Psicothema

Psicothema 2022, Vol. 34, No. 1, 18-24
doi: 10.7334/psicothema2021.113

ISSN 0214 - 9915 CODEN PSOTEG

www.psicothema.com

Article

Improving Access to Psychological Therapies in Spain: From IAPT to PsicAP

Antonio Cano-Vindel[1], Paloma Ruiz-Rodríguez[2], Juan A. Moriana[3], Leonardo Adrián Medrano[4], César González-Blanch[5], Elisa Aguirre[6], and Roger Muñoz-Navarro[7]

[1] Universidad Complutense de Madrid, [2] Centro de Salud Castilla La Nueva, Servicio Madrileño de Salud, [3] Universidad de Córdoba, [4] Pontificia Universidad Católica Madre y Maestra, [5] Hospital Universitario Marqués de Valdecilla - IDIVAL, [6] NELFT NHS Foundation Trust IAPT Service, and [7] Universitat de València

Abstract

Background: Anxiety and depression are very prevalent in primary care, with high rates of chronic cases, comorbidity and lost quality of life, along with huge economic costs. The Improving Access to Psychological Therapies (IAPT) project, launched in the United Kingdom in 2007, has become an international benchmark for the treatment of common mental disorders. In Spain, Psicofundación developed the PsicAP clinical trial, following the precedent set by the IAPT. **Method:** This study reviews and compares and contrasts the methods, results, and contributions of the IAPT and PsicAP. **Results:** The IAPT is a project for the pragmatic implementation of evidence-based psychological therapies in primary care. PsicAP is a randomized clinical trial whose results demonstrated that adding a psychological treatment (seven group sessions of transdiagnostic cognitive-behavioural therapy) to treatment-as-usual (TAU) for anxiety and depression in the primary care setting was more effective and cost-effective than TAU alone. The therapeutic gains and the cost-effectiveness were maintained at a 12 months follow-up. Moreover, the percentage of reliably recovered patients was comparable to the numbers from the IAPT. **Conclusions:** This brief psychological treatment should be implemented in the Spanish public health system, similar to the precedent set by the IAPT initiative.

Keywords: Anxiety, depression, primary care, IAPT, PsicAP.

Resumen

Mejora del Acceso a Terapias Psicológicas en España: de IAPT a PsicAP. **Antecedentes:** la ansiedad y la depresión son muy prevalentes en atención primaria, tienen altas tasas de cronicidad, comorbilidad y pérdida de calidad de vida, así como altos costes económicos. El proyecto IAPT (Mejora del Acceso a Terapias Psicológicas) que se inició en Reino Unido, supuso un referente internacional en el abordaje de estos trastornos mentales comunes. En España, Psicofundación promovió el ensayo clínico PsicAP (Psicología en Atención Primaria), siguiendo el camino de IAPT. **Método:** en este trabajo se revisan el método, resultados y aportaciones de IAPT y PsicAP, detallando sus similitudes y diferencias. **Resultados:** IAPT es un proyecto de implementación pragmática sanitaria en atención primaria de terapias psicológicas basadas en la evidencia. PsicAP es un ensayo clínico aleatorizado cuyos resultados señalan que añadir un tratamiento psicológico (siete sesiones en grupo de tratamiento cognitivo-conductual transdiagnóstico) al tratamiento habitual para estos trastornos en atención primaria, es más eficaz y costo-eficaz que el tratamiento habitual solo. Estas ganancias terapéuticas, así como la relación coste-eficacia se mantienen a los 12 meses. Además, el número de casos recuperados de manera confiable es equiparable a los conseguidos en IAPT. **Conclusiones:** este tratamiento psicológico breve debería ser asumido por la sanidad pública española, siguiendo la iniciativa IAPT.

Palabras clave: ansiedad, depresión, atención primaria, IAPT, PsicAP.

The World Health Organization (WHO) states that common mental disorders such as depression and anxiety will soon become the leading cause of disability worldwide (WHO, 2017). Therefore, for the last 20 years, the WHO has recommended policies to improve access for the general population to psychological therapies that have proven to be effective and cost-effective (Clark, 2018; Layard & Clark, 2015). Given that two-thirds of patients diagnosed with a mental disorder are treated by their family physician (WHO, 2017), it is imperative to improve the care of these common mental disorders in the primary care (PC) setting.

