Developing and Disseminating Effective Psychological Treatments: Science, Practice and Economics

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Abstract
In many countries there is growing interest in the identification, development, and dissemination of evidence based psychological therapies. The cognitive–behaviour therapy (CBT) movement has been particularly successful in developing effective new treatments. It has been suggested this is partly because of the close interplay between theory, experimental psychopathology, and treatment development that characterizes much of CBT research. This article provides an illustration of such an interplay before moving on to discuss one of the world’s largest attempts to disseminate evidence-based therapies to the general public. The English Improving Access to Psychological Therapies (IAPT) program aims to vastly increase the availability of evidence-based psychological treatments for anxiety disorders and depression by training an extra 6,000 psychological therapists and deploying them in new, stepped care therapy services. Outcomes are assessed with a session-by-session monitoring system that achieves unusually high levels of data completeness. Around 600,000 patients per year are currently being seen in IAPT services. The background to the initiative, the scientific and economic arguments on which it is based, the training and clinical service models, a summary of progress to date, and future developments are described.

Keywords: dissemination, cognitive-behaviour therapy, anxiety disorders, social anxiety, depression, outcome monitoring, cost-effectiveness, IAPT

Clinical psychology is at a potentially important moment in its history. For decades clinical psychologists have been providing assessments and treatments to aid people with mental health problems. Unfortunately, in most countries only a small proportion of people with such problems have been able to benefit from such help. However, there are now real possibilities for expanding the provision of psychological therapies in many western countries. Policymakers have long been aware of the individual suffering produced by mental health problems. Recently, they have also become aware of the enormous economic cost of untreated mental health problems. This new awareness, in conjunction with a general political move toward seeing the success of a nation at least partly in terms of the well-being of its population, has created a new openness to consider the potential value of psychological therapies. It is crucial that clinical psychologists respond to this by promoting the case for the individual, societal, and economic benefits of making evidence-based psychological treatments more widely available.

The Canadian Psychological Association is strongly and positively responding to this challenge through the work of its evidence-based practice task force and other activities. As a fellow traveller on the road, I am touched to have been selected as the Association’s Honorary President for 2012. My presidential address covers two aspects of evidence-based therapy. First, how can psychological science be used to develop new, and hopefully more effective, psychological therapies? Second, how can these therapies be made more widely available?

A Strategy for Developing New Therapies

The way in which psychological therapies are developed is rarely discussed in the literature. Informal discussion with researchers indicates that there are a multitude of routes. My own research team has pursued a particular strategy over the last 20 years that has proved fruitful in developing effective forms of therapy for panic disorder (Clark et al., 1994, 1999), hypochondriasis (Clark et al., 1998; Warwick, Clark, Cobb, & Salkovskis, 1996), posttraumatic stress disorder (PTSD; Duffy, Gillespie, & Clark, 2007; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Ehlers et al., 2003; Smith et al., 2007), and social anxiety disorder (Clark et al., 2006, 2003; Mörtberg, Clark, Sundin, & Åberg Wistedt, 2007; Stangier, Heidenreich, Pietz, Lauterbach, & Clark, 2003; Stangier, Schramm, Heidenreich, Berger, & Clark, 2011). Here I briefly describe the strategy in the hope that it may prove a useful template for other researchers.

Our work has focused on developing new forms of cognitive therapy. The strategy (Clark, 2004) has been to: (a) use clinical interviews and cognitive psychology paradigms to identify the
core cognitive abnormality in an anxiety disorder; (b) construct a theoretical account that explains why the cognitive abnormality does not self-correct; (c) test the hypothesised maintaining factors in rigorous experimental studies; (d) develop specialized cognitive treatments which aim to reverse the empirically validated maintaining factors; and (e) test the efficacy of the treatments in randomized controlled trials.

The Example of Social Anxiety Disorder

I would like to use social anxiety disorder as an example of how this strategy has been deployed. Social anxiety disorder is one of the most common anxiety disorders with a lifetime prevalence of up to 12% (Kessler, Berglund et al., 2005) and a 12-month prevalence of up to 7% (Kessler, Chiu, Demler, & Walters, 2005). Prospective, longitudinal studies (Bruce et al., 2005) show that it is also particularly persistent in the absence of treatment. Given this point, it is concerning that the condition can severely impact on many areas of life, including educational achievement, interpersonal relationships, and work.

