A PODCAST
BY PHYSICIANS
FOR PHYSICIANS

HOSTED BY DR. DAVID GRATZER

August 31, 2022

Expanding Access to Psychotherapy: David Clark on the English Experience

[Edited for grammar and clarity by CAMH]

The audio quality of this episode is just not up to our usual standards, but the quality of the content is. So we ask that you listen and, of course, enjoy the conversation.

[Musical intro]

David Gratzer: It's difficult for patients to get access to psychological interventions. Said in that paper a couple of years ago, published in the *Canadian Journal of Psychiatry*, suggest just 13 percent of Canadians get access to any form of counselling or psychotherapy. However, it's different in England. Joining us today is Professor David Clark, who is a professor of experimental psychology at Oxford. He's also an adviser to the government of the United Kingdom, and he talks to us today about psychotherapy free at the point of use. Welcome, Professor Clark.

David Clark: Pleasure to be here.

David Gratzer: Professor Clark, tell us about what you've been doing in England.

David Clark: Well, so we've been trying to scale up the availability of evidence based psychological therapies. We had the same problem that you have here in Canada. We have psychological therapies that are very powerful, very effective for mental health conditions, but very few people got them. And so we created the Improving Access to Psychological Therapies, or IAPT program, which trains sixteen thousand new psychological therapists and then delivers evidence based treatments. And a really key component of it is that we try and capture the outcomes on everyone who has a course of treatment and published that data, so we have proper public transparency about the effects of our mental health interventions.

David Gratzer: IAPT is an extraordinary program literally helping hundreds of thousands of people a year.

David Clark: Yeah. The IAPT program has got to a point where, in England, we were only seeing about five percent of people in the community with anxiety and depression within evidence-based treatment. But we've greatly increased the number of people who get an evidence-based treatment on the health service now. We've still got some distance to go, though, but the IAPT services are seeing about a million people a year who wouldn't have previously had psychological therapy.

David Gratzer: How many of them get care?

David Clark: So some people find that an assessment and some straightforward advice is all that they need. But other people really need to have a course of treatment. And so about five hundred and sixty thousand people each year have a course of psychological treatment in the IAPT services.

David Gratzer: Free at the point of use?

David Clark: Free at the point of use.

David Gratzer: Self-referral?

David Clark: We have self-referral because we found that's more equitable. We found that if we just rely on referral from the family doctors, there are some sectors of the community that don't seem to come through in the rate should expect. One of the key findings was that people from the black and ethnic minority groups were less likely to be referred through the normal medical channels. But if we open up the system to self-referral, then we see them in the numbers that you would expect given their rate in the local populations.

David Gratzer: One thing that's very unique about your program is the commitment to collecting data.

David Clark: Yes, that's really been absolutely critical to this program. Traditionally, in mental health, people have not been very good at collecting data. So people plan services on what we call 'input variables': how many people get seen; how long they wait. But of course, what the public wants to know is when they get whatever they get, is it going to help? And usually people try and measure outcomes in psychological therapy services, but often someone is given a questionnaire at the beginning and then another questionnaire at the end. But we find that about 60 percent of patients you don't get the post-treatment questionnaire completed often because someone might have finished treatments a bit earlier than you'd expect. So I have had to solve that problem, and the solution turned out to be very simple. It's just to give people a brief but well validated measure of their anxiety and depression each time they're seen. So then it doesn't really matter whether they finish when you expect or not, you still have a clinical endpoint. And so we've really transformed outcome monitoring. So before IAPT our. Psychological therapy services were only getting outcome data on thirty eight percent of people nationally. We now get it on ninety nine point four percent of people, so that's ninety nine point four percent of the five hundred and sixty thousand people we treat each year.

David Gratzer: It's an incredible data capture. How has that informed decision making around the program?

David Clark: Well, it's been wonderful. We thought about one in every two people should be able to recover. So about 50 percent. We're doing fifty two percent at the moment. And we also thought that quite a few people may not fully recover, but they show really worthwhile improvements and we hoped we might get to 70 percent and that's essentially where we're at. But we didn't start that way, and it's only because we were collecting all the data that we could detect. So at the start of the program, we were getting about 40 percent recovery, and it has taken us almost eight years to get to the point where we now have what we expected. In fact, we're going beyond it.

David Gratzer: Extraordinary. You've just you have a very large, real-world experiment. I mean, in a journal talking about a therapeutic intervention an N of two hundred would be great. An N of three hundred would be great. What's the total data set to date of IAPT?

David Clark: Well, at the moment we're treating five hundred and sixty thousand people a year, and we've been running for just over ten years now. We've, of course, been scaling up in that period. But I guess we must be at seven or eight million people.

David Gratzer: Wow, seven or eight million. And what are some things one can derive from that data in terms of care? Historically, we've said cognitive behavioural therapy needs to be 15 sessions.

David Clark: Well, it turns out that that isn't necessary. We should be offering people up to 15 or 20 sessions because that's what the clinical guidelines say. But we find that quite a lot of people recover with substantially less so in our data. The sort of optimal average number of sessions for a service is around about nine. But that doesn't mean you limit people to nine sessions. Of course, you allow people to have up to 20 or so. But because a lot of people recover with less, that's how you get that average. So it's not a very expensive intervention.

David Gratzer: The core of the treatment for most patients would be cognitive behavioural therapy.

David Clark: Well, cognitive behavioural therapy is recommended in the clinical guidelines for all of the conditions that we cover – depression and all the anxiety related disorders. So it is true that of the sort of high intensity therapies, the largest proportion is cognitive behavioural therapy, but that's only fifty seven percent of all the therapy sessions. And the reason for that is because in depression, there's also good evidence for a range of other modalities of therapy, and we try to offer people with depression a choice of treatments. The most common alternative that people are offered in the services is a form of counselling specifically focused on depression. But we also support brief psychodynamic therapy. Some people get depressed in the context of a relationship issue, and their partner is willing still to work with them in the therapy, and they can benefit a lot from couple's therapy. And we also have a treatment called interpersonal psychotherapy that we offer.

David Gratzer: For the psychiatrist or the family doctor listening right now. What are lessons from IAPT for their practice?

David Clark: Well, one of the first lessons, I think, is in terms of detection. There are many people in the community who particularly have anxiety problems that are not picked up. We find one of the sort of key studies is every seven years. We have an epidemiological survey in England looking at the prevalence of mental health problems in the community that identified people with depression or anxiety problems. It asked each of them Has anyone ever commented on this before? And for depression, it looked quite good. So if you're currently suffering from depression, about 70 percent of people said, yes, my doctor has mentioned this before or some other professionals mentioned it. But if you look at anxiety problems, say social anxiety, which is a very chronic condition, very disabling or obsessive compulsive disorder, only about one in 10 people had ever had that picked up. So at the moment, at least in England, it means that our primary care physicians have been trained well to pick up depression, but perhaps not as well as we would like to pick up what are often more chronic anxiety problems. So that's one of the lessons from all of this. Of course, those problems are very treatable in the IAPT service, so we really want to encourage broader detection of these problems because we can change people's lives with them

David Gratzer: Professor Clark, an absolute delight to have spoken with you. Thank you very much.

[Outro]

Quick Takes is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at porticonetwork.ca/web/podcasts. If you like what we're doing here, please subscribe.

Until next time.