Emotional disorders (anxiety and depressive disorders) are the most prevalent mental health disorders in the general population (Codony et al., 2007b; Haro et al., 2006). They are also the most common mental health disorders seen in the PC setting PC in Spain, together with somatoform disorders (Roca et al., 2009). These disorders are highly disabling, significantly reducing quality of life (QoL), and causing enormous economic losses (Whiteford et al., 2015). In Spain, the economic costs of mental disorders are estimated to be €45,988 million (representing 4.4% of gross domestic product [GDP]), while the costs of depressive, anxiety, and somatoform disorders is estimated at €22,778 million (2.2% of GDP), which is almost half the cost of all mental disorders (Parés-Badell et al., 2014). Although subclinical cases were not

Received: March 26, 2021 • Accepted: July 26, 2021
Corresponding author: Roger Muñoz-Navarro
Facultad de Psicología
Universitat de València
46010 Valencia (Spain)
e-mail: roger.munoz@uv.es

included in these cost estimates, data from the European Study of Epidemiology of Mental Disorders (ESEMeD-Spain) (Codony et al., 2007a) indicate that 11.9% of the Spanish population consumes psychotropic drugs without having clinical symptoms of anxiety or depressive disorder. Also, the extra costs associated with chronic health problems (approximate prevalence rate: 16%) were not included in this study. But, when these patients present comorbid anxiety and depressive disorders (approximately half, 8%), the costs double. In other words, anxiety and depression-related problems, which are present in a large number of people, are enormously costly, and some studies suggest that these expenses may even be underestimated (Ruiz-Rodríguez et al., 2017). A study on the costs of generalized anxiety disorder (GAD) found that patients with this disorder are more expensive to treat due to PC and specialist consultations, laboratory tests, and medications than patients without this disorder (Rovira et al., 2012). Published estimates suggest that the costs to treat patients with GAD are 2.7 times higher than the costs of treating patients without emotional problems. Likewise, expenses associated with frequent medical consultations were 3.4 times higher, with a 3.3 fold increase in medication costs. According to that study, GAD entails direct healthcare costs of €1,206 per patient, which represent only 20% of the total cost (€5,819 per patient), while the remaining costs (80%) are related to non-healthcare costs, such as medical leave and productivity losses (Rovira et al., 2012). A recent review on the economic impact of mental disorders found that depression is the mental disorder that generates the greatest economic burden in Spain, accounting for 25% of the costs of all mental disorders (50% if anxiety and depression are included), as well as the leading cause of disability (Ruiz-Rodríguez et al., 2017). Much of this burden could be reduced if these disorders are treated in a timely manner with effective, evidence-based therapies (Clark, 2018; Moriana, Gálvez-Lara, & Corpas, 2017), which are also likely to be cost-effective (Layard & Clark, 2015).

In Spain, patients with emotional disorders either do not receive any treatment (39% of cases of anxiety disorder in the last 12 months) or are prescribed psychotropic drugs, which may not recover their disorder either, nor do these drugs reduce the high health and social costs (Codony et al., 2007a; 2007b). A substantial proportion of the Spanish population uses tranquilizers, hypnotics and antidepressants to alleviate symptoms. In the most recent European Health Survey, published in 2015, 18.9% of Spaniards ≥ age 15 used psychotropic drugs (tranquilizers, relaxants, sleeping) in the prior two weeks, and 8.4% took antidepressants or stimulants (INE, 2015). Benzodiazepines, whose use is discouraged in the NICE clinical practice guidelines (National Institute for Health and Care Excellence, 2011) due to the lack of long-term efficacy and their addictive properties, are, the most commonly used psychotropic drugs in Spain, surpassing the OECD (Organization for Economic Co-operation and Development) average by 2.4 times. Spending on this group of drugs in Spain has continued to grow, and Spain is the first country in the OECD in percentage of spending on psychotropic drugs over total pharmaceutical spending, per inhabitant and economic unit (OECD, 2015). This high percentage of spending on psychotropic drugs does not correspond to the prevalence of anxiety and depressive disorders in the Spanish population, which is the lowest in Europe in the ESEMeD-Europe study (De Girolamo, Alonso, & Vilagut, 2006), but rather with the low use of psychological treatments. One study in Spain found that only 0.9% of patients with anxiety disorder received a psychological intervention alone (only treatment) in the prior 12 months versus 33% of patients who took some type of psychotropic drug and 27.1% who received combined therapy (psychological and pharmacological) (Codony et al., 2007a).

