Post-RCT implementation of FearFighter™ in Primary Care Trusts across England

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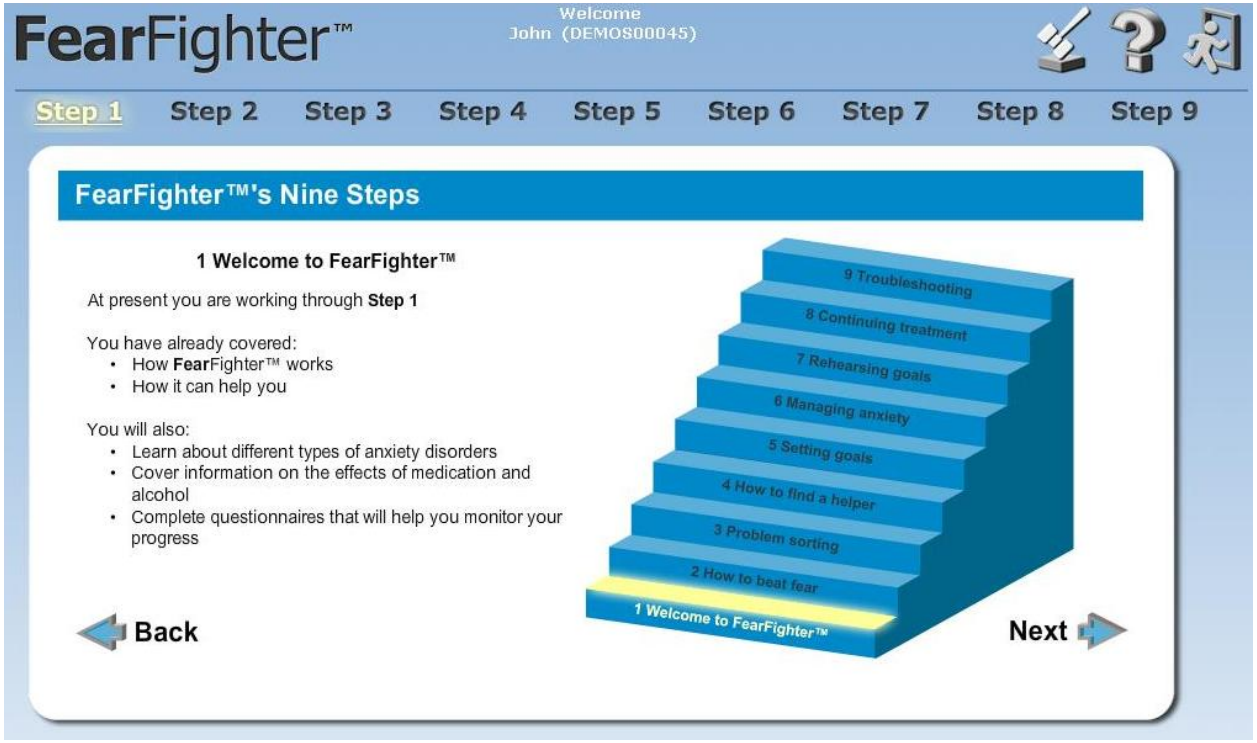
Presentation structure

- Intro to FearFighter™
- From RCTs to implementation - conceptual issues
- Characteristics of FearFighter™ implementation
- Barriers to implementation
- Conclusions

FearFighter™

- 9-step internet-accessed CCBT for panic/phobia
- Recommended by NICE for English National Health Service in 2006



Evidence base for FearFighter™

	Stand-alone FF	Internet-accessed FF
Open studies	Kenwright et al, 2001	Kenwright et al, 2004
RCTs	Marks et al, 2004	Schneider et al, 2005
Cost-effectiveness	McCrone et al, 2009	
Independent study		Hayward et al, 2007 MacGregor et al, 2009

Hayward L et al *Beh Cog Psychother, 35*, 409-419.
Kenwright, M et al *Brit J Psych, 179*, 456-459.
Kenwright, M et al *Brit J Psych, 184*, 448-449.
MacGregor, A. D. *Beh Cog Psychother, 37*(1), 1-9.
Marks, I. M. et al *Psych Med, 34*(1), 9-17.
McCrone, P. et al *Cog Beh Ther, 18,* 1-9.
Schneider, A. J et al *Psych and Psychosom, 74*(3), 154-164.

