Institution: University of Oxford		
Unit of Assessment: 4 - Psychology, Psychiatry and Neuroscience		
Title of case study: The IAPT programme: Improving Access to Psychological Therapies for people with anxiety disorders and depression		
Period when the underpinning research was undertaken: 2000 to December 2020		
Details of staff conducting the underpinning research from the submitting unit:		
Name(s):	**Role(s) (e.g. job title):**	**Period(s) employed by submitting HEI:**
David M Clark	Professor of Psychology	1983-2001, 2011-present
Ann Hackmann	Research Psychologist	1986-2011
Melanie Fennell	Research Psychologist	1981-2014
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Lauren Canvin	Research Assistant	2014-2016
Period when the claimed impact occurred: August 2013 to December 2020		
Is this case study continued from a case study submitted in 2014? N		

1. Summary of the impact

Between mid 2013 and the end of 2020, the IAPT programme has trebled in size. From seeing 434,000 people a year with depression and/or anxiety related problems in 2012/13, it now sees approximately 1,200,000 people per annum and is committed in the *NHS Long-Term Plan* to increase this further. Outcome data is collected from an unprecedented 99% of treated patients. The England-wide recovery rate for individuals who receive a course of psychological treatment has improved from 43% to 52% during the REF2021 impact period, meaning 230,000 more people recover each year. New integrated IAPT services that bring together mental health and physical health care have been created and are achieving substantial savings in physical health care costs. IAPT is being copied in other countries and provinces (Norway, Ontario, Israel, Australia). The work of David Clark's research group at the University of Oxford has played a critical role in all of these developments.

2. Underpinning research

How to collect outcome data on everyone who has a course of psychological therapy. The University of Oxford group were asked to train local clinicians in Northern Ireland in cognitive therapy for PTSD so they could treat traumatized survivors of the 1998 Omagh car bomb. As part of the initiative they created a simple session-by-session outcome monitoring system that ensured almost everyone who was treated between 1999 and 2001 had a pre and post treatment measure of the severity of their symptoms [1]. This was a radical improvement on the data completeness rates normally reported in NHS mental health services. The Oxford team's session-by-session outcome monitoring system was subsequently adopted with great success in the IAPT programme.

Understanding the determinants of variability in outcome between different IAPT services. The almost complete dataset generated by IAPT showed that there was considerable variability in the outcomes achieved by different services even though they are ostensibly delivering similar treatments with a workforce who are all trained according to consistent standards. In an analysis in 2013 of the first wave of IAPT services (n=32), Clark and colleagues [2] showed that certain types of treatment and ways of delivering those treatments were associated with better patient outcomes. In a subsequent *Lancet* paper [3] Clark analysed publicly available aggregate data and showed that key organisational features of IAPT services (n=200) accounted for a substantial amount of the between service variability in outcomes during 2014/15. Furthermore, change in these features between 2014/15 and 2015/16 was shown to explain over 40% of the improvement in outcomes during the same period of time. Dissemination of these findings helped IAPT services to substantially improve the outcomes they achieve with patients.

The clinical and economic case for expanding IAPT and for creating integrated IAPT services. In their 2014 book (*Thrive: The power of psychological therapies* [4]), Layard and Clark drew on an extensive research literature to argue that : (i) expanding the IAPT programme would be clinically effective and would pay for itself in savings to the NHS and improvements in employment / presenteeism, and (ii) that creating new integrated IAPT services for people with anxiety/depression in the context of long-term physical health problems (diabetes, cardiovascular disease, chronic obstructive pulmonary disease etc) would result in substantial savings in managing the physical health problems. These arguments were accepted by the Treasury and NHS England.

Developing the NICE recommended first line treatment for social anxiety disorder. Clark's Oxford group developed a novel form of cognitive therapy for social anxiety disorder (CT-SAD) during the period 1998 to 2001 and ran the first randomized controlled trial [5] of the treatment in Oxford. The trial found that the treatment was superior to the leading medication. Subsequent independent RCTs in Germany, Japan, Norway, and Sweden showed that CT-SAD is also superior to multiple other psychological therapies (interpersonal therapy, psychodynamic psychotherapy, group CBT) and twice confirmed its superiority to medication. These findings were included in a network meta-analysis [6] that led NICE (Clinical Guideline 159, May 2013) to recommend the Oxford CT-SAD as a first line treatment for social anxiety. Therapists in England and internationally are now being trained in this treatment.