IAPT

In 2007, the government of the United Kingdom (UK) launched the Improving Access to Psychological Therapies (IAPT) program aimed at offering treatment for common mental disorders in the general population using cognitive-behavioural therapy (CBT) in the PC setting, following recommendations provided in the NICE guidelines. In the first three years, this program was offered to more than one million people. The focus of this treatment approach is to offer strategies to help patients manage anxiety, depression and emotional symptoms. Importantly, the program has provided excellent results—better than those obtained with the usual treatment (psychotropic drugs), which was the approach used in the UK in PC prior to implementation of the IAPT (and which we continue to maintain in Spain). In addition, psychological treatment was not only more effective than usual treatment, but also showed greater cost-effectiveness and cost-utility, further reducing disability, social benefits and healthcare costs (Clark, 2018).

The IAPT project is an evidenced-based programme in which the average cost of psychological treatment per patient was estimated at £650 (€743), with a greater than 50% probability of achieving clinical remission, and a low probability of relapse due to the effectiveness of the therapy. Given that monthly non-health-related expenses in patients of working age with common mental disorders is similar to the total cost of the IAPT treatment, and that disability benefits are received by 4-5% of patients of working age, if only 4% of treated patients recovered sufficiently to allow a return to work for 25 months, this would cover all of the costs of treating these patients. This is a conservative estimate from data reported in meta-analyses that have assessed recovery from work disability in patients who have received psychological treatment. Moreover, it is estimated that the cost of treating patients with chronic physical conditions with comorbid mental disorders such as anxiety and depression are approximately £2,000 (€2,286) higher per year compared to patients without emotional disorders. Therefore, if the remission rate of psychological treatment in the IAPT is at least 50%, the savings would be approximately £1,000 (€1,143) annually, on average, in treated patients; thus, in the first year, this savings would cover the expenses of the entire treated group, and would continue to accumulate over time (Layard & Clark, 2015).

The first pilot study for the IAPT was carried out in two PC centres (Newham and Doncaster) in 2009, showing significant intra-group symptom improvement with effect sizes of $d = 1.39$ for anxiety-related problems (measured with the GAD-7), and $d = 1.41$ for depressive symptoms (measured with the Patient Health Questionnaire-9; PHQ-9). In addition, high recovery rates (76% for depression and 74% for anxiety), decreased risk of relapse, and maintenance of long-term positive outcomes were achieved (Richards & Suckling, 2009). Of the patients who completed the IAPT treatment, 45% recovered reliably. The concept of reliable improvement is based on a clinically significant change and reliable rate of change methods proposed by Jacobson and Truax (1991). In the IAPT, clinical improvement was obtained through a strict double criterion applied to cases whose scores on any of the screening scales are suggestive of the presence of an emotional

disorder (i.e., above the cut-off point of the specific scales). Thus, reliable recovery refers to achieving a scoring below the clinical threshold for anxiety and depression on the PHQ-9 or the GAD-7, respectively and that the decrease in symptom intensity is sufficient that there is no doubt about possible measurement error of the scale itself. For example, if the decrease is below the case level (10 points), and there is also at least 6 points of difference between the initial and final PHQ-9, then the patient is deemed to have achieved a reliable recovery.