Theoretical Model

In order to develop a theoretical model of the persistence of social anxiety disorder, Adrian Wells and I interviewed a cohort of sufferers and synthesized our observations with the results of existing experimental studies. The resulting model (Clark & Wells, 1995) proposed that the condition is maintained by three interlinked processes. The first is a shift in focus of attention. It is suggested that socially anxious individuals focus relatively more attention on observing themselves than observing others when in a social situation. One of the adverse consequences of such self-focused attention is that they often fail to notice that other people are responding to them in a reasonably accepting manner. The second process is the use of internal information (negative self-imagery and feelings of anxiety) to generate excessively negative impressions about how they think they appear to others. For example, people with social anxiety often overestimate how anxious they look because they erroneously assume that they look as anxious as they feel. The third process is the use of safety behaviours (often mental operations), which are motivated by the desire to prevent or minimise feared outcomes (such as “I will appear boring”) but have the consequence of preventing patients from discovering that their fears are excessive. In addition, safety behaviours can “contaminate” the social interaction by making it appear as though the person with social phobia is not interested in, or dislikes, other people. For example, someone who is worried that other people might think they are stupid may try to remember everything they have said in a conversation and compare it with what they are about to say to ensure that it sounds “clever enough.” If the conversation goes well they are likely to think afterward that was only because of the extra monitoring they performed. So, their basic fear that other people will think they are stupid persists. In addition, the monitoring may make them appear distracted and convey the misleading impression that the patient is not interested in other people. This in turn may elicit less friendly behaviour from others.

Experimental Tests of the Model

We used a series of experiments and clinical studies to test key hypotheses in the model. As well as confirming the key hypotheses, some experiments produced unexpected findings that helped us to further elaborate the model and develop therapy targets. Mansell, Clark, and Ehlers (2003) investigated whether socially anxious individuals do indeed shift to a more self-focused mode of attention under conditions of perceived social threat. High and low socially anxious individuals performed a task involving simultaneous detection of external and internal stimuli with the relative speed of detection being used as an index of the direction of attention. As can be seen from Figure 1, both groups were relatively externally focused in the absence of threat. However, when they were told that they were about to make a presentation to an audience, the low socially anxious individuals became more externally focused (perhaps anticipating interacting with the audi-

![Figure 1.](https://example.com/figure1.png)
ence), whereas the high socially anxious individuals became internally focused.

Support for the hypothesis that socially anxious individuals use internal information to decide how they appear to others was provided by Mansell and Clark’s (1999) finding of a strong correlation between ratings of subjective anxiety and how one thinks one appears to others in high socially anxious individuals but not in low socially anxious individuals. Other studies further explored the types of internal information that socially anxious individuals access when making judgments about how they are perceived by others. A structured interview study (Hackmann, Suraway, & Clark, 1998) found that patients with social phobia report a high frequency of negative, distorted self-images in which they see themselves as if from an observer’s perspective. A subsequent study (Hackman, Clark, & McManus, 2000) found that these images were generally recurrent, in the sense that individuals reported essentially similar content images in a wide range of different social situations. Furthermore, the images appeared to date from early, socially traumatic experiences, suggesting that individuals may construct a negative self-representation in early life that is not updated in the light of subsequent experience. Hirsch, Meynen, and Clark (2004) demonstrated that such images have a causal role by asking individuals with social anxiety disorder to switch between their usual negative self-images and more realistic images while having a conversation with a stranger. When holding negative self-images in mind, individuals felt more anxious and thought they came across less well. Their impressions were distorted in the sense that the other person in the conversation rated them more positively. However, holding the image in mind did have an effect on the conversation as the other person rated the individual as less warm and friendly when he or she was holding a negative self-image in mind. Other data suggested this was because individuals used more safety behaviours when they were dwelling on their negative self-images. Clearly, a small change in self-imagery can trigger a complex chain of cognitive and behavioural events.

Wells et al. (1995) provided a particularly clear demonstration that safety behaviours play a key role in maintaining social anxiety by asking patients to use, or avoid using, their usual safety behaviours during a stressful social interaction. Avoiding using safety behaviours led to a reduction in anxiety in a subsequent behaviour test, whereas using the safety behaviours did not.