3. References to the research

(bold for researchers who were employed in Oxford at the time of the research)

1. Gillespie K, Duffy M, **Hackmann A, Clark DM.** (2002) Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb. *Behavioural Research and Therapy,* 40, 345-57. Journal paper, DOI: 10.1016/s0005-7967(02)00004-9
2. Gyani A., Shafran R., Layard R, and **Clark DM.** (2013) Enhancing recovery rates: lessons from year one of IAPT. *Behaviour Research and Therapy, 51,* 597-606. Journal paper, DOI: 10.1016/j.brat.2013.06.004
3. **Clark DM, Canvin L,** Green J, Layard R, Pilling S, and **Janecka M**. (2018) Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data. *Lancet, 391, 679-686.* Journal paper, DOI: 10.1016/s0140-6736(17)32133-5
4. Layard R and **Clark DM** (2014) *Thrive: The power of psychological therapy.* London: Penguin. Book, ISBN 9780241960516. Available upon request.
5. **Clark DM, Ehlers A, McManus F, Hackmann A, Fennell MJV, Campbell H, Flower T, Davenport C, and Louis B.** (2003). Cognitive therapy versus fluoxetine in generalized social phobia: a randomized placebo-controlled trial. *Journal of Consulting and Clinical Psychology, 71*, 1058-1067. (Submitted July 2002). Journal paper, DOI: 10.1037/0022-006x.71.6.1058
6. Mayo-Wilson E, Dias S, Mavranezouli I, Kew K, **Clark DM,** Ades AE, Pilling, S (2014) Psychological and pharmacological interventions for social anxiety disorder in adults: a systematic review and network meta-analysis. *Lancet Psychiatry, 1,* 368-376. Journal article, DOI: 10.1016/s2215-0366(14)70329-3

Funding to the University of Oxford included a Wellcome Trust grant to D Clark, 'Cognitive Processes in the maintenance and treatment of social phobia and post-traumatic stress disorder', GBP994,135 (reference 037158/Z/96/, 1998-2003).

4. Details of the impact

The English Improving Access to Psychological Therapies (IAPT) has greatly increased public access to effectively delivered, NICE recommended psychological therapies for anxiety disorders and depression [A]. From small beginnings in 2008 (when less than 80,000 patients were seen) it now sees around 1,200,000 people per year (NHS Digital, 2020) [B] and the NHS Long-Term Plan (2019) [C(iii)] commits to a further expansion with the programme seeing 1.9 million people per year by 2024. During the impact period the IAPT programme

has tripled in size (from 434,247 in 2012/13 to 1,165,653 in 2019/20) [B]. The England-wide clinical recovery rate for individuals who receive a course of psychological treatment has improved from 43% to 52% [B] on the same timescale and is now in line with expectation from randomised controlled trials. Furthermore, nearly 7 in every 10 treated patients (68%) show reliable improvement [B]. New integrated IAPT services that bring together mental health and physical health care have been created and are achieving substantial savings in physical health care costs [D]. Clark has been the National Clinical and Informatics Advisor for IAPT since the programme started and is widely considered to be its principal architect. The work of his research group at the University of Oxford has underpinned substantial parts of the impact of IAPT, as outlined below.

Collecting Outcome data on everyone who has a course of treatment (two or more sessions before discharge). When Alan Johnson MP, announced the IAPT programme on 10th October 2007, he stated that, once it was established, 50% of treated patients will recover "as expected by NICE guidelines". In order to assess whether this ambitious target was met, it was necessary to devise a system for collecting outcome data from everyone who was treated. The existing NHS outcome monitoring system, which involved giving patients a symptom questionnaire to compete at the first and last session of treatment, was not up to the job. A national audit of counselling services showed that this system only collected outcome data on 38% of treated patients [A]. To get around this problem, IAPT adopted the session-by-session monitoring system pioneered by Clark and Hackmann [1] in their Omagh community treatment project [E]. On advice from Clark, the programme also decided that the nationally reported outcome metrics for IAPT (recovery rate and reliable improvement rate) would remove any incentive for services to fail to collect data as they would assume that anyone without a post-treatment (last available session) score would have failed to recover/improve. Together, these two decisions have enabled IAPT to achieve an unprecedented pre-post treatment data completeness rate of 99% for everyone who is seen at least twice (NHS Digital) [B]. This is better than in most randomized controlled trials and means that IAPT can accurately assess the outcomes that it achieves.