So, in the IAPT, 45% of participants achieved a reliable improvement, and an additional 16% showed improvement that was close to complete recovery. In just a few years, the IAPT has treated more than half a million people per year, with around 50% have recovered reliably and about 75% having significantly improved (Clark, 2018). A recent meta-analysis of studies conducted in routine clinical practice in the IAPT (not clinical trials) showed large intra-group effect sizes before and after treatment for depression (d = 0.87, [0.78 -0.96], p <0.0001) and anxiety (d = 0.88, [0.79-0.97], p<0.0001) and a moderate effect on functional impairment (d = 0 .55, [0.48-0.61], p<0.0001) (Wakefield et al., 2021). These results are similar to those reported in the initial pilot studies, in which 50-55% of patients who attended at least two sessions, including the evaluation interview, could be classified as recovered; moreover, these results were largely maintained at the 10-month follow-up (Clark et al., 2009).

Given these remarkable results, the IAPT project has become an international reference, leading other countries to implement similar projects, including Australia (Cromarty et al., 2016), Norway (Knapstad et al., 2020), Canada (Naeem et al., 2017), and Japan (Kobori et al., 2014). Studies on the efficacy of CBT in the PC setting have grown rapidly and meta-analyses have shown that psychological therapy is effective in treating common mental disorders in PC, have longer lasting effects than drugs, have no side effects, are preferred by most patients, and can be applied flexibly with different formats in different target groups (Cuijpers et al., 2019; Zhang et al., 2019).

PsicAP

The IAPT project in the UK also set a precedent in Spain, inspiring research to determine the optimal therapeutic approach to the two most prevalent emotional disorders (anxiety and depression) that cause the greatest amount of disability. In 2010, after publication of the results of the IAPT in the UK, the General Council of Psychology and its foundation, Psicofundación (Spanish Foundation for the Promotion and Development of Scientific and Professional Psychology), decided to undertake a research project to compare psychological therapy to TAU for the management of common mental disorders. This is how the randomized PsicAP (Psychology in Primary Care) clinical trial was launched in the PC setting, the first level of the public health care system. Clinical trials offer the strongest level of evidence in scientific research, which is why this approach was selected. The objective was to design a protocol to evaluate the efficacy of adding psychological treatment for the most common mental disorders in PC to TAU (see Cano-Vindel et al., 2021). Table 1 shows a comparison of the characteristics of the IAPT and PsicAP.

Method

Participants

A total of 1691 patients from 22 PC centres within the Spanish public health system, in 8 of the 17 Autonomous Communities

Table 1
Characteristics compared between IAPT and PsicAP

	IAPT	PsicAP
Project design	Pragmatic health implementation in PC	Phase IV clinical trial
Type of patients	Common mental disorders such as anxiety, depression, phobias, trauma, OCD	Emotional disorders (anxiety, depression, and somatizations)
Main outcome scales	GAD-7 and PHQ-9	GAD-7, PHQ-9 y PHQ-15
Therapists	*CBT therapists* clinical psychologists, general health psychologists, counselling psychologists, social workers, nurses with master's level training in cognitive behavioural therapy *PWP* psychological wellbeing providers	*Psychologists specialized in clinical psychology* (psychological treatment) *PC physicians* (treatment-as-usual)
Treatment duration	3-20 weeks	12 – 14 weeks
Type of treatment	Individual or group cognitive-behavioural treatment for specific common mental disorders Internet therapies Self-help bibliography	Transdiagnostic group cognitive-behavioural treatment (7 sessions)
Objectives	Treat about 500,000 patients/year with a minimum recovery rate of 50%. Labour reintegration	To demonstrate the efficacy of adding a psychological treatment implemented by clinical psychologists in primary care
Application context	PC within a stepped model with actions selected according to the patient's condition and symptoms	PC within a model with two levels of Primary Care - Secondary Care or specialized)

(regions) in Spain, were initially considered eligible for the trial. All participants were required to present criteria suggestive of moderate or moderate-to-severe emotional disorders. As patients with mild cases or severe major depression were excluded, the final sample contained 1,061 patients.