Developing a New Treatment Based on the Model

We developed a specialized form of cognitive therapy that specifically focuses on the cognitive abnormalities and maintaining processes specified in Clark and Wells’ (1995) model. The treatment is delivered on an individual, as opposed to group, basis. Key procedures include the following: (a) developing an individual version of Clark and Wells’ (1995) model using the patient’s own thoughts, images, attentional strategies, safety behaviours, and symptoms; (b) experiential exercises in which self-focused attention and safety behaviours are systematically manipulated during social interactions in order to demonstrate their adverse effects; (c) behavioural experiments in which patients test their negative predictions while dropping their safety behaviours and focusing externally during social interactions; (d) systematic training in externally focused attention. Two types of externally focused attention are trained. The first is externally focused evaluative attention that is used during behavioural experiments in order to collect specific information related to the patients’ negative predictions (e.g., did other people think I was boring?). The second is externally focused nonevaluative attention in which patients are taught how to get lost in conversations and social interactions without thinking about how they might be coming across. The latter is the long-term aim of therapy; (e) techniques for dealing with distorted self-imagery, including video feedback and rescripting of early memories associated with the development of a self-image; and (f) surveys to collect data on other people’s beliefs about issues such as blushing, trembling, sweating, and so forth. Unlike in some forms of cognitive–behaviour therapy (CBT), patients are not encouraged to develop positive self-talk before or during social situations, and there is no formal social skills training. Instead the emphasis is on testing ones beliefs in action and reversing the cognitive and behavioural processes that have been maintaining the beliefs. Several procedures in the treatment (e.g., experiential exercises to demonstrate the effect of self-focused attention) were initially developed in the experimental studies and then transferred directly into the treatment.

Evaluating the Treatment

Cognitive therapy (CT) derived from the model has now been evaluated in six randomized controlled trials, conducted in the United Kingdom, Sweden, and Germany. Figure 2 illustrates the results of one of the trials (Clark et al., 2006) in which CT was compared with a well-known behavioural treatment (exposure in vivo) and no treatment (waitlist control). CT and exposure in vivo were both effective. However, CT led to significantly greater improvement at both posttreatment and 1-year follow-up. Eight-six percent of patients treated with CT no longer met diagnostic criteria for social anxiety disorder, compared with 45% of those who received exposure. The other trials found that CT was superior to two forms of Group CBT (Mörtberg et al., 2007; Stangier et al., 2003), interpersonal psychotherapy (Stangier et al., 2011), psychodynamic psychotherapy (Leichsenring, 2012), fluoxetine (Clark et al., 2003), medication-based treatment as usual (Mörtberg et al., 2007), and pill placebo (Clark et al., 2003). Such broad evidence for differential effectiveness is rare in psychotherapy re-
search and suggests that there is some merit in pursuing a strategy in which experimental and clinical studies are closely interwoven in the process of treatment development.

Making Evidence-Based Treatments More Widely Available

While it is pleasing when the hard work of one’s team eventually results in the development of an effective psychological treatment, such apparent progress will have little impact on mental health in the community unless the treatment can be made widely available. This is not easy. When a pharmaceutical company develops a new drug that has beneficial effects, it invests enormous sums of money on lobbying the medical profession and on marketing in order to ensure that the drug is widely used. There is no equivalent process for psychological treatments. Development of psychological treatments is usually publically funded. Governmental and charity research bodies have multiple calls on their scarce resources and generally cannot invest in the dissemination of their research products. As a consequence, developments in evidence-based psychological treatments often have only a limited impact on the community.

In order to overcome this problem in England, a coalition of researchers, clinicians and economists worked together in 2004–2005 to bring to the attention of the government the potential benefits to society, and to the economy of vastly increasing public access to evidence-based psychological treatments for depression and the full range of anxiety disorders. Thankfully, the government listened and committed to a large scale Improving Access to Psychological Therapies (IAPT) program. The next section describes the program, how it developed, what it has achieved so far, and how it is likely to progress in the future. Of course, every country is different and I would not wish to be so presumptuous as to suggest that IAPT would be right for Canada. However, it may be that some aspects of the program may be of interest to Canadian Psychologists as you work with your policymakers and health commissioners to improve the treatment options available to Canadians with mental health problems.

The English Improving Access to IAPT Program

Overview of the Program

The IAPT program aims to vastly increase access to psychological therapies for depression and anxiety disorders by training 6,000 new therapists by 2014 and deploying them in new services for these conditions. The training follows national curriculae and initially particularly focused on CBT, because this was where the manpower shortage was considered greatest. As the programme matures, training in other National Institute for Health and Clinical Excellence (NICE)-recommended treatments for depression is also being made available. The clinical and other outcomes of patients who access the services are carefully monitored and reported on a publically accessible website (www.ic.nhs.uk).

