

New Ways of Working for Psychological Therapists

WORKSTREAM ONE

The Evidence base for Psychological Therapies: Implications for Policy and Practice.

Compiled and edited by:

Graham Turpin and Peter Fonagy

EXECUTIVE SUMMARY

Introduction

The purpose of this workstream is to identify and prioritise, according to the available evidence and published guidelines, psychological therapies for possible future government investment in order to fulfil the Improving Access to Psychological Therapies (IAPT) Programme's commitment to widening choice, as indicated by the Statement of Intent (<http://www.iapt.nhs.uk/2008/12/statement-of-intent-november-2008/>).

Although the report focuses on the implications for IAPT, the brief of the workstream was wider and considered, in general terms, the implementation of psychological therapies from primary to tertiary care and across both physical and mental health conditions but focused on psychological therapies for common mental disorders, particularly affective disorders. Since Workstream 5 focused on child and adolescence services, we restricted our considerations just to adults.

A list of recommendations of evidence-based psychological interventions based on published NICE guidance is provided in order that service users and commissioners can make informed choices.

It is intended that the report will be disseminated in such a way that the benefits of psychological therapies can be recognised widely by service users, and especially those from communities where psychological interventions are unfamiliar.

Background and methods

The report has arisen due to the recent investment in widening access to psychological therapies via the IAPT Programme. Despite the planned improved access to therapy via

new services, the scale of the development has challenged some existing practices within the psychological therapies community and led to vigorous debate. This report is informed by some of this dialogue.

The report was written following a series of meetings of representatives from the major counselling and psychotherapy professional bodies, the voluntary sector and user groups, together with researchers and members of the academic community.

Major issues identified, together with specific issues for discussion:

User and carer choice in psychological therapies

The report identifies choice of therapies as a real challenge for services and commissioners. Effective choice requires that a range of evidence-based therapies are locally available, that users are fully informed about the nature of individual therapies and their effectiveness, and that the provision of choice takes into consideration aspects of cultural acceptability, gender, location, ways of delivering therapies and the need to be outcome and recovery-focused. It is suggested that:

- Commissioners should agree with users and carers the range of choice from the available evidence-based therapies as established in NICE guidance that local services should be providing. The voluntary sector, grounded in community work, may have additional expertise to offer in making such decisions.
- More guidance and research should be provided around how users can make informed choices of evidence-based therapies, whether choice affects outcomes and when choice might not be appropriate.

Clinical guidelines and commissioning for choice and effectiveness

The development and current good practice surrounding clinical guidelines is reviewed. Guidelines should focus on:

- Allocating resources towards treatments shown to be effective by research and/or in practice and away from less effective treatments.
- The avoidance of harmful or ineffective therapies.
- Improved access through the development of effective service delivery systems.

NICE and the range of possible recommended interventions within IAPT

The implementation of NICE guidelines with respect to mental health is summarised. With respect to anxiety disorders and depression, the report recommends in order of priority the following psychological therapies for funding and support within the IAPT programme:

Intervention	Indication in the treatment of depression
Cognitive Behaviour Therapy	Recommended by NICE for all severities of depression.
Interpersonal Therapy	Recommended by NICE for all severities of depression.

Couples Therapy based on behavioural principles	Mild to moderate depression in people who have a regular relationship and where the relationship may contribute to the development or the maintenance of the problem, or where involving the partner is considered to be of potential therapeutic benefit.
Brief Dynamic Therapy	Mild to moderate depression when an individual declines medication CBT, interpersonal therapy, BA or couples therapy or prefers an alternative, or hasn't responded to other interventions.
Counselling	Mild to moderate depression when an individual declines medication CBT, interpersonal therapy, BA or couples therapy or prefers an alternative, or hasn't responded to other interventions.
With the exception of cognitive behaviour therapy, none of these interventions are recommended by NICE for the treatment of anxiety disorders.	

The relationship between NICE and the evidence base within psychological therapies

The report outlines the strengths and limitations of randomised controlled trials, together with the contributions that evidence-based practice (EBP) and practice-based evidence (PBE) can make to the IAPT programme. It suggests that:

- Routine patient-reported outcome data should always be collected and that methods should be used to characterise the type of intervention employed and the competence/fidelity with which it was delivered.
- The routine collection of outcomes through the IAPT programme offers a unique opportunity to examine the translation of EBP into PBE.
- The routine collection of outcome data might enhance the competence and effectiveness of individual clinicians through appropriate feedback and supervision.
- An expert panel should be established through NICE to consider how the full range of high quality evidence could be used in order to ensure within the NICE guideline development process that effective interventions are identified and efficiently and competently implemented.

The context of therapies: the role of group, family and integrative approaches.

The report comments that much of the existing focus from IAPT has been on individual psychological therapies based around a single well-validated model. This section discusses the need to consider other ways of engaging with clients through the couple relationship or within families. It also recognises that psychological therapies and

therapists often adopt approaches which integrate elements from different therapies and which currently have a relatively under-developed evidence base. It suggests that:

- Modalities such as couple, group and family therapy are considered and evaluated in comparison to individual therapies in depression and anxiety as well as other disorders.
- The workstream recommended that further research is commissioned to assess the efficacy of currently under-researched areas of psychological therapy, to newly emergent therapies and especially those based around integration of approaches (e.g. Cognitive Analytical Therapy).

Importance of the evidence base for the training of psychological therapists

The report emphasises the importance of training psychological therapists to be aware and critical of the evidence-base within psychological therapies and to have a critical knowledge of research methods.

- All psychological therapy training should include teaching on evidence-based practice and more general research methods within the field.

Developing a national infrastructure for research

The report emphasises the lack of unified support or co-ordination of funding for psychological therapies research. Researchers are often located across different University departments, returned historically across various Research Assessment Exercise (RAE/REF) panels and are funded from a myriad of sources, but can identify with no one single funding body. It is suggested that:

- Consideration is given to establishing a National Psychological Therapies Institute to oversee the development and promotion of research strategy and funding within this area.
- The institute could focus on supporting individuals to develop research projects on therapies not currently supported by NICE and, through Fellowships, to develop expertise in psychological treatment research, to conduct pilot studies, and to conduct small scale RCTs.
- The risks and benefits associated with such a development to be carefully assessed.

