matched care or other high-intensity interventions and lack of data about cost-effectiveness. However, the results of this REA suggest that the development and trial of stepped care interventions for depression and PTSD in an Australian context would be warranted.

Background

Depressive and anxiety disorders are two of the most common mental disorders, with Australian 12-month prevalence rates of 4.1% and 14.4% respectively[2]. Some occupational groups have even higher rates of depression and anxiety than the general community. For example, the prevalence rate of 12-month depressive episode in the Australian Defence Force is significantly higher than that found in the community (6% vs 3%) as is posttraumatic stress disorder (8% vs 5%)[3]. High rates of clinically significant anxiety and depression symptoms (23-33%) have been observed in some samples of veterans even 50 years after combat exposure[4]. As such treatments designed to treat these disorders are essential.

A number of efficacious psychological treatments for depression exist, such as cognitive-behavioural therapy[5,6] and interpersonal therapy[5,7]. Cognitive-behavioural therapy has also been shown to be effective for anxiety disorders such as generalised anxiety disorder (GAD)[8] and obsessive-compulsive disorder (OCD)[9]. However, the delivery and uptake of these well-established treatments is often suboptimal, with the majority of sufferers receiving no treatment[1,10]. Poor uptake of care is associated with many issues including difficulties in accessing care, poor efficiency of care and a limited number of therapists trained in evidence based therapies[1,10].

Over the past decade, different health care delivery models have been developed in an attempt to overcome some of these difficulties. Stepped care is one of these health care delivery models. Fundamental to stepped care is the recognition that there are different treatments for a given disorder, and that these treatments have different levels of intensity associated with them[10] . Under stepped care the first intervention offered to a patient is the least intensive or least restrictive of those available, but still likely to provide significant gain[1,10-12]. The 'least intensive' intervention is usually defined as the intervention that requires the least time from a professional relative to other interventions. However, intensity may also refer to therapists' level of expertise[1] . 'Least restrictive' refers to the impact on patients in terms of cost and personal inconvenience[12,13]. Another central feature of stepped care is that it is self-correcting[10,11] . A patient's progress is monitored systematically, and interventions offered may vary according to a patient's changing needs and response to treatment[1,14]. More intensive treatments may be thus reserved for people who do not benefit from simpler first-line treatments[10,15] .

A key goal of stepped care is to maximise efficiency of resource allocation[15]. If less intensive interventions are able to deliver the desired outcome, this limits the burden of disease and costs associated with more intensive treatments[10,11,14]. As such, stepped care may involve a

hierarchy of interventions of differing intensity. Least intensive interventions may involve watchful waiting or self-help treatments such as bibliotherapy[1,10] . Subsequent steps may include guided self-help, group therapy, brief individual therapy and longer-term therapy, with these being distinguished by the degree of therapist input per patient[10].

Unlike psychotherapy, it is not always possible to characterise pharmacotherapy as having different degrees of intensity[1,10]. Since pharmacotherapy is commonly used alongside psychotherapy, the term ‘stepped care’ can also refer to switching between or adding treatments from either modality[1]. Thus, despite the hierarchies of interventions ordered by intensity inherent in most definitions of stepped care, some authors[12] prefer to emphasise the self-correcting nature of stepped care as opposed to the interventions or structure of interventions comprising it.

Stepped care may be progressive or stratified[11]. In the progressive approach, all patients would commence with the least intensive intervention, with subsequent or more intensive interventions only offered to those who do not respond to the least intensive intervention[16]. However, in the stratified approach, patients may begin their journey at any step of the hierarchy, in accordance with the severity of their symptoms and the available resources[12,14,16]. Thus, the initial treatment a patient receives would not necessarily be the most basic; it is simply less intensive relative to subsequent options.