Historical Background

The IAPT program had its roots in several clinical and policy developments. Two deserve particular mention. First, starting in 2004, NICE systematically reviewed the evidence for the effectiveness of a variety of interventions for depression and anxiety disorders. These reviews led to the publication of a series of clinical guidelines (NICE, 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2011) that strongly support the use of certain psychological therapies. CBT is recommended for depression and all the anxiety disorders. Some other therapies (interpersonal psychotherapy, behavioural couples therapy, counselling, brief psychodynamic therapy) are also recommended (with varying indications) for depression, but not for anxiety disorders. In the light of evidence that some individuals respond well to “low-intensity” interventions (such as guided self-help and computerized CBT), NICE also advocates a stepped-care approach to the delivery of psychological therapies in mild to moderate depression and some anxiety disorders. In moderate to severe depression and in some other anxiety disorders (such as PTSD), low-intensity interventions are not recommended and instead it is suggested that patients should at once be offered “high-intensity” face-to-face psychological therapy.

In the second development, economists and clinical researchers combined resources to argue that increasing access to psychological therapies would largely pay for itself by reducing other depression and anxiety-related public costs (welfare benefits and medical costs) and increasing revenues (taxes from return to work, increased productivity, etc.). The argument was advanced in academic articles (e.g., Layard, Clark, Knapp, & Mayraz, 2007), but also in the more populist pamphlets, such as the Depression Report (Layard et al., 2006) and We need to Talk (a report sponsored by numerous mental health and other charities). The latter were widely distributed to the public and to policymakers. For example, the Depression Report was included in every copy of a national newspaper (the Observer) on Sunday 18th June 2006.

The United Kingdom Government was receptive to NICE’s recommendations and to the broader arguments advanced in the Depression Report and elsewhere. A general political commitment to increase the availability of evidence based psychological treatments was secured in 2005. To test the viability of a national program, two pilot projects (termed “Demonstration Sites”) were established.

Doncaster and Newham Demonstration Sites

In 2006 the National Health Service (NHS) in England comprised 154 primary care trusts (PCTs), each of which had responsibility for the health care of its local population. Doncaster and Newham PCTs were chosen as the pilot sites. Full details of the clinical services that were developed in the two demonstrations sites and the outcomes they obtained in their first year can be found in Clark et al. (2009) and Richards and Suckling (2009).

Briefly, each site received substantial funds to recruit and deploy an expanded workforce of CBT focused psychological therapists. Doncaster had been pioneering the use of low-intensity therapies (especially guided self-help) and chose to particularly expand the workforce that delivered these treatments, although some additional capacity to deliver high-intensity interventions (face-to-face CBT) was also developed. Many of the guided self-help sessions were delivered over the telephone. Newham initially placed greater emphasis on high-intensity CBT, although it also operated a stepped care model when appropriate, using a newly
recruited workforce of low-intensity therapists (subsequently called Psychological Well-being Practitioners or PWPs). The low-intensity therapies included computerized CBT (cCBT), guided self-help, and psycho-education groups.

In order to determine whether the demonstration sites were able to achieve the outcomes one might expect from the randomized controlled trials that led to NICE’s recommendations for the use of psychological treatments in depression and anxiety disorders, both demonstration sites agreed to adopt a session-by-session outcome monitoring system that had demonstrated its worth in achieving high levels of prepost treatment data completeness in community samples (Gillespie, Duffy, Hackmann, & Clark, 2002). At every clinical contact, patients were asked to complete simple measures of depression (Patient Health Questionnaire (PHQ-9); Kroenke, Spitzer, & Williams, 2001) and anxious affect (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006). If specific anxiety disorders (agoraphobia, social phobia, obsessive-compulsive disorder [OCD], PTSD, etc.) were being treated, patients were also encouraged to complete a validated measure of that disorder (e.g., the Revised Impact of Events Scale in PTSD; Weiss & Marmar, 1997). This is because the GAD-7 does not cover key features of specific anxiety disorders, such as phobic avoidance, compulsive behaviour, and intrusive thoughts, images, or impulses.

The main findings from the first year of operation of the two demonstration sites were as follows:

Clinical problems. The two sites saw somewhat different populations. In Doncaster referral letters mentioned depression as the main problem in 95% of cases. In the remaining 5% anxiety was mentioned as the main problem, patients were also encouraged to complete a validated measure of that disorder (e.g., the Revised Impact of Events Scale in PTSD; Weiss & Marmar, 1997). This is because the GAD-7 does not cover key features of specific anxiety disorders, such as phobic avoidance, compulsive behaviour, and intrusive thoughts, images, or impulses.