Conclusions

1. The efficacy of psychological therapies has been robustly demonstrated, both through recent research and the conclusions from systematic reviews that have constituted the evidence-base for many different clinical guidelines constructed across many countries throughout the world. The efficacy of many psychological interventions, as demonstrated by the number needed to treat convention from evidence-based medicine, far exceeds the efficacy of many common medical

- procedures or pharmacological agents (Wampold, 2007). Moreover, psychological interventions, in general, tend to preserve clinical outcomes at follow-up and may offer a more enduring form of clinical change process or adjustment to the patient or client than acute pharmacological interventions or maintenance regimes (Roth & Fonagy, 2005; Posternak & Zimmerman, 2007)
2. Accordingly, an overarching recommendation from this report is that access to psychological therapies should be freely available and that patients should have equivalent access to these treatments as to any other treatment endorsed by NICE for delivery within the NHS. Furthermore, although this recommendation supports the aims and objectives of the IAPT programme, we would wish to see the widening of access to all evidence-based psychological therapies, extended beyond the treatment of common mental health problems/disorders, to all other physical and mental health conditions that would benefit from such an approach.
 3. We recognise that not all psychological interventions or therapies may be beneficial to clients and patients. Some may be ineffective whereas others may actually do harm. There are also major variations in the range, depth and extent of evidence to support different psychological therapies. This limits the authority of clinical guidelines to recommend a broad range of therapies that are widely practised. We also wish to stress that the effectiveness of individual practitioners and their routine clinical outcomes vary significantly within any service, irrespective of the severity or type of clinical problem treated (and type of treatment offered). Again, there is the potential for a minority of therapists to practice ineffectively or to harm or abuse their patients and clients irrespective of their modality of treatment.
 4. Ongoing controlled trials research and the regular monitoring of routine clinical outcomes are the solutions to the variability within efficacy (evidence-based practice) and effectiveness (practice-based evidence). Each approach to data collection (from experimental contexts and from routine practice) has its unique strengths and merits, and we strongly urge that through the IAPT programme those two approaches (National Institution on Drug Abuse, 1999), which are often seen by clinicians as irreconcilable, are enabled to contribute to the development of future therapists, services and clinical guidelines. To that end we also recommend that NICE should review the extent to which the psychological therapies evidence base can support guideline development and consider including a broader range of evidence and methodologies, and embrace a more psychologically-orientated approach to mental and physical health conditions than its current medical and diagnostically-based approach. We also recommend that training programmes must ensure that therapists are familiar with both of these approaches to collecting evidence.
 5. Further research is necessary for those therapies that have a relatively weak evidence-base and those emerging therapies that are currently in development. A level playing field in research investment within mental health, and increased

resources directed to investigation and development of psychological therapies is desired. making the investment comparable to that in developing new pharmacological agents which are equivalent in terms of effectiveness. The group considered that to improve the current position; consideration is given to establishing a unifying body to oversee the development and promotion of research strategy and funding within this area (for example a National Psychological Therapies Institute).

WORKSTREAM ONE

THE EVIDENCE BASE FOR PSYCHOLOGICAL THERAPIES: IMPLICATIONS FOR POLICY AND PRACTICE.

MAIN REPORT

1. PURPOSE

Workstream brief

The brief for Workstream 1 was to decide whether on the basis of published evidence of effectiveness it was feasible to identify and prioritise the many different psychological therapies that exist, which might be supported by possible future government investment, particularly from within the IAPT programme. It was agreed that decisions would be based on the extent of the evidence in support of the efficacy of psychological therapies using existing summaries derived from the research databases, and NICE clinical guidelines.

A list of recommendations of evidence-based therapies which have been derived from NICE guidelines, applicable for a full range of psychological problems treated in a range of contexts, has been compiled (see ANNEX 3). It is suggested that this might be adopted by service users to inform their choice of therapy, and by commissioners to help decisions about the *public* funding of therapist training and service provision and supplement existing NICE commissioning guidance some of which relates to psychological therapies.

The workstream report will specifically focus on the decisions required to implement the Secretary of State's recent pledge known as the Statement of Intent about the Improving Access to Psychological Therapy Programme (<http://www.iapt.nhs.uk/2008/12/statement-of-intent-november-2008/>), aimed at ensuring that service users have an informed choice of evidence-based psychological interventions.

The report will not seek to review the evidence first-hand or to make *direct* challenges to the methodological approaches or findings published by NICE. Such critiques are already readily available (e.g.. Lobban & Jones, 2008; Mollon, 2009) and we are aware that the methodologies used by NICE are kept under constant review within the organisation itself (NICE Guidelines Manual, National Institution for Health and Clinical Excellence 2007b; Rawlins, 2008). We will merely suggest some ways in which the nature of research and collection of evidence, which aims to inform funding decisions about the future provision of psychological therapies, might be improved.

Limitations

The resources available to us enabled the group to focus most of its discussions to the treatment of so-called “common mental health problems” such as anxiety disorders and depression, across a range of different client groups but primarily addressing working age adults. Regrettably, we had no opportunity to consider a number of important client groups for psychological therapy, such as individuals with eating disorders, where some research data are available, and there is a strong evidence base supporting several different therapeutic approaches.

Nevertheless, the project also aimed to identify principles from the current work that might be extended to other psychological problems amenable to psychological intervention. In this respect, we would wish to emphasise the breadth of application of psychological therapies across a range of both psychological and physical disorders, ranging from common psychological problems and disorders, chronic health problems and disabilities, through to serious/enduring mental health problems such as bipolar, eating, personality and psychotic disorders (see New Horizons Report, Department of Health, 2009).

By contrast, it is also worth noting that some psychological therapies do not aim to ameliorate personal problems or relieve particular individual distress or symptoms along the lines of a medical model, but instead target personal growth and self-improvement/knowledge. Moreover, many psychological therapists would reject the notion of a medical or psychological disorder outright, but instead would focus on providing help to overcome many of life’s problems, especially the distress associated with bereavement, substance misuse, relationship problems etc.

Traditionally, members of the public wishing to use psychological therapies for self-knowledge or advancement have purchased therapy through the private sector. However, this distinction between personal development and medically targeted treatment is becoming less obvious with the recent recognition by the NHS of the importance of such constructs as mental capital, psychological well-being, emotional intelligence and resilience, and positive psychology (Department of Health, 2009; Foresight Mental Capital and Wellbeing, 2008).

Dissemination of this report and equality of access

We are committed to ensuring that formal psychological interventions, especially those identified by NICE clinical guidelines and requested by patients and clinicians, are accessible and relevant to all sectors of society as opposed to only being available to a minority of individuals who are sufficiently aware of the benefits of psychological therapy and are in a position to secure treatment assertively either through the NHS or by independent means.

We also acknowledge that some individuals will fail to recognise or even understand some of the basic premises of psychological treatment as they are commonly

espoused, and that some of those basic tenets might be incompatible with some cultures.

We are keen to ensure that the report is disseminated widely to many diverse stakeholders and we will also address general issues of equalities and access, together with education and cultural acceptability across different people and cultures.

