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ScienceDirect
Behaviour Research and Therapy 46 (2008) 293–295
BEHAVIOUR RESEARCH AND THERAPY
www.elsevier.com/locate/brat

Commentary

Expansion in the provision of psychological treatment in the United Kingdom

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A momentous expansion in the provision of psychological treatment services was announced by the UK Health Secretary, Mr. Alan Johnson, on 10 October 2007. The UK government has embarked on a 6-year programme "to provide better support for people with problems …such as anxiety and depression", and a sum of approximately 300 million pounds sterling (over 600 million US $) has been allocated for the first 3 years.

"Psychological therapies have proved to be as effective as drugs in tackling these common mental health problems and are often more effective in the long run" (www.gnn.gov.uk—the Government News Network, 10 October 2007).

It continues, "The National Institute for Health and Clinical Excellence (NICE) guidelines on treatment for depression and anxiety recommend therapies, such as cognitive behaviour therapy (CBT)…Improving access to psychological therapies will give people…a real choice of treatment, helping to reduce dependence on medication". (An important and notable advance is that people will be able to seek psychological treatment directly. Self-referrals are now added to the usual medical referral system.)

The aim is to "reduce the average waiting time for psychological treatment from the current 18 months to a few weeks… as the service rolls out". Naturally, this will require an enormous expansion of the numbers of trained therapists, and the plan is to introduce "3600 more newly trained psychological therapists giving evidence-based treatment", in the first 3 years, steadily rising to a total of 8000. An immediate challenge is develop more efficient and effective ways of training therapists to administer evidence-based treatments in a manner consistent with research findings. Ideally, we would be able to identify necessary and sufficient elements of intervention and understand mechanisms of change. This would facilitate the most efficient treatment, and less complex treatments may prove more easily disseminable.

The expansion of psychological treatment services had been under consideration for many years and a key recent influence was the argument by Lord Layard (a distinguished economist (see the Depression Report: http://cep.lse.ac.uk/research/mentalhealth/) that expansion would be largely cost-effective. This helped to secure a firm commitment. However, the government wisely collected evidence from two demonstration projects (in Doncaster and Newham) before embarking on the new programme. Some of the findings to emerge from the demonstrations include:

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0005-7967/$ - see front matter
doi:10.1016/j.brat.2008.01.005

> Impressive recovery rates that replicate clinical trial (results) and are in line with NICE guidelines.
> Excellent recording of treatment outcomes …(90%), leading to an opportunity for a nationwide system of routine outcomes monitoring and thus to more improvements.
> Meeting previously unidentified and unmet needs by opening to self-referral—in (the demonstration site at) Newham community people came forward who were just as ill as those referred by GPs and whose conditions were twice as chronic (4 years long rather than 2). They responded as well as those referred by GPs.
> Treating large numbers of people in a short period of time from a standing start (www.gnn.gov.uk—10 October 2007).

What is the significance of all this? In addition to the expansion of care, and the commitment to providing timely and effective treatment for very large number of people, the programme and the thinking and explorations that led to its evolution are of considerable theoretical significance.

Implicit in the planning of the expansion is an acceptance of the need to insist on evidence-based treatments. This necessary insistence is a relatively recent development in clinical psychology and in psychiatry, and recalls the story of a conversation between a psychologist and a senior engineer/scientist. The psychologist was explaining the steady adoption of demands for evidence-based psychological treatments, and the engineer listened with interest but was puzzled, and asked this question: ''What was it based on before?''

As is evident in the quotations set out above, the expansion programme also reflects another theoretical/practical shift. It recognises that psychological treatment can be at least as effective as drugs in treating depression and anxiety, and that it is desirable to ''reduce dependence on medication''. It should be added that when psychological treatment is provided none of the intimidating list of side effects is encountered. This shift is also reflected in the introduction of self-referrals. Many, perhaps most, people who are referred to psychological treatment by their GPs/psychiatrists are taking medications. Presumably, as the self-referral system becomes common and the use of medications will decline somewhat.

As averred in the Government announcements, the self-referral system is intended to give people a greater choice of treatment options, and is a shift away from those traditional health care practices that were hierarchical and often expected patients to be just that—patient and passive. The self-referral system will no doubt be linked to the NHS web service, which provides information about the nature and seriousness of a range of psychological problems, and the availability of services in one's local area.

Another matter of theoretical and practical significance that arises from the expansion programme is the acceptance that evidence from randomized control trials is transferable to routine practice. This remains a matter of debate because some critics argue that the evidence from such trials is not applicable to clinical practice. Undoubtedly, careless or ill-prepared transfers will disappoint. Certainly, more studies of transfer need to be completed and we need to find out how to enhance them, but on presently available data the standard rejection of evidence from controlled trials is no longer tenable. Hence the acceptance within the programme of controlled trial evidence, and this mostly through the evaluations made by NICE, is a progressive step. The endorsement of a need to keep records of treatments and outcomes is similarly progressive. The linkage with NICE is of course a great strength, and provides a fine model of constructive interplay between the results of research and the continuing improvement of clinical practice.

The considerable merits of the new programme have been described and attention drawn to the important theoretical significance of this advance. It is to be hoped that other countries/regions will follow this model. For example, in 2006 Australia introduced a scheme to provide better access to psychological treatment, and people who are referred by their GP or psychiatrist for this treatment are covered for 12 sessions per calendar year. ''It is recommended that cognitive behaviour therapy be provided'' or any other evidence-based psychological treatment, as deemed relevant (www.psy.org.au/medicare/).

From the vantage of Behaviour Research and Therapy the introduction of this massive expansion of evidence-based psychological treatment services is gratifying. The founding Editor of this Journal, Professor Hans Eysenck, was a strong, early advocate of the value of carrying out randomized control trials to test the

effects of therapy. Since its establishment in 1963 the Journal specialized in publishing and promoting the new approach, then called behaviour therapy and later expanded to cognitive behaviour therapy. The optimism of the Founding Editor and numerous contributors from different countries prevailed despite the coldly critical atmosphere in which the Journal was launched. The recent advances in the UK appear to justify that optimism and early judgement.