Numbers seen. Taken together, the two sites saw an impressively large number of people (over 3,500) in the first year, with the use of low intensities therapies and stepped care being the key ingredients for managing large numbers.

Data completeness. The session-by-session outcome monitoring system ensured that almost all (over 99% on Doncaster and 88% on Newham) patients who received at least two sessions had pre- and posttreatment outcome scores. For patients who discontinued therapy earlier than expected, the scores from the last available session were used as posttreatment scores. As well as the new session-by-session outcome monitoring scheme, the sites also obtained outcome data on the CORE-OM (Barkham, Margison, & Leach, 2001) using a more conventional pre- and posttreatment only data collection protocol. As is usual in community samples, this protocol produced a much lower data completeness rate (6% in Doncaster, 54% in Newham), mainly because of missing posttreatment scores. Figure 3 shows the mean improvements in depression (assessed by the PHQ-9) and anxiety (assessed by the GAD-7) in patients treated in Newham who did, and did not, provide posttreatment data on the conventional (CORE-OM based) outcome monitoring protocol. Patients who failed to provide posttreatment data on the conventional system showed less than half of the improvement of those who provided posttreatment data. This finding led the IAPT national team to conclude that services that have substantial missing data rates are likely to overestimate their effectiveness. For this reason, session-by-session outcome monitoring was adopted in the subsequent national rollout of IAPT (see below).

Outcomes. The high level of data completeness on the PHQ-9 and GAD-7 made it possible to accurately assess any clinical improvements that patients achieved while being treated in the demonstration sites. All patients who received at least two sessions (including assessment) were included in the analysis, irrespective of whether they were coded as completers or drop-outs by their therapist. As a group, patients treated in both sites showed large improvements (prepost treatment uncontrolled effect sizes of
0.98–1.26). Individuals were considered clinically recovered if they scored above the clinical cut-off on the PHQ and/or the GAD at pretreatment and below the clinical cut-off on both at posttreatment. Using this criterion, 55% (Newham) and 56% (Doncaster) of patients recovered.

The economic argument for IAPT (Layard et al., 2007) assumed that such clinical improvements would be largely sustained and that there would be improvement in employment status as well as symptoms. To see whether the clinical improvements were sustained, patients in both sites were asked to complete the outcome measures 9 months (on average) after discharge. Among those who provided data gains were largely maintained. It had been assumed that IAPT services would achieve an overall improvement in employment status in 4% of the total treated cohort (Layard et al., 2007). The observed rate was 5%.

Although the outcomes observed in the demonstration sites were broadly in line with expectation, it is important to realise that the sites were not set up as randomized controlled trials, and it is likely that some of the observed improvement would have happened anyway (e.g., natural recovery). Various studies suggest that natural recovery rates over a period of time that is similar to the duration of IAPT treatment are high among recent onset (<6 months) cases of depression and anxiety disorders but are substantially lower among more chronic cases. Building on this observation, Clark et al. (2009) separately computed the recovery rates among recent onset and chronic cases. Most cases had been depressed or anxious for over 6 months and it seemed safe to conclude that treatment had provided added benefit to this group as the recovery rates (52% at each site) comfortably exceeded the 5%–20% one might expect from natural recovery or minimal intervention. However, among the minority of cases with a recent onset, it was not possible to exclude the possibility that much of the improvement may have been because of natural recovery (see Clark et al., 2009, p. 919).

The National Rollout of IAPT

Following the success of the Newham and Doncaster Demonstration sites, the Government announced a phased national rollout that would last several years (Department of Health, 2008, 2010). Funding for the first 3 years (approximately Canadian $470 million) was announced in 2007, with funding for a further 4 years (up to Canadian $630 million) announced in February 2011. The initial funding was allocated to train up to 3,600 new psychological therapists (60% high-intensity CBT therapists, 40% PWPs) and to deploy them, along with existing experienced clinicians, in new psychological treatment services that would operate on stepped care principles. The training programme initially focused on CBT because (a) it is recommended by NICE for both depression and anxiety disorders and (b) it is the therapy where the manpower shortage was considered to be greatest. The further funding is to train an additional cohort of 2,400 PWPs and high-intensity CBT therapists and to also train therapists in four other therapies that NICE (2009a) recommends for some depressed individuals but not for anxiety. The four therapies are interpersonal psychotherapy, behavioural couples therapy, counselling for depression, and brief psychodynamic therapy.