2. BACKGROUND

Psychotherapy, counselling, arts therapies and psychology services have been available through the NHS for many years, but only recently have these services started to attract the attention they deserve from both service users and commissioners.

There are many reasons, therefore, why access to psychological therapies is now regarded as a priority area, including:

- Its effectiveness as demonstrated through the publication of NICE guidelines.
- Patient choice in wanting greater access to talking therapies (Department of Health, 2004, 2006, 2006 ; Rankin, 2005; Sainsbury Centre for Mental Health, 2006; Warner, Mariathasan, Lawton-Smith, & al, 2006) together with the accompanying media attention (e.g. Pidd, 2006).
- The socio-economic benefits of individuals' well-being and the nation's wealth, as recently emphasised by Lord Layard (Centre for Economic Performance, 2006; Layard, Clark, Knapp, & Mayraz, 2007).

In fact, within the last two years the Government has announced significant investment in the Improving Access to Psychological Therapy programme, which seeks to expand access to and choice of evidence-based psychological therapies. Details of the programme have been widely disseminated and copies of the National Implementation Plan, Workforce and Education/Training Guidance, Commissioning Guidance and other relevant documents are available from the www.iapt.nhs.uk website.

Although the major investment in psychological therapy services represented by IAPT has been generally and enthusiastically welcomed (New Savoy Declaration, 2007), it does present a series of challenging issues for psychological therapists. Indeed, this has been part of the rationale underlying the existing project.

Amongst the major concerns that have been expressed are:

- The impact on existing counselling, psychotherapy and psychology services of service redesign around the provision of new IAPT services.
- The reliance on NICE guidance and the perceived privileging of CBT.

- The challenge of choice between different evidence-based psychological therapies for both commissioners and users.

Many of these issues have been the focus of discussion within this workstream and the outcomes of these debates are presented later in this report.

3. METHODS

Following a series of introductory meetings the Terms of Reference and Membership of the Workstream were agreed, and these are included as Annex 1 and 2 of this report. The intended membership was to draw on professional bodies (e.g. BABCP, BCA, BACP, BPS, Relate, Royal College of Psychiatrists, UKCP) representing a range of different psychological therapies, including psychotherapy, counselling, arts psychotherapies and psychology, together with representatives from user, voluntary and third sector organisations, Skills for Health, the Health Professions Council and the Department of Health.

We were keen to engage service users and made contact with a number of mental health charities, together with the “We need to talk” coalition. It was agreed that users’ perspectives would be reviewed towards the end of the process when the recommendations from the workstream were starting to emerge.

The report has been written through a consensual and collaborative process involving all members of the workstream. Initially, two versions of the report were available: the current version which is part of the over-arching NWW for Psychological Therapists report and a longer version which had not been through the process of consensual review and it was agreed within the group, therefore, that it would remain unpublished.

4. MAJOR ISSUES IDENTIFIED

4.1 User and carer choice in accessing psychological therapies

Exercising choice around mental health services

Laurie Bryant, service user/carer lead representative working with CSIP (cited in Care Services Improvement Partnership, 2005) stated:

‘Choice listens to me, involves me, responds to me, values me, and supports me on the road to recovery. If we are serious about putting service users at the heart of modern mental health services, providing choice is essential’.

Moreover, Rankin (2005) suggests that choice within psychological therapy and mental health services could transform service provision and change societal perceptions of mental/emotional distress.

The notion of choice for people using psychological services differs significantly from people accessing elective physical healthcare. For example, while the choice of one provider out of four or five options and fast-track day surgery may be appealing for someone with a physical ailment, research evidence from mental health service users suggests that other priorities are uppermost for this group.

How can choices be made?

Clearly, ensuring that choices are available in the delivery of psychological therapy services poses some significant challenges. The fundamental task of informing users about the nature of individual therapies and how they might differ has yet to be properly realised by many services. This should involve a full dialogue in relation to each of the options concerning:

- How helpful is this psychological therapy likely to be?
- What are the key aspects of the processes of therapy?
- What will be required of me?
- What can I expect the therapist to do?
- What are the usual results (positive and negative) of this treatment and what proportions of people trying it stay the course?

If users are to be properly informed, it is likely that there will be need for a variety of supporting educational materials using a range of media and languages (e.g. http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm). The National Occupational Standards for Psychological Therapies, currently under development, will be a useful part of such a package (ptherapies@skillsforhealth.org.uk).

There are other necessary organisational changes that commissioners should be encouraging service providers to adopt. It is important that the value of choice within mental health services is understood not only by psychological therapists but by the entire workforce, starting with primary care staff and the relevance of training programmes such as Mental First Aid (<http://www.mentalhealthfirstaid.csip.org.uk/>). Another critical aspect is the interface between primary and secondary care. This requires urgent attention to ensure that services are seamless and encompass the choice ethos and a person-centred approach which incorporates more individualised and flexible care packages, especially in light of personalisation.

An important consequence of choice concerns inequalities and ensuring that services are able to offer a range of therapies suitable for individuals with different cultures or backgrounds. Choice must assist the removal of barriers to health, by for example ensuring that IAPT staff are culturally competent, so that disadvantaged groups are

provided with equal access to different care pathways (Department of Health & National Health Service, 2005).

There should also be dialogue around the timing and location of therapy and the opportunity to see therapists in valued and non-stigmatising environments. There should also be a range of modes for delivering psychological therapies including individual, family, couples and groups, together with guided self-help approaches (books, leaflets, web-based, audio and DVD based materials). Arts psychotherapies and other non-direct talking therapies should be available for those people who can use or need to use a creative medium to access and work through their problems. Services should be based around a philosophy of recovery and ensure that users are able to contribute actively and meaningfully to the service and its development.

Future challenges

Finally, we need to recognise that the choice agenda also raises several difficult issues, which will need to be addressed in the future.

- What are the consequences when a user doesn't have a choice due to the lack of provision of an appropriate range of services?
- How much choice should a client have when they believe that they are receiving the wrong therapy or the wrong therapist?
- What impact would this have on therapist's ability to manage and work with therapeutic ruptures?
- Should choice be limited to those therapies that have an evidence-base in the absence of agreement in the field about what constitutes appropriate evidence? For example, inequalities could arise in access to different therapies across the devolved nations within the UK, due to differences in both content and approach of clinical guidelines although currently differences are minimal.

Increased choice within the NHS and in non-statutory provision will facilitate a lever for service users to achieve a position of control, and provide an important opportunity for services to facilitate and support this therapeutic move. By engaging with choice service users may feel less isolated and stigmatised and increase their engagement with their community bringing them closer to full participation in forms of paid and unpaid work, education and/or training.