Improving clinical outcomes. The initial clinical outcomes achieved in IAPT (recovery = 40%) were well-below target. Clark & colleagues' patient level analysis [2] of outcomes during the first year of the programme showed that better outcomes were associated with giving the NICE recommended treatment, and with services that had higher average numbers of therapy sessions and higher step-up rates. Their subsequent service level analysis [3] of data from 2014 confirmed the importance of an adequate number of sessions and higher step-up rates. It also showed the services that had shorter waiting times, lower DNA rates, and consistently identified the problems they were treating using ICD-10 codes, had better outcomes. Clark fed these findings back to services in an extensive series of regional and national workshops between 2013 and 2018 and they were incorporated into NHS England's IAPT Manual (2018) [C(iv)], advance draft copies of which were available from late 2016. IAPT activity and outcomes have improved dramatically (recovery from 43% to 52%), during the REF2021 Impact period, meaning that 230,000 more people a year recover and 314,000 more a year improve than in 2013. Regional variation in outcomes has also halved. Longitudinal analyses show that improvements in services' outcomes are strongly related to adoption of the quality standards identified in the Oxford analyses. Using the full national dataset, Clark et al [3] showed that the between-year improvements they identified in the service organization features (2014/15 to 2015/16) predicted service-level improvement in outcome. Subsequently, Clark reported that services continued to improve on these variables and that the degree of these improvements between 2015/16 and 2018/19 predicted over half the variance in service improvements in the proportion of people who have recovered by the end of treatment (R^2=.54) [F(i)]. These findings were independently confirmed using data collected from London IAPT services between 2013 and 2019 [F(ii)].

Providing the combined clinical and economic arguments for further expansion and development of IAPT. On 14th July 2014 the arguments outlined in Layard and Clark's 2014 book entitled *Thrive: the power of psychological therapies* were presented at a major public event [G] in London, chaired by Andrew Marr and attended by senior politicians of all

persuasions (including Alan Johnson MP for Labour and Norman Lamb MP for the Coalition). This event, and multiple private meetings with politicians and treasury officials, helped ensure that Labour, the Liberal Democrats and the Conservatives all included a commitment to expand IAPT in their manifestos for the 2015 General election [H]. The government and the NHS subsequently confirmed major expansions of IAPT in the *NHS Five Year Forward View* (February 2016, page 15) [C(ii)] and the *NHS Long-Term Plan* (January 2019, page 68) [C(iii)]. *Thrive* (page 209) also argued for the creation of integrated IAPT services that provide co-located mental and physical healthcare for people with anxiety/depression and a long-term physical health condition. In March 2015, NHS England asked David Clark and the President of the Royal College of Psychiatrists to co-chair a working group to define the operational principles that would underpin integrated IAPT [H]. The working group's recommendations were confirmed by the British Psychological Society, and the Royal Colleges of Psychiatry, General Practice and Physicians in a joint statement issued in November 2015 [C(i)]. Clark was then asked by NHS England to Chair the Education and Training Group that would develop curricula for training the psychological therapists who would work in the new integrated IAPT services and to also join the group that elaborated the clinical model, selected CCGs to receive early adopter funding, and set-up national and local evaluations [H]. 37 CCGs were funded to develop integrated IAPT services in 2016-2018. The official NHS England Blog (10th July 2019) [C(vi)] confirmed that these services were achieving excellent clinical outcomes while savings physical healthcare costs as predicted in *Thrive*. NHS England has confirmed that 75% of all CCGs in England are now developing integrated IAPT services.

Take-Up of NICE recommended treatment for social anxiety disorder. The specialised cognitive therapy for social anxiety disorder (CT-SAD) that Clark and colleagues developed and initially tested in Oxford [5] had been recommended as the first line treatment for social anxiety disorder in the NICE Clinical Guideline (CG159, May 2013) that was published just before the start of the Impact period. This recommendation has since facilitated its widespread adoption. CT-SAD is in the national training curriculum for IAPT CBT therapists (latest edition January 2019 [C(v)]), has been taught to over 4,800 English IAPT therapists and has been used to treat 64,000 patients during the Impact period. During COVID all the IAPT therapists moved to delivering treatment remotely (by video link). NHS England asked Clark and colleagues to provide detailed guidance on how to do this and the resulting webinar was viewed by 2,613 NHS therapists up to 22/07/20. The Canadian Province of Ontario has recently started its own IAPT programme (called "Structured Psychotherapy") and has adopted CT-SAD as the social anxiety treatment to be included in its therapist training programme [I]. To assist with such the training initiatives, the Oxford team created a free therapist resources website [J] that includes the therapist manual, specialized measures to guide treatment, and stream-able videos of a full-day clinical workshop by Clark plus 45 short videos illustrating key techniques. As well as being extensively used by IAPT training courses, the website had over 16,500 registered clinical users in 144 countries. Together they visited the site 268,459 times during 2020.