Targets were set for the number of patients that would be seen by the services and there was an expectation that as the services matured 50% would “move to recovery” in terms of their symptomatology. In addition, it was expected that fewer people would be on sick pay or receiving state benefits. At least 20 of England’s 154 PCTs were expected to establish new “IAPT” services during the first year, with further PCTs joining in future years. A large number of documents providing guidance to courses and PCTs were produced, most of which can be viewed on the IAPT website (http://www.iapt.nhs.uk). Table 1 lists the key documents.

Training. To facilitate training of the new workforce, the Department of Health commissioned and distributed separate national curriculae for the training of high-intensity CBT therapists and PWPs. Because the main aim of the IAPT programme is to increase the availability of treatments recommended by NICE, the high-intensity CBT curriculum is closely aligned to the particular CBT programmes that had been shown to be effective in the RCTs that contributed to NICE’s recommendations. A wide range of general CBT assessment and intervention strategies are included in the curriculum. In addition, trainees are required to be taught at least two evidence based treatments for depression (cognitive therapy and behavioural activation) and at least one specific, evidence-based treatment for each anxiety disorder. In panic disorder examples include Barlow and colleagues’ CBT programme and Clark & colleagues’ cognitive therapy programme. In social anxiety disorder, examples include CT based on Clark and Wells’ model and Heimberg’s CBT program. Roth and Pilling (2008) developed a competency framework for many of the leading, empirically supported CBT treatments for depression and anxiety disorders and the high-intensity curriculum aims to ensure that these are covered in IAPT training programmes. In addition to specifying the skills that trainees should acquire, the curriculum also specifies how these skills should be assessed (through a mixture of ratings of actual therapy sessions and written assignments in the form of case reports and essays).

A separate curriculum was issued for PWP training. The four sections of the curriculum cover (a) engagement and assessment; (b) evidence-based low-intensity treatments; (c) values, policy, culture, and diversity; and (d) working within an employment, social, and health care context. Both the high-intensity CBT and

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<td>IAPT Commissioning Toolkit (April 2008)</td>
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the PWP training programs are conceived as joint university and in-service trainings. Trainees attend a university base for lectures, workshops, and case supervision for some of each week. For the rest of the week they work in an IAPT service. The services are also encouraged to provide trainees with the opportunity of directly observing therapy sessions conducted by experienced staff.

Recently, training programs for the four non-CBT therapies supported by the IAPT program have also been launched. As with the CBT training, these programs follow national curricula and are aligned to a published competency framework for each therapy (details available at www.iapt.nhs.uk).

IAPT service model. A general service framework was outlined in the National Implementation Plan (2008). The framework specifies key principles for the operation of the services while leaving considerable scope for local determination. The key principles include:

• A person-centred assessment that identifies the key problems that require treatment and their social and personal context. Goals for therapy are identified and a treatment plan is jointly agreed.
• Stepped care in which many people with mild to moderate depression or anxiety disorders are offered treatment with a PWP initially. Many people recover with such treatment. Individuals who do not should be offered a further course of high-intensity treatment. For people with more severe depression or anxiety and for everyone with PTSD, immediate high-intensity treatment is recommended. All treatments that are offered should be in line with NICE recommendations.
• Access to an employment advisor if employment (lack of, or danger of losing) is an issue. Services are encouraged to involve employment advisors in treatment plans from the very beginning as making progress with employment issues can greatly facilitate psychological recovery and vice versa.
• Use of the IAPT minimum dataset (see IAPT Data Handbook 2 for full details). This includes giving the PHQ-9 and GAD-7 every session along with some other patient self-report measures that focus on specific anxiety disorders, when these are relevant. All data is entered into an electronic database that enables therapists and their supervisors to monitor patients’ progress and adjust treatment plans, if required.
• All therapists should receive weekly, outcome-informed supervision that ensures that all cases are discussed at regular intervals and decision about step-up/step-down are made in a timely fashion (see IAPT Supervision Guidance).
• Because of the importance of obtaining outcome data on almost all patients who receive treatment, the services are asked to ensure that at least 90% of patients who are seen at least twice in a service have a pretreatment and posttreatment (or last available session) score on the main outcome measures.

What Has Been Achieved So Far?