Recommendations:

It is recommended that:

- Commissioners should agree with users and carers the range of choice of evidence-based psychological therapies that local services should be providing. The voluntary sector, in particular, may have expertise to offer in making such decisions.

- More research and guidance is required around how users can make informed choices between evidence-based therapies.
- Supporting educational materials should be developed to support users in making decisions about therapies providing best available information in an accessible and culturally sensitive manner.
- Choice should be limited to effective therapies and secondarily under-researched but widely accessed therapies for which there is no evidence of harmful effects.

4.2 Clinical guidelines and commissioning for choice and effectiveness

Guidelines and clinical judgement

Clinical guidelines are defined as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances” (p.8) (Field & Lohr, 1990). They differ from standard literature reviews and textbooks in the explicit methods used in their construction, which usually involve a representative guideline development group of expert professionals, service users and carers who use a systematic approach to identify and evaluate the evidence.

Evidence from secondary research, usually in the form of systematic reviews, is used in combination with the expertise and knowledge of the guideline development group to arrive at a set of recommendations for clinical practice. Guideline development groups increasingly follow standard methods for development of recommendations including, where appropriate, formal and informal consensus methods (National Institute for Health and Clinical Excellence, 2007b). An important characteristic of high quality clinical guidelines is that the method is transparent and well described so that the evidence supporting each recommendation is clearly identifiable.

Purpose and functions of guidelines

A primary aim of clinical guidelines is to promote clinically effective and cost-effective care and in order to achieve this they need to be based on the best available evidence. In seeking to achieve this aim, guidelines set standards for interventions by healthcare professionals which should guide professional behaviour. However, they are not a substitute for the clinical judgement exercised by a healthcare professional when determining the most effective care for an individual (National Institute for Health and Clinical Excellence, 2007b). Since clinical guidelines are based on the needs of the hypothetical typical patient, whereas patients’ actual needs inevitably vary from the average, recommendations may require adaptation to suit the needs of the individual.

The focus in clinical guidelines on setting standards for and improving patient outcomes has a number of direct and indirect consequences. In addition to improved quality of care, these include:

- The allocation of resources towards more effective treatments and away from less effective treatments.
- The avoidance of harmful or ineffective treatments.
- Improved access to effective care, particularly if the guidelines also make recommendations about the nature of service delivery systems.

Clinical guidelines are also increasingly used to inform patients about the type of care they may expect. NICE produces publications for all its guidance which specifically aims to inform patients and their carers about the guidance it has issued (National Institute for Health and Clinical Excellence, 2007b). Guidelines may also be used by healthcare commissioners and managers to guide the purchasing of services.

Recommendations

Guidelines should focus on:

- Allocating resources towards more effective therapies and away from less effective treatments.
- The avoidance of harmful or ineffective therapies and should clearly distinguish between therapies with no evidence base and those which have been shown to have no effect or negative effect.
- Improved access through the development of effective service delivery systems.

4.3 NICE and the range of possible recommended interventions within IAPT

What activity does NICE commission?

The National Institute for Health and Clinical Excellence (NICE) was established in 1999 to develop guidance for the National Health Service (NHS) in England and Wales. It operates as an independent body within the NHS, but its funding and the remit for its work comes from central government. NICE's role is to provide recommendations on the best practice in health care and thereby set standards by which health care and health outcomes can be improved. It produces guidance in four areas:

- Clinical practice guidelines, focussed primarily on a disorder or condition, such as depression or Type I diabetes.
- Technology appraisals reviewing the cost effectiveness of health technologies, usually, but not limited to, drugs (for example, mental health technology

appraisals have covered psychological therapies in primary care, ECT, drugs for the treatment of ADHD and parent training in conduct disorder).

- Interventional procedures which are concerned primarily with the efficacy and safety of surgical procedures but do on occasion move outside this field to consider non-surgical interventions, for example trans-magnetic stimulation for the treatment of depression.
- Public health guidance concerned with public health interventions whose brief extends beyond health care to involve social care and the wider environment.

These four elements constitute the largest single programme for the development of clinical guidance in the world. It should be noted, however, that NICE serves only England, Wales and Northern Ireland, Scotland has separate responsibilities for guideline development which may in some instances not be consistent with NICE.

While sometimes criticised as a rationing body, the implementation of NICE guidelines is one of the standards assessed by the Care Quality Commission. The Government has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by NICE technology appraisals, normally within three months from the date that NICE publishes the guidance.

NICE guidelines and mental health

Currently, there are 16 guidelines on mental health and behavioural conditions (see summary in Annex 3).

The main recommendations for *anxiety disorders* include individual, group or computerised cognitive behavioural therapy (CBT) for panic disorder and generalised anxiety disorder, along with self-help (bibliotherapy) based on CBT principles. NICE recommends that CBT for panic disorder should be delivered by suitably trained and supervised people who offer weekly sessions of 1 – 2 hours, completed within four months. The optimal range of sessions is 7 – 14 hours in total (briefer CBT – 7 hours) and for some patients intensive CBT over a short period may be appropriate. For Post-traumatic Stress Disorder NICE recommends trauma-focused CBT and Eye Movement Desensitisation and Re-processing. For Obsessive-Compulsive Disorder the recommendation is for individual CBT (including exposure and response prevention) which can vary in duration and intensity. There are no recommendations yet for treatments for social phobia.

The updated guideline on the management of *depression* (National Institute for Clinical Excellence, 2004; National Institute for Health and Clinical Excellence, 2007a; National Institute for Health and Clinical Excellence, 2009 #11454) lends support to the stepped care framework and gives general support for competency based training, supervision and outcomes monitoring. In addition, it makes the following recommendations:

- The value of low intensity interventions for mild to moderate depression is confirmed.
- Behavioural activation is now recommended.
- Group CBT is emphasised more strongly than before.
- For severe depression CBT and IPT are recommended as before.
- For mild to moderate depression, most people would be expected to have been offered a low intensity intervention first. If they have failed to respond to, or refuse, the low intensity intervention, they should "normally" have CBT, behavioural activation, IPT or couples therapy (recommendation 8.10.3.1).
- Counselling and brief dynamic psychotherapy also appear as high intensity treatment options for mild to moderate (but not severe) depression and should be available for those patients who don't improve with the first-line treatments identified above, or who prefer other options. However, patients should be aware that there is less evidence to support their efficacy compared to CBT or IPT. (See recommendation 8.10.3.4).
- Individual CBT and mindfulness based CT are now recommended for relapse prevention.
- Finally collaborative care is recommended for people who have a long term condition and depression.