Stepped care may be contrasted with matched care which is often the default approach for delivering mental health care. In this approach the patient is referred to a certain therapist or therapy, based on the patient’s characteristics and preferences. As such, the treatment may vary (e.g. antidepressant medication and/or one of many types of psychotherapy) as well as the setting (primary care, public mental health care, online therapy, group therapy, individual therapy) and the provider (e.g. GP, nurse, psychologist, psychiatrist). However, in efficacy studies, stepped care is often compared with a potentially less active ‘usual care’ condition.

This aim of this review was to examine the efficacy of stepped care for the treatment of adults with depression or anxiety disorders. In consultation with the Department of Veteran’s Affairs (DVA) a number of focal conditions were identified and the evidence to support the use of stepped care in the treatment of these was reviewed. The conditions initially identified were depressive disorders and anxiety disorders (i.e. generalised anxiety disorder (GAD) and posttraumatic stress disorder (PTSD)); however, an initial search of the literature suggested that other anxiety disorders such as OCD might also be considered, as well as anxiety disorders and symptoms thereof taken together.

Evaluation of the evidence

Assessment of the evidence was based on the following criteria:

- the **strength of the evidence base** which incorporated the quality and risk of bias, quantity of the evidence (number of studies), and level of the evidence (study design)
- the **consistency** across studies
- the **generalisability** of the studies to the target population
- the **applicability** to an Australian context.

Ranking the evidence

After the evidence was evaluated, the evidence for stepped care for the treatment of specific depression and anxiety disorders or symptoms thereof was ranked as follows:

SUPPORTED	PROMISING	UNKNOWN	NOT SUPPORTED
Depressive disorders and/or symptoms	PTSD and/or PTSD symptoms	Anxiety disorders and/or symptoms OCD	

'**Supported**' means there was clear and consistent evidence of a beneficial effect of stepped care interventions relative to usual care for depressive disorders and symptoms; '**Promising**' means the evidence was suggestive of beneficial effect, but requires confirmation with additional evidence/research; '**Unknown**' is defined as insufficient evidence at present on whether or not to support the use of stepped care, or additional evidence is required to determine its efficacy; **'Not supported'** is defined as evidence suggesting that stepped care does not have an effect, or produces a harmful effect when implemented.

Implications for policy makers and service delivery

On the basis of these findings, the development and trial of stepped care interventions for depression and PTSD in an Australian context would be warranted. Non-inferiority studies comparing stepped care with matched care or high-intensity interventions should be a research priority. These studies should be preceded by pilot studies that validate step-up or stratification criteria and accompanied by assessments of cost-effectiveness[1,19]. Given the heterogeneity of the stepped care interventions reported on in this REA, direct comparisons of progressive stepped care interventions with stratified stepped care interventions or stepped care not characterised by series of interventions of increasing intensities would also be of interest[1]. Additionally, when reporting the outcomes of trials of stepped care interventions, researchers need to detail what treatment was actually received by participants in the usual care conditions as well as rates of recovery after each step and progression to the next step of participants in the intervention conditions[1]. This is important not just to examine the possibility that participants may be reluctant to commence higher-intensity treatments after the failure of lower intensity treatment [1,10,16], but to clarify exactly what treatments are being compared.

This review did not identify any studies of stepped care interventions in veteran samples. When developing, evaluating or implementing stepped care interventions in veteran populations, a number of issues need to be considered. Firstly, stigma can be a significant concern for veterans with mental disorders and may reduce help-seeking behaviour in general [20]. A low-intensity intervention as the first step of a stepped care approach, such as self-help or relaxation, may thus be more palatable to veterans than high-intensity 'talk therapy' interventions such as cognitive behavioural therapy, and may aid in assessing or increasing readiness for subsequent, more traditional interventions [21,22]. On the other hand, veterans may prefer higher-intensity interventions to some lower-intensity interventions (e.g. individual to group therapy)[23,24], perhaps owing to similar stigma-related concerns. This preference for higher intensity interventions may also apply to the general population[10]. Either way, stepped care interventions for veterans will need to take into account this veteran-specific experiences and concerns in order to maximise uptake and efficacy.

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