At the time of writing (Summer 2012), we are just over half way through the rollout of the IAPT programme. Progress to date includes the following:

• IAPT services have been established in 99% of PCTs. It is intended that by 2014 the services will be able to see around 900,000 people per year, which equates to 15% of the prevalence of depression and anxiety disorder in the community. At the moment they are seeing approximately 600,000 per year (10% of prevalence). However, there is wide variation in the number of therapists employed in the services and, as a consequence, they vary substantially in the percent of local prevalence that they can address.

• The initial target of training approximately 3,600 new high-intensity therapists and PWPs in the first 3 years has been achieved. The further cohorts of therapists that are expected to be trained in the coming years are needed to help all areas reach their goals in terms of therapy access numbers.
• The percentage of treated patients who meet clinical recovery criteria has steadily increased as the programme progresses and is now running at an average of 46% (data from last quarter year). Of course, it is possible to achieve worthwhile gains without making a full recovery. Consistent with this, an analysis of the year one data (Gyani, Shafran, Layard, & Clark, 2011) found that 64% of patients showed statistically reliable improvement. Calculations of recovery and reliable improvement rates are based on individuals who had at least two sessions and have finished their involvement with the services (even if they dropped out). A sizable proportion of people are only seen once (often being assessed, offered advice, and perhaps signposted to services such as debt counselling and housing assistance). A systematic system for assessing their outcomes has yet to be developed. Finally, numbers moving of sick pay and state benefits are in line with the program targets.

Lessons From the First Phase of the Program

As well as the broad performance figures given above, the United Kingdom Department of Health has released two reports that provide more detailed analysis of the IAPT program during its first year of operation (1st October 2008 to 30th September 2009). During this period 35 health areas (PCTs) established an IAPT service, 32 of whom provided data for analysis.

The first report (Glover, Webb, & Evison, 2010) focused on issues to do with equity of access, descriptions of the treatments offered, and overall outcome. With respect to equity of access, both genders were fairly represented in the year one IAPT services. The most recent Adult Psychiatric Morbidity Survey (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009) shows that 61% of people in the community with a common mental disorder are female, which was very similar to the rate in IAPT services (66% female). However, people over 65 years old and people from the black and minority ethnic (BME) groups were somewhat under-represented. Looking at clinical conditions, it was difficult to assess equity of access accurately as for 39% of patients a formal diagnosis was not recorded. However, among the 61% for whom diagnoses were recorded, there was an overrepresentation of patients with Depression or Mixed Anxiety and Depressive Disorder (MADD), compared with prevalence rates found in community studies. There was also under representation of patients with persistent anxiety disorders, such as PTSD, OCD, panic disorder, social phobia and agoraphobia, because less than 10% of patients had these diagnoses, whereas around a third of patients should have these disorders if access was equitable (see McManus et al., 2009).

The first report also found that the majority of patients received NICE compliant treatment. The NICE recommended low-intensity interventions that were provided included: guided self-help, psychoeducation groups, behavioural activation,
computerized CBT, and structured exercise. NICE recommends CBT as a high-intensity psychological therapy for depression and for all the anxiety disorders that are currently covered by guidelines. In line with this recommendation, almost everyone with a recorded diagnosis of social phobia, specific phobia, agoraphobia, or OCD received CBT. For patients with a recorded diagnosis of GAD or PTSD CBT was also the most commonly provided treatment. However, a significant number of patients received counselling, which is not recommended by NICE for these conditions. For patients with a recorded diagnosis of depression, CBT and counselling were equally likely to be offered and both are recommended by NICE. Turning to clinical outcomes, a recovery rate of 42% was observed. However, there was considerable between site variability in recovery rates.

The second report (Gyani et al., 2011) explored the observed variability in recovery rates in further detail in order to identify site and other characteristics that were associated with higher recovery rates. The analyses focused on patients who were clinical cases on entry into the service, had received a least two sessions and had completed their involvement with the services. Pre- to posttreatment data completeness for these patients was good (>90%). The findings, which are briefly summarised below, generally support the IAPT clinical model and highlight the value of following NICE guidelines.

Patients had a higher chance of meeting recovery criteria if they were treated at sites that had the following characteristics:

- Higher step-up rates from low-intensity to high-intensity therapy among those who had failed to respond adequately to the former (i.e., the services were making good use of stepped care).
- Higher average numbers of therapy sessions at low-intensity and at high-intensity (highlighting the importance of providing an adequate dose of treatment).