International Impact of IAPT. The success of IAPT has attracted considerable international attention during the REF impact period. As the NHS's Clinical and Informatics Advisor for IAPT and the author of *Thrive*, Clark has been invited to advise health commissioners and ministers in multiple countries [I]. Many of these countries have subsequently started IAPT-like services and others are considering doing so. The most advanced is Norway, which now has over 50 IAPT services (termed "Prompt Mental Health Care") that use the same outcome monitoring system to England and report similarly good outcomes [I(i)]. The Ontario [I(ii),(iii)], Israel [I(iv)] and Australia initiatives are also all adopting the outcome monitoring system and other IAPT features that derive from Clark's research. International press coverage includes a feature length article in the *New York Times* (24th July, 2017) [K] described it as "*the world's most ambitious effort to treat depression, anxiety and other common mental illnesses*", and a December 2018 article that discussed IAPT in the Canadian *Globe and Mail* [K] was simply entitled, "*For better mental health care in Canada: look to Britain*". An independent report in 2018 [L], commissioned by the Ontario (Canada) Department of Health, concluded that IAPT was the world's most successful attempt to increase public access to evidence-based psychological therapies for mental health problems. Finally, IAPT was selected for

presentation as an outstanding example of UK innovation in mental health at the First Global Ministerial Mental Health Summit Government in London on 10th October 2018 and in the main plenary session of the World Government Summit in Dubai on 10th February 2019.

5. Sources to corroborate the impact

A. Journal article: Clark, DM (2018) Realising the mass public benefit of evidence-based psychological therapies: the IAPT program. *Annu Rev Clin Psychol, 14,* 159-183. (Detailed account of the IAPT programme, its origins, development and achievements). DOI: 10.1146/annurev-clinpsy-050817-084833

B. NHS Digital Annual Reports on the performance of IAPT services, 2012/13-2019/20.

C. NHS England IAPT programme: (i) Royal College of Psychiatrists joint position statement PS02/2015, 'Providing evidence-based psychological therapies to people with long-term conditions and/or medically unexplained symptoms' (2015),
(ii) Mental Health Taskforce: Five Year Forward View for Mental Health (2016),
(iii) NHS Mental Health Implementation Plan 2019/20 – 2023/24 (2019),
(iv) the IAPT Manual (2018), (v) IAPT High intensity CBT training curriculum (2019)
(vi) the official NHS England blog on national and local evaluations of the new integrated IAPT services (2019). https://www.england.nhs.uk/mental-health/adults/iapt/

D. Journal article: Toffolutti et al (March 2021). The employment and mental health impact of integrated improving access to psychological therapies services... *J. Health Services Research & Policy.* DOI: 10.1177/1355819621997493, for evidence of cost savings.

E. Letter from Lord Layard (1997-2010 government's 'Happiness Tsar') confirming that: a) Clark was responsible for the outcome monitoring system and reporting conventions adopted by IAPT and b) meetings were held with Ministers and Civil Servants in 2014 that helped secure the Manifesto commitments and the subsequent expansion of IAPT.

F. (i) Keynote Address by Clark to Graham Boeckh Foundation Mental Health Conference in Canada, 27 May 2020. https://grahamboeckhfoundation.org/en/what-we-do/transform-mental-health/videos-and-more/; (ii) Journal article: Saunders et al. (2020). Improvement in IAPT outcomes over time: are they driven by changes in clinical practice? The *Cognitive Behaviour Therapist* 13:e16. doi: 10.1017/S1754470X20000173

G. Video of Andrew Marr interviewing Clark & Layard at the 2014 public launch of *Thrive*, 10 July 2014. https://www.youtube.com/watch?v=a9eHyZmcLCk

H. Letter from previous Head of Mental Health and Dementia at NHS England, summarising Clark's research contributions to the IAPT programme.

I. Letters corroborating development of IAPT-like services in other countries:
(i) President, Norwegian Association for Cognitive and Behavioural Therapies (summarising Clark's contribution to the development of Norway's version of IAPT);
(ii) Clinical Lead, Mental Health and Addictions Centre of Excellence, Ontario Health;
(iii) Professor of Psychology, Ryerson University, Toronto and Clinical lead for the Ontario Structured Psychotherapy Program; (iv) Sam and Helen Beber Chair of Clinical Psychology, Hebrew University of Jerusalem.

J. Oxford Centre for Anxiety Disorders Training Website for Therapists listing materials available at https://oxcadatresources.com (archived copy 4 August 2020).

K. Press coverage of IAPT: (i) *New York Times* feature article, 'England's Mental Health Experiment: Free Talk Therapy' 24-7-2017; (ii) Canadian *Globe & Mail* Opinion 'For Better Mental Health Care in Canada: Look to Britain' 18-12-2017.

L. Mental Health Commission of Canada report for the Ontario Department of Health, 'Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context' (August 2018), concluding that IAPT is the most successful initiative worldwide. https://www.mentalhealthcommission.ca/sites/default/files/2018-08/Expanding_Access_to_Psychotherapy_2018.pdf