Instruments

The patient recruitment process was as follows. First, in the course of routine practice in PC, if general practitioner (GP) detected a patient with negative emotional symptoms, the patient was asked to participate in the study and referred to a first interview with a psychologist, who administered a battery of questionnaires. The PHQ was used to detect the presence of emotional disorders (anxiety, depression and somatizations). This questionnaire was previously validated in a sample of 178 patients who also underwent a structured diagnostic interview, which allowed for determination of the most appropriate cut-off points for the depression (PHQ-9) and anxiety (GAD-7) scales, which was established at 10 points for both tests; participants also completed the PHQ-15 diagnostic algorithm (for more information, see Muñoz-Navarro et al., 2017). Patients who met the study inclusion criteria were blindly randomized to two arms, either a control group (TAU) or the experimental group, which was TAU plus transdiagnostic treatment (TD). A total of 534 patients were included in the control group and 527 in the experimental group (Cano-Vindel et al., 2021).

Procedure

The experimental intervention consisted of a novel brief (7 sessions) therapeutic protocol of CBT delivered in group format. Currently, CBT is the psychological therapy with the most evidence to support its efficacy in the treatment of psychological disorders. A transdiagnostic approach was used in order to treat patients with different disorders in the same therapeutic group. The model was designed to overcome some of the deficiencies of the biomedical and categorical models of the DSM, to make it closer to dimensional psychopathological models, transdiagnostic and causal networks, based on emotional learning, cognitive distortions and emotional regulation, as well as more realistic and practical (Cano-Vindel, 2011). The approach was designed to be practical to provide the best training to the patients, allowing them to learn a series of simple techniques based on an active role in acquiring information and training in how to manage thoughts, emotions and behaviours in the face of common psychosocial problems in everyday life that can sometimes cause significant discomfort or dysfunction. This therapy was based on the application of elements of CBT such as cognitive restructuring, behavioural techniques (exposure, operant techniques, behavioural activation), psychoeducation, relaxation and imagination techniques, and relapse prevention (González-Blanch et al., 2018). Another aim was to ensure better detection of these common mental disorders among PC physicians in Spain using validated screening psychometric tests in the such as the PHQ (Muñoz-Navarro et al., 2017), which is widely used internationally (Clark et al., 2009).

The objectives of the trial were as follows: 1) to determine whether adding psychological treatment (seven sessions of psychological treatment in a transdiagnostic group) to treatment-as-usual is more effective than the usual treatment for moderate or moderate-to-severe emotional disorders in the PC setting; 2) to assess whether the effects of psychological treatment are maintained in the long term (12 months); and 3) to analyse the cost-effectiveness and cost-utility of the experimental treatment versus the control treatment. The primary outcome measures were symptoms of anxiety, depression and somatization. Secondary outcome measures were level of social functioning and QoL.

Data analyses

Intention-to-treat (ITT) analysis were performed in which all randomized patients (n=1061) were included, using the chained equations multiple imputation procedure in the SPSS statistical software program, with five imputations. A per protocol (PP) analysis was also performed for primary and secondary outcomes.

Primary results

The primary results of the ITT analysis after treatment showed significant between-group differences, which were better in the experimental group (which received seven group sessions of TD) versus controls, who received only TAU. Patients in the experimental group achieved greater reduction in the symptoms of emotional disorders, as follows: anxiety, d = -0.65; depression, d = -0.58; and somatic symptoms, d = -0.40. These effects were maintained at 12 months of follow-up: anxiety, d = -0.44; depression, d = -0.36; and somatic symptoms, d = -0.32. In the PP sample (experimental group = 315 and control group = 316), the effect sizes were even greater: anxiety, d = -1.01; depression, d = -0.92; and somatic symptoms, d = -0.65. Again, these effects were maintained at 12 months of follow-up (experimental group = 208 and control group = 180): anxiety, d = -0.91; depression, d = -0.61; and somatic symptoms, d = -0.57 (for a detailed description see Cano-Vindel et al., 2021).

Secondary results

In the secondary outcome measures, the ITT analyses showed that patients in the TD + TAU group also had significantly better results in the different domains of functioning (d = -0.16 to -0.33) and QoL (d = 0.24 to 0.42), with a sustained improvement at the 12-month follow-up in both functioning (d = -0.25 to -0.39) and QoL (d = 0.58 to 0.72). These results were similar for the post-treatment PP analyses for functioning (d = -0.26 to -0.41) and QoL (d = 0.31 to 0.61), which were also sustained at the 12-month follow-up assessment for both functioning (d = -0.44 to -0.51) and QoL (d = 0.29 to 0.73).