The stepped care model recommended by NICE has been adopted by the Improving Access to Psychological Therapies programme as the framework for the delivery of the service. The IAPT programme may be considered one of the best developed implementations of the system recommended by NICE for ensuring access to cost-effective interventions for a wide range of people suffering from depression, particularly if supported by systems for routine outcome monitoring which enable prompt stepping up of care for those who have not benefited from a low intensity intervention.

The IAPT programme aims to support Primary Care Trusts in implementing NICE guidelines for people suffering from depression and anxiety disorders. IAPT is training a new workforce in CBT, which NICE has approved as the main treatment for depression and anxiety disorders, but IAPT also considers counselling to be important in the spectrum of talking therapies (<http://www.iapt.nhs.uk/2009/05/counsellingandiapt/>), aiming to help people with mild to moderate depression explore their feelings and make dynamic change in their lives and relationships. Of course, these advantages apply equally well to other psychological therapies such as interpersonal psychotherapy (IPT) or psychodynamic psychotherapy. The Government is committed to providing patients with a choice of NICE-indicated treatments as the new psychological therapy services mature.

Recommendations

With respect to anxiety disorders and depression, the report recommends in order of priority the following psychological therapies for funding and support within the IAPT programme:

- **For the anxiety disorders**
 - *Panic Disorder*
 - Individual CBT
 - Guided self-help (based on CBT principles)
 - Computerised CBT
 - *Generalised Anxiety Disorder*¹
 - Individual CBT
 - Guided self-help (based on CBT principles)
 - Computerised CBT
 - Large Group CBT
 - *Post-traumatic Stress Disorder*
 - Trauma-focused CBT
 - Eye Movement Desensitisation and Re-processing
 - *Obsessive-Compulsive Disorder*
 - Individual CBT (including ERP) – *vary duration/intensity*
- **For depression (including depression with chronic physical health problems)**
 - *For mild to moderate depression and persistent sub-threshold symptoms*
 - Guided self-help (based on CBT principles)
 - Computerised CBT
 - A structured group physical activity programme.
 - Group-based CBT (for those who decline the above three interventions)
 - *For mild to moderate depression and persistent sub-threshold symptoms which have not benefited from a low intensity intervention*
 - CBT
 - Interpersonal therapy (IPT)
 - Behavioural activation
 - Couples therapy (based on behavioural principles) for people who have a regular partner
 - *For mild to moderate depression and persistent sub-threshold symptoms and those who decline CBT, IPT, Behavioral activation or Couples therapy*
 - Counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression
 - Short-term psychodynamic psychotherapy for people with mild to moderate depression

¹ Note this guideline is currently being updated

- *For mild moderate to severe depression²*
 - CBT
 - Interpersonal therapy (IPT)
- *For relapse prevention in depression*
 - Individual CBT
 - Mindfulness-based Cognitive Therapy
- **Additional/Modified Interventions for Depression with Chronic Physical Health Problems**
 - *For mild depression and persistent sub-threshold symptoms*
 - Group based peer support (self-help) groups
 - *For mild depression and persistent sub-threshold symptoms who decline a low intensity intervention*
 - Group based CBT
 - *For moderate to severe depression³*
 - Individual CBT

4.4 The relationship between NICE and the nature of the evidence base within psychological therapies

Although the primary purpose of the workstream has been to translate appropriate NICE guidance into pragmatic recommendations that could be considered by IAPT in implementing the Statement of Intent and broadening the range of evidence-based therapies available to services and users, several key issues emerged surrounding the implementation of NICE recommendations within the disciplines of counselling and psychotherapy.

The nature of the evidence base

This concerns the nature of the evidence, the place of practice based evidence⁴, and the lack of funding for research for some approaches and the consequent absence of evidence in relation to commonly practiced and possibly effective therapies. We have summarised some of these issues below in order to promote a wider discussion about how NICE implementation within the world of psychological therapies can be strengthened and better understood by users and therapists alike.

² Normally in combination with antidepressant medication

³ There is not sufficient evidence to support the use of IPT

⁴ 'Practice based evidence' in this context refers to outcomes data collected from clients during the course of routine treatment as opposed to part of an experimental study such as a randomised controlled trial which in the past at least has been the major source of 'evidence-based practice' denotation. An overlapping dichotomy referred to in this document concerns treatment efficacy versus effectiveness studies. A therapy is considered efficacious when demonstrated to be superior to control condition in a well controlled trial. Effectiveness studies, commonly less rigorously controlled, show superiority to comparison group under more realistic and therefore more generalisable conditions (Roth & Fonagy, 2005)

It is hoped that in the future, IAPT will not need to restrict its provision of therapies to a group of the most frequently mentioned treatments as no one would argue that most frequently mentioned by NICE is equivalent to most effective. This is taken but narrow reading of the NICE headline conclusions may be unhelpful as it reflects the quality of the research available in relation to a treatment and the guarantee that provides of effectiveness for commissioners and users of services. We identified the need for more high quality research on potentially efficacious readily accessible treatments and for improvements in engaging the psychological therapy research community in the future work of NICE. This could include technical recommendations such as the establishment of generalisability criteria for outcome research ensuring that conclusions are invariably applicable to the service delivery contexts in which psychological therapies are provided.

The perceived importance attached by NICE to Randomised Controlled Trials (RCTs) and hierarchies of evidence has been a major concern within the psychotherapy and counselling community. NICE has stated that it has moved away from simplistic models of evidence hierarchies (Rawlins, 2008) and lays considerable emphasis on the need for the guideline development group to exercise its judgment about what kind of evidence is best placed to answer the important clinical questions facing the group. We wish to endorse NICE's explicit commitment to make use of the best available and most appropriate in relation to a particular question. In this context, rigorously collected practice based evidence may indeed inform NICE recommendations and be helpful to the development of the IAPT programme.

While RCTs can give clear answers to certain research questions, relying entirely on good RCTs has limitations, as the Chair of NICE, Sir Michael Rawlins (Rawlins, 2008) has pointed out. One is that there are important research questions that cannot be answered by RCTs, such as:

- Prognostic indicators, for which case cohort studies would usually be the best source of evidence.
- Problems evaluating harm, where data mining studies may be the best source of patient experience, and where evidence from qualitative studies is of real value.

Moreover, the uneven distribution of research funding may distort the representativeness of the existing evidence base. Most evidence (over 80% of RCTs in systematic reviews of psychological therapies) were carried out in the US where funding decisions for trials were and to some extent remain associated with particular methodological priorities that not only reduce their generalisability but also the chances of commonly practiced and possibly efficacious therapies such as art therapy, integrative therapies and psychodynamic therapies receiving adequate funding for large scale trials. Because weight which large well controlled trials receive in the conclusions of systematic reviews (such as those of NICE) it is inevitable that therapies that are unresearched will never find their way into

guidelines, unless this bias of research funding is urgently addressed at least in the UK context.