Beyond RCTs - Implementation issues

"Ideas embodied in innovative social programs are not self-executing"(Petersilia, 1990)

- Takes **17 years** on average to implement clinical innovations in routine practice (Balas et al, 2000)
- Negative results might be caused either by an ineffective intervention or by an effective but inadequately applied intervention (Campbell et al, 2007)
- Need conceptual frameworks to guide still-'embryonic' implementation science (Proctor et al, 2009)

Balas, A et al *Yearbook of medical informatics, 65-70. Bethesda, MD: Nat Lib of Med*

Campbell, N et al *BMJ, 334*(7591), 455-459.

Petersilia, J *Crim and Del, 36(1), 126-145.*

Proctor, E et al *Adm Policy Ment Health, 36*(1), 24-34.

National implementation of FearFighter™

"Invention is hard, but dissemination is even harder" (Berwick, 2003)

- **In hands of 153 Primary Care Trusts (PCTs) across England**
- **Uncontrolled settings:** Company sells FF licences to PCTs, has no control over referral pathway, screening and patient support
- **Competition with many other interventions** offered by PCT staff (face to face individually and in groups, self-help books, relaxation, yoga…)
  - PCT staff decide treatment options for patients, frequently resist offering CCBT
  - Staff often offer non-CCBT care lacking an evidence base
- **Relationship among the teams implementing FF is crucial**
  - Willingness to work together to succeed

Berwick, D. M. *JAMA, 289*(15), 1969-1975.

Barriers to FearFighter™ implementation 1/2

1. **Economic**
   - Almost half of English PCTs have recently commissioned FearFighter™

2. **Cultural**
   - *"I do believe that a person can only change through a personal relationship"* (Primary Care Mental Health Worker, London)

3. **Referral pathway**
   - Unduly long screening – dictated by policy (CCBT is just one option among many treatments)
   - GP-direct referrals and self-referrals still rarely accepted though they have best outcomes (Mataix-Cols et al, 2006)

Mataix-Cols D et al *Compreh Psychiatry, 47*, 241-245.

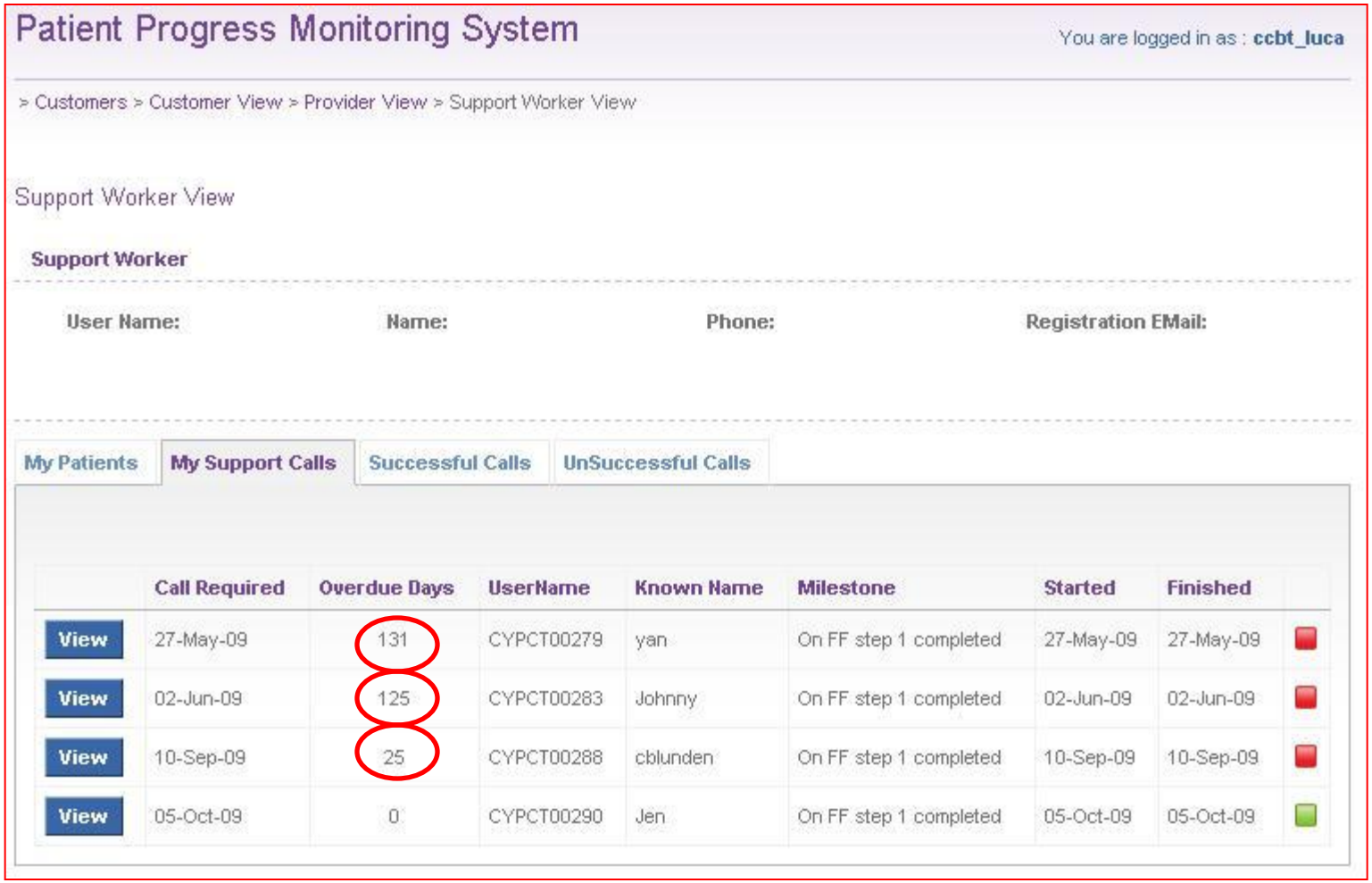
Barriers to FearFighter™ implementation 2/2