Although most patients received NICE-recommended treatments, for some clinical conditions a significant minority of patients received a treatment not recommended by NICE. This created a natural experiment in which it was possible to assess whether deviation from NICE recommendations was associated with a reduction in recovery rates. One of the natural experiments concerned the contrast between CBT and counselling. For depression, NICE recommends both treatments for mild to moderate cases. Consistent with this recommendation, there was no difference in the recovery rates associated with CBT and counselling among patients with a diagnosis of depression. In contrast to the recommendations for depression, NICE does not recommend counselling for the treatment of GAD. Consistent with this position, CBT was associated with a higher recovery rate than counselling among patients with a diagnosis of GAD. A further natural experiment concerned the contrast between guided self-help and pure (nonguided) self-help. NICE only recommends guided self-help in depression. Consistent with this position, guided self-help was associated with a higher recovery rate than pure self-help among patients with a diagnosis of depression. Taken together these findings would appear to support the value of aligning clinical interventions with NICE guidance. However, this conclusion needs to be treated with caution because these “natural experiments” are not randomized clinical trials.

Future Development of the Program

Full details of the next phase can be found in the mental health policy entitled No Health Without Mental Health (Department of Health, 2011a) and in the accompanying document entitled Talking Therapies: Four Year Plan of Action (Department of Health, 2011b).

Briefly, the aim is to complete rollout of the adult depression and anxiety disorders program and to start a version of IAPT that focuses on child and adolescent treatment services. There will also be pilot studies with people with long-term physical health problems in conjunction with depression or anxiety, as well as with people with psychosis and personality disorders. All will aim for high levels of prepost treatment data completeness so policymakers and commissioners can assess the clinical benefits and limitations of the work.

Conclusion

It has been a great privilege to hold the post of Honorary CPA President for 2012. Canada has made enormous contributions to world psychology over many decades. With guidance from Dr. David Dozios (your “real” President) and the Evidence-based Practice Task Force1 that he cochaired with Dr. Sam Mikail, it is showing leadership in the development of evidence-based practice. I greatly enjoyed learning about these developments at the national conference in Halifax, Nova Scotia, this year. In return, I hope that some aspects of the recent developments in England outlined in this article may also be of interest to Association members as you push forward in further developing your mental health services in a way that is right for Canadians.

Résumé

Dans de nombreux pays, on s’intéresse de plus en plus au repérage, à l’élaboration et à la diffusion de thérapies psychologiques fondées sur des preuves. Le mouvement de la thérapie cognitivo-comportementale (TCC), en particulier, est parvenue à concevoir de nouveaux traitements efficaces. Selon certains, ce succès est partiellement attribuable à l’interaction étroite entre la théorie, la psychopathologie expérimentale et l’élaboration de traitements qui caractérise une bonne partie de la recherche en TCC. Le présent article illustre une telle interaction avant de traiter d’une des tentatives les plus vastes de diffusion au grand public de thérapies fondées sur des preuves. Le programme anglais « Improving Access to Psychological Therapies » (IAPT) (Amélioration de l’accès aux psychothérapies) vise à accroître considérablement la disponibilité des traitements psychologiques fondés sur des preuves pour les troubles anxieux et la dépression. Il compte le faire en formant 6 000 psychothérapeutes supplémentaires et en les affectant à de nouveaux services de soins par paliers. Les résultats sont évalués par un système de suivi d’une séance à l’autre qui permet d’obtenir des taux exceptionnellement élevés d’exhaustivité des données. Chaque année, près de 600 000

1 The evidence-based taskforce comprises: Lynn Alden, Peter Bieling, Guy Bourgon, David A. Clark, David Dozios (Co-Chair), Martin Drapeau, Dave Gallas, Les Greenberg, John Hunsley, Charlotte Johnston, and Sam Mikail (Co-Chair).
patients font appel aux services de l’IAPT. L’article présente le contexte de l’initiative, les arguments scientifiques et économiques sur lesquels celle-ci repose, les modèles de formation et de service clinique, un résumé des progrès accomplis jusqu’à présent et les prochaines étapes.

Mots-clés : diffusion, thérapie cognitivo-comportementale, troubles anxieux, dépression, suivi des résultats, rapport coût-efficacité, IAPT.

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Behavior Research and Therapy, 41, 555–572. doi:10.1016/S0005-7967(02)00029-3

Received October 6, 2012
Revision received November 9, 2012
Accepted November 13, 2012 □