Routine practice data also has an invaluable role in:

- Providing a strong case for funding and conducting an RCT of a treatment that has not been rigorously investigated.
- Looking at how the treatment fares in various different settings once its efficacy has been demonstrated in an RCT (an absolutely fundamental question for dissemination).
- Looking at how a service overall performs.

Improving the evidence base

For both RCT and routine outcome (correlational) designs there are certain basic methodological requirements that are particularly desirable if clear cut conclusions are to be reached. These include:

- The need to have pre- and post-treatment data that are as complete as possible.
- The need for the dataset to include information which is obtained relatively independently from the clinicians (e.g. patient reported outcomes).
- The ability to demonstrate that the therapies that are being assessed were delivered as one would expect (i.e. that the results pertain to the treatment that is being evaluated or at least that the treatment actually offered is clearly described).

There are a number of good strategies that may contribute to greater confidence that we know what practitioners actually did in the therapies evaluated in a study. First, we must go beyond the bare claim by a therapist that his or her work is best described under a particular modality title. Our judgement should be based on objective evidence (e.g. a checklist) which confirms that particular defining features of the therapy were in fact delivered. Second, where judgements based on independent observation (ratings of tapes, for example) are available we should be satisfied whether or not the therapist was following a manual describing an evidence-based treatment and assess the extent to which therapists complied with that manual. Of course, manuals are not invariably appropriate to specific cases and we need recommendations about how they can be best applied or even created with the clinical context and with the average clinician in mind (Weisz, Doss, & Hawley, 2005). The final issue concerns the complex problem of assessing the competence with which a treatment was delivered which is made easier now with the availability of a framework of competencies for psychological therapies (e.g. http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm and The National Occupational Standards for Psychological Therapies, ptherapies@skillsforhealth.org.uk).

Alternative perspectives from psychological therapies research.

As has been previously emphasised, psychological therapy has a long research tradition which has encompassed other approaches as well as the RCT. Rather than attempting to determine the efficacy of particular and well-specified interventions for diagnosed disorders or problems, the focus of research has often been more process-orientated and has sought to identify so-called “non-specific” factors such as therapist characteristics, the quality of the therapeutic alliance, and the match between therapist and client etc in determining clinical outcomes.

This type of research has often looked for correlations between such factors and clinical outcomes within routinely collected data sets. In addition, more in-depth process-orientated research studying aspects of interpersonal interaction, therapist non-verbal behaviour and the like have also been adopted to understand the contributions that common factors might make.

Much has been written about comparative efficacy and the “Dodo bird of therapeutic equivalence”⁵, and the debate continues in relation to psychological interventions suitable for IAPT (Clark, Fairburn, & Wessely, 2008; Stiles, Barkham, Mellor-Clark, & Connell, 2008). Indeed, many practitioners are swayed both by the arguments in favour of clinical guidelines and the importance of efficacy (i.e. evidence-based practice) and by those emphasising the importance of routine clinical outcome collection and the determination of service effectiveness (i.e. practice-based evidence).

Unfortunately, this can lead to confusion about how to reconcile these two apparently opposing perspectives that result in opposing conclusions about therapeutic equivalence. This question is not purely academic, since commissioners of services may be influenced by NICE guidelines and arguments in support of efficacy, whereas practising clinicians will be faced with the realities of delivering effective services on the ground. We suggest that IAPT provides an opportunity to exploit the strengths of these two apparently opposing approaches. Rigorously and intensively collected PBE will give us the most realistic idea we can have about the relative effectiveness associated with a treatment in the service context while experimental studies will provide support for the causal relationship we assume in everyday practice between the treatments we offer and the improvements we observe. In the psychological therapies we need all the evidence we can have.

The apparent contradiction between the lack of difference between therapies on the ground and the differences identified when reviewing experimental studies and other discrepancies between ‘efficacy’ and ‘effectiveness’ can be resolved if we keep in mind that therapies have to be delivered by therapists within the context of a relationship with the client. In deciding which therapies to resource and invest in for

⁵ The Dodo bird in Alice in Wonderland declares, that everyone has won and they all deserve prizes. A lack of clear superiority of a new psychological therapy over another would call for a similar judgement (Luborsky et al., 2002).

training and development, it is appropriate to examine the evidence-base regarding comparative efficacy. We believe that the clinical guidelines produced by NICE are sound starting points for examining investment decisions. However, the intention to deliver a particular psychological intervention, whether it is CBT, IPT or any other evidence-based intervention, is only an intention and the process underlying the implementation of RCTs has to be translated into routine clinical practice with reference to local circumstances.

The contribution that IAPT can make

We believe that IAPT should enable the translation of efficacy into effectiveness through its emphasis on selecting therapists with appropriate training and experience, the development of a competency-based training programme and the provision of regular and outcome focused supervision. Moreover, a major feature of IAPT services may have the potential to bridge the philosophical divide between evidence-based practice and practice-based evidence, between the university laboratory and the clinicians delivering an essential service. Rigour of data collection is the chief advantage of university based research and, with its current design, the IAPT context is able to deliver this with the added advantage of an unselected and therefore representative group of clients and highly trained but generalist therapists who have to have competence in just one intervention? (e.g. CBT for social anxiety).

IAPT services are based upon the principle of regular outcomes monitoring for all clients and therapists. We would hope that over time IAPT services will build up large-scale databases similar to those developed by psychotherapy researchers in the US (e.g. Lambert; Scott-Miller etc) that have allowed the identification of reliable differences in therapist performance regarding client outcome, independent of case severity or mix. Less intensive observation appears to give an unrealistically flattering picture of how well a treatment works. But periodic assessment using instruments such as CORE-OM would be helpful in offering comparability with other populations, particularly specialist psychological therapy clinics, where these instruments are in routine use. The variance in therapist outcomes should be a major factor when considering the implementation of clinical guidelines and IAPT should provide an ideal research opportunity for identifying those factors related to therapist performance and how this might be optimised by ongoing organisational factors such as professional development and supervision. IAPT's training, supervision and competence models may have already succeeded in reducing therapist based variability, and if not, would offer a wonderful opportunity to understand these processes better with a view of further improving treatment effectiveness.

The way forward?