4. **Promotion**
   - Difficult to see General Practitioners about referrals (PCTs may deny contact, hundreds of GPs per PCT sometimes, GPs very busy and may lack interest in mental health)
   - PCT staff often fear being overloaded, have many non-CCBT responsibilities

5. **Training of supporters**
   - High turnover rate of supporters (move to higher-paid jobs) e.g. 90% turnover in just 6 weeks leaving almost none who had original FF training, no cascading of training skills to new supporters
   - Resistances due to fear of being deskilled. *"If CCBT is as effective as face to face…, what am I doing here?"* (FearFighter™ trainee, East of England)

6. **Patients' support**
   - Not in hands of company

Company can track poor support of FF users, can't force better practice



Patient Progress Monitoring System

You are logged in as : **ccbt_luca**

> Customers > Customer View > Provider View > Support Worker View

Support Worker View

Support Worker

User Name: **Name:** **Phone:** **Registration EMail:**

My Patients | My Support Calls | Successful Calls | UnSuccessful Calls

	Call Required	Overdue Days	UserName	Known Name	Milestone	Started	Finished	
View	27-May-09	131	CYPCT00279	yan	On FF step 1 completed	27-May-09	27-May-09	
View	02-Jun-09	125	CYPCT00283	Johnny	On FF step 1 completed	02-Jun-09	02-Jun-09	
View	10-Sep-09	25	CYPCT00288	cblunden	On FF step 1 completed	10-Sep-09	10-Sep-09	
View	05-Oct-09	0	CYPCT00290	Jen	On FF step 1 completed	05-Oct-09	05-Oct-09	

Research in progress

is testing the following 5 hypotheses:

1. active promotion of CCBT's availability raises throughput significantly.

2. proper initial training of staff on how to deliver CCBT increases users' completion rate significantly.

3. initial suitability for CCBT of patients chosen by screening staff boosts completion rate and clinical improvement significantly.

4. good subsequent coaching of supporting staff enhances patients' completion rate significantly.

5. efficient support (quantity and quality) of patients raises their completion rate and clinical improvement significantly.

(Organisational/cultural variables will be taken into account as moderators)

Conclusions

"As anyone knows who has worked in the field, implementation of new practice is the biggest challenge of all"(Hollin et al, 2001)

- It will take time to achieve good implementation of the new treatment-delivery mode of CCBT on a national scale
- Uncontrolled settings that offer many alternative interventions (often untested and/or implicitly preferred by screeners/assessors) slow the diffusion of CCBT. A dedicated CCBT service would be better if a viable business model emerges
- Standards for CCBT dissemination are still lacking (Andersson & Cuijpers, 2008). Their development and, more importantly, their translation into policy can significantly speed up adoption of CCBT across many different settings

Andersson, G., & Cuijpers, P. *Brit J Psych, 193*(4), 270-271.

Hollin, C et al in G.A. Bernfeld et al, *Offender rehabilitation in practice: Implementing and evaluating effective programs (pp. xv-xviii). London:* Wiley.