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Improving Access to Psychological Treatment with Patient-Led Appointment Scheduling

By Professor Timothy A. Carey

Timely access to effective and efficient services is an important component of successfully resolving mental health problems. A large amount of evidence has been accumulated through Randomised Controlled Trials (RCTs) regarding the efficacy of various treatments but very little research effort has been directed towards establishing what the ideal treatment protocol should be. Given the disparity between the research context of an RCT and the clinical settings in which treatments are delivered translating the findings from research to practice has not been straightforward.

RCTs of psychological treatments typically use manualised treatments which are delivered according to regular, standardised time frames. These time frames are established a priori by the researcher or research team prior to the conduct of the study. For example, some researchers might develop a 12 session treatment protocol of cognitive behaviour therapy (CBT) which is to be delivered weekly over a three month period. In routine clinical practice, however, patients typically vary in their attendance patterns. The numbers missed of and cancelled appointments which are costly to services are strong evidence of the fact that patients make their own decisions about when to attend even if that is different to what the therapist has recommended.

Furthermore, patients accessing psychological treatment in clinical rather than research settings, do not attend the number of appointments that manualised treatments are designed to provide. There is in fact a substantial disconnect between the number of sessions treatments are designed to be and the number of appointments patients attend. Typically researchers design treatments to be greater than ten sessions whereas patients typically attend between four and six sessions on average. Guidelines for treatment also recommend lengths of treatment that far exceed what most patients require. The NICE guidelines for the treatment of depression, for example, recommend that if people are receiving CBT they should receive 16 to 20 sessions over a three to four month period. It is the case, however, that very few patients ever attend that many sessions and yet they still experience benefits from the treatment.

It is seldom recognised that the evidence provided by RCTs is evidence of what *can* be effective but not evidence of what is *necessary* for effective outcomes. For example, demonstrating with an RCT that 12 sessions of Treatment A is more efficacious than 12 sessions of Treatment B is *not* a demonstration that 12 sessions of treatment A is *required* for satisfactory outcomes. Clearly, designing treatments to be longer than what most patients require is inefficient and may contribute to compromised access to services.

An extended program of research that began in rural Scotland and has continued in remote Australia has investigated a patient-led model of service delivery. In this approach, systems are established so that patients, rather than clinicians, determine when and how many sessions of psychological treatment will be scheduled. Patients make appointments to see a psychological therapist in much the same way they would make an appointment to see a GP. Patients are able to attend as often as they need to for as long as they need to within the constraints of the service context.