We recommend that a group should be convened to agree on acceptable standards of evidence for the full range of RCT and non-RCT studies. The group should include staff of NICE and experienced researchers from a representative range of psychotherapies. This is not a trivial task, and will take time and adequate funding. For NICE's conclusions to be owned by the professionals charged with implementing them, their greater engagement in the NICE Guideline Development process would be valuable. This is an acute problem in the field of psychological therapies where misunderstandings and misapprehensions about NICE processes and conclusions abound.

In the meantime we propose that an equivalent group be set up to advise IAPT about how to make good use of the material in the existing NICE guidelines. Our concern is that provision will be restricted according to the headline conclusions of the published guidelines. NICE guidance includes substantial additional and contextual material that should justify a more flexible and realistic approach. However notwithstanding the inclusion of recommendations related to such issues in all NICE guidelines, commissioners and sometimes service managers may not consider the importance of working with interpersonal relationships, including the needs of families and carers. Similarly, the impact of patient choice, preference and expectations upon the effectiveness of the interventions that are offered deserves further consideration. We strongly urge IAPT to plan its provision on the basis of full reading of all of the careful thinking and reviewing of the research literature that has gone into the NICE recommendations. In the longer term we hope that NICE will engage with the task of working with professional research groups of psychotherapy and counselling organisations to ensure that its rules of evidence in the NICE Guideline Development manual are fully understood and take cognisance of the concerns of psychological therapists working in the field.

Recommendations

We recommend that:

- Routine patient-reported outcome data should always be collected and that methods are used to characterise the type of intervention employed and the competence/fidelity in which it was delivered.
- A unique opportunity to examine the translation of EBP into PBE exists with the routine outcomes collected through the IAPT programme.
- That routine outcome data might enhance the competence and effectiveness of individual clinicians through appropriate feedback and supervision.
- An expert panel is established through NICE to consider how other sources of evidence relating to the effectiveness of psychological interventions could be more strongly utilised within the NICE guideline development process.

4.5 The context of therapies: the role of group, family and integrative approaches

Often therapies are delivered in a group context, which because of their social dimension, have generic advantages in these and other modalities. The advantages of having peers in a treatment situation include:

- Reducing stigma and the sense of isolation.
- Instilling hope.
- Promoting self-esteem through acceptance by others.
- Providing insights through the multiple sources of feedback from others.
- Giving opportunities for learning.
- Allowing participants to practice behaviours and communication helpful to social interactions in non-clinical settings.

All these factors apply of course to potentially increasing motivation and active engagement in any specific form of therapy being utilized within the group setting.

However, the specific competencies required for the facilitation of group work must not be underestimated. Group work requires special skills of managing social dynamics regardless of the modality of treatment, and this has implications for the competencies required of the psychological therapy workforce.

Similar considerations of specific advantages apply to therapies delivered in a family context. It is possible that when the roots of a problem lie within a family structure or system, addressing this directly, with the entire family attending, could have advantages.

While as with groups, a number of modalities of therapy can be practiced in the context of family work (behavioural, psychodynamic), systemic family therapy has a relatively well-established evidence base in relation to a number of problem behaviours, particularly schizophrenia, eating disorders, depression, and a range of health-related problems. Working with couples and families, just like working with groups, requires special training and competencies that may not be generally available without the collaboration of experienced training bodies specialising in providing therapies in these treatment contexts.

Similarly, approaches incorporating a number of different therapeutic elements require specific competencies and need to be considered despite their relative newness and small numbers. Cognitive Analytic Therapy (CAT) and the Arts Psychotherapies both have a growing evidence base. CAT has a particular use where dysfunctional interpersonal relations are a significant underlying feature of the difficulties which people seek help for and where a focus on symptoms alone is not productive. Arts psychotherapies are a state registered group of four professions - art, music, movement, drama. They are often offered in groups and provide

alternative forms of self-expression and communication that can help a person to get in touch with feelings beneath immediate conscious awareness. The creative medium also enables the recipient to work at his or her own pace, without necessarily naming feelings or processing difficult problems until after a 'creative/expressive' phase in the therapy. Fortunately, because of the creativity of psychological therapists, even well established therapies are constantly developing with new contexts or applications being added to routine practice (e.g. home based family therapy). Resources must be made available for the rapid evaluation of these new treatments so they can be added to and improve the effectiveness of the IAPT portfolio of services. There is no currently competent body to judge the potential importance of such evaluations and the resources available, as mentioned above, are very limited.

Recommendations

We recommend that:

- Priority should be given to research to be carried out on extending the range of applicability of current therapies and the effectiveness of new therapies integrating effective components of existing treatments.
- Modalities such as couple, group and family therapy should be carefully considered and evaluated alongside individual therapies.
- The development of newer therapies based on integrative principles (e.g. Cognitive Analytic Therapy) and the practice of integrative therapies are acknowledged, and supported to develop a future evidence-base.

4.6 Importance of the evidence base for the training of psychological therapists

Currently, the extent to which counselling and psychotherapy (including arts psychotherapy Masters degree) courses help trainees develop an appreciation of the evidence base for their practice, including evidence on possible harmful effects of psychotherapy, is unclear. Recent research by the British Association of Counselling and Psychotherapy (2009), for instance, indicates that only around 50% of psychotherapy and counselling courses require students to undertake research projects. There is also extensive evidence to indicate that many therapists have little interest in, or familiarity with, empirical research findings in their field (Boisvert & Faust, 2006).

While there are significant differences of opinion across the field about the most appropriate forms of evidence to inform practice and training (e.g. Clark et al., 2008; Stiles et al., 2008), there is general agreement amongst trainers (e.g., Cooper, 2008), professional bodies (e.g., BACP, UKCP, BCP, BABCP) and regulating authorities (e.g., HPC) that trainees should be required to develop an understanding of relevant research findings and the methods by which these have been generated, as well as developing the capacity to evaluate their own practice.

When finalised, all training courses wishing to have their students registered by the HPC as counsellors and/or psychotherapists will likely need to ensure that their curricula support students in attaining these threshold proficiencies. Trainings will need to cover the application of evidence-based practice in private practice as well as ensuring that their trainees are competent to apply the evidence base, critically appraise evidence and evaluate their own practice to the standards expected in public sector provision.

Recommendations

- All psychological therapy training should include teaching on evidence-based practice and more general research methods within the field.
- Research teaching should require candidates to recognize the evidence indicating for which client groups a particular modality of treatment may be effective and where evidence exists for harm.

4.7 Developing a national infrastructure for research

Research in the fields of counselling and the psychotherapies uses a broad range of quantitative and qualitative research methods to answer a broad range of questions related to therapeutic agency, process and outcomes, as well as settings and types of intervention. It is generally agreed that the knowledge base that underpins the delivery of psychotherapy and counselling services, while increasing, is currently inadequate. Moreover, there is currently no strategic framework for developing counselling and psychotherapy research in the UK.

The research challenge?

The professions of counselling and psychotherapy are beginning to engage with research, both as consumers of research findings to improve practice, and as producers of research to answer the questions of importance to these professions and the wider community. However, this is a relatively recent interest and the profession is often perceived externally as not having a substantive research base, assuming that this is assessed through RCTs, with the exception of certain specialised areas such as CBT. The Arts Psychotherapies professions are beginning to address this problem with the creation of an International Centre for Research in the Arts psychotherapies (ICRA) at Imperial College, London.

If the evidence base of these professions is to be significantly enlarged over the next decade, we will need to invest resources to develop a cadre of counselling and psychotherapy researchers who will increase the knowledge base with which the profession functions and the technologies it has at its disposal to monitor the outcomes it routinely achieves. This could be best achieved if a national

infrastructure for research in the psychological therapies were to be developed, to include minority disciplines as well as those with established research frameworks.

A strengthened infrastructure for counselling and psychotherapy research could achieve several important goals including:

- Improving the capacity of the workforce to routinely practice with regard to evidence.
- Developing a more comprehensive and sophisticated evidence base for the profession.
- Evolving the research paradigms available specifically for the psychotherapies.
- Researching mechanisms of pathogenesis and therapeutic change.
- Developing effective new treatments making use of evidence gathered from relevant related disciplines (e.g. developmental psychology, genetics, cognitive and affective neuroscience where new sources of evidence are available).

What needs to be done?

Counselling and psychotherapy research currently takes place in departments of psychology and psychological medicine, psychiatry, social work and education, with numerous journals, conferences and databases underpinning their academic activity. Not surprisingly, research is sometimes subsumed into activity in these better-established disciplines, which are assessed as part of the research assessment exercise (RAE). Counselling and the psychotherapies are not recognised as a distinct subject area for RAE purposes, which can be problematic for would-be career researchers and has not encouraged the development of methodologies specific to practice.

The Science and Innovation Investment Framework sets out the Government's aspiration for the knowledge-based economy that 2.5% of GDP should be invested in R & D by 2014 (Joint University Council Social Work Education Committee, 2006). In health, more than half the research funding comes from industrial sources such as pharmaceutical companies. National charities such as the British Lung Foundation, Diabetes UK and others fund research programmes to meet the priorities of their chosen area.

Research priorities for health and social care are determined by topic selection processes through the offices of major funding bodies, such as the MRC, ESRC, NCCHTA and Big Lottery. The DoH, a major funder, funds through the NIHR and ASHSC NHS R & D programmes and gives core funding to a range of research centres (such as the Centre for Reviews and Dissemination at the University of York and the NCCHTA at the University of Southampton) for systematic reviews. In addition, the DH funds networks (such as the Primary Care Research Network) to undertake research and to increase research capacity and capability.

There is currently no specific national funding stream or prioritisation process for research into counselling and psychotherapy, either through the good efforts of the professional bodies, or through strategic activity/partnerships with major funders, including government other than specific calls by NHS research bodies such as Health Technology Assessment, SDO, and the NIHR programmes.

Bodies investing in counselling and psychotherapy need to develop a long-term strategy by creating a National Psychological Therapies Research Institute to:

- Secure adequate resources.
- Build research capacity and awareness.
- Undertake research programmes that produce innovation particularly among the less heavily researched therapies.
- Ensure that research activity has maximum impact on policy and practice.

The development of the strategy requires action by the counselling academic and professional community, but its success also depends on external support, systems and partnerships to increase research activity in counselling and psychotherapy over the next 5 -10 years.

Recommendations

It is recommended that:

- A National /Psychological Therapies Research Institute is established to oversee the development and promotion of research strategy and funding within this area.

5. CONCLUSIONS

5.1. The efficacy of psychological therapies has been robustly demonstrated both through recent research and the conclusions from systematic reviews that have constituted the evidence-base for many different clinical guidelines constructed across many countries throughout the world. The efficacy of many psychological interventions, as demonstrated by the number needed to treat convention from evidence-based medicine, far exceeds the efficacy of many common medical procedures or pharmacological agents (Wampold, 2007). Moreover psychological interventions, in general, tend to preserve clinical outcomes at follow up and may offer to the patient or client a more enduring form of clinical change process or adjustment than acute pharmacological interventions or maintenance regimes (Roth & Fonagy, 2005; Posternak & Zimmerman, 2007).

5.2. Access to psychological therapies should be freely available and patients should have equivalent access to treatments as to any other treatment endorsed by NICE for delivery within the NHS. Furthermore, they wish to see the widening of access to all evidence-based psychological therapies, extended beyond the treatment of

common mental health problems/disorders, to all other physical and mental health conditions that would benefit from such an approach.

- 5.3. It is recognised that not all psychological interventions or therapies may be beneficial to clients and patients. Some may be ineffective whereas others may actually do harm. There are also major variations in the range, depth and extent of evidence to support different psychological therapies. This limits the authority of clinical guidelines to recommend a broad range of therapies that are widely practised. The effectiveness of individual practitioners and their routine clinical outcomes vary significantly within any service, irrespective of the severity or type of clinical problem treated (and type of treatment offered). The group wished to draw attention to the fact that without effective supervision and clinical governance procedures, there remains the potential for a minority of therapists to practise ineffectively or to harm or abuse their patients and clients irrespective of their modality of treatment.
- 5.4. Ongoing controlled trials research and the regular monitoring of routine clinical outcomes are the solutions to the variability within efficacy (evidence-based practice) and effectiveness (practice-based evidence). Each approach to data collection (from experimental contexts and from routine practice) has its unique strengths and merits, and we strongly urge that through the IAPT programme those two approaches which are often seen by clinicians as irreconcilable, are enabled to contribute to the development of future therapists, services and clinical guidelines. To that end, the group would encourage a greater dialogue with NICE to review the extent to which the psychological therapies evidence base can support guideline development and consider including a broader range of evidence and methodologies, and embrace a more psychologically-orientated approach to mental and physical health conditions than its current medical and diagnostically-based approach. Training programmes should ensure that therapists are familiar with both of these approaches to collecting evidence.
- 5.5. Further research is necessary for those therapies that have a relatively weak evidence-base and those emerging therapies that are currently in development. A level playing field in research investment within mental health, and increased resources directed to investigation and development of psychological therapies is desired, making the investment comparable to that in developing new pharmacological agents which are equivalent in terms of effectiveness. The group considered that to improve the current position; consideration is given to establishing a unifying body to oversee the development and promotion of research strategy and funding within this area (for example a National Psychological Therapies Institute).

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