Results of recovery and reliable recovery

In the ITT analysis, recovery rates for the TAU group at the post-treatment and 12-month evaluations were 18% and 29%, respectively. By contrast, for the TD + TAU group, the recovery rates at those same time points were 51.7% and 52%, respectively. The proportion of individuals considered to have achieved recovery or reliable recovery at the post-treatment and 12-month evaluations in the TAU group was 13.3% and 11%, respectively versus 49.5% and 45% in the TD + TAU group (see Table 2 for details). The results of the per-protocol analyses were similar (data not provided).

Table 2
Recovery, reliable recovery and deterioration rates of the PsicAP study

	Treatment-as-usual	Transdiagnostic treatment	*p*	Cohen's *d*[a]
Recovery				
Post-treatment	18% (14% – 22%)[b]	51% (46% – 57%)	<.0001	0.76 (0.60 – 0.92)
12 months	29% (22% – 36%)	49% (45% – 60%)	<.0001	0.51 (0.36 – 0.67)
Reliable recovery				
Post-treatment	13.3% (9% – 17%)	49.5% (44% – 55%)	<.0001	0.84 (0.68 – 1.05)
12 months	11% (5% – 16%)	45% (37% – 48%)	<.0001	0.83 (0.67 – 0.99)
Deterioration				
Post-treatment	14% (10% – 17%)	3% (1% – 5%)	<.0001	0.41 (0.26 – 0.57)
12 months	12% (7% – 14%)	3% (1% – 5%)	<.0001	0.35 (0.19 – 0.50)

Note: [a]The Odds Ratio of the treatment effect size was transformed into an effect size of Cohen's d family applying the formula d = ln (OR) × √3 (Polanin & Snilstveit, 2016); [b]The values within the parentheses correspond to the 95% confidence intervals

Results for deterioration and treatment satisfaction

Deterioration rates were also evaluated at the post-treatment and 12-month evaluations, as follows: 14% and 12% for the control group, and 3% and 3% for the experimental group. The rates of reliable recovery and deterioration in the TAU arm were similar (around 11-14%), but differed markedly in the TD + TAU arm, with a close to a 50% difference between the reliable recovery rate and 3% difference in the deterioration rate (see Table 2). Similar results were obtained in the per-protocol analyses (data not provided).

In addition, patients in the experimental group were more satisfied with treatment outcomes than those in the control group [9.75 (1.49) vs 7.72 (2.68)] after the treatment period, a large effect size (d > 0.90).

Results of the cost-effectiveness and cost-utility studies

A subanalysis of the results of the PsicAP trial was carried out in 487 patients in the Madrid region to evaluate treatment related costs, cost-effectiveness, and the cost-utility ratio in the two study arms (Ruiz-Rodríguez et al., 2018). In terms of costs, no significant between-group differences were observed, and standard deviations were higher than the means, both in the pre- and post-evaluations and at the 12-month follow-up assessment. The cost-effectiveness ratio, based on the reduction in symptoms of depression, anxiety and somatizations in the two groups, showed better results in the experimental group (Ruiz-Rodríguez, 2019).

Cost-utility analyses were also performed because these types of analyses facilitate comparisons with other health care interventions. In this analysis, we calculated the extra cost necessary to increase on quality of life-adjusted life year (QALY), a measure that weights the years of life to the utility associated with the health-related QoL for both treatments and their ratio. Based on this analysis, the experimental group had better outcomes than the TAU group at both time points (post-treatment and 12-month follow-up). The cost-utility ratio, which was better in the experimental group, was less than €1500/QALY, which is well below the €30,000/QALY considered by consensus of the authors as the cut-off point for considering the implementation of new treatments. Therefore, these results were sufficiently robust to allow us to recommend switching treatment from TAU to TD+TAU in the Spanish national health system. Importantly, the results were even better at the 12-month evaluation in the experimental group. In addition, sensitivity analyses showed that they could be generalized to other scenarios such as the reduction of 20% in the costs of drugs, their implementation in other regions in Spain, and the increase in the costs of psychological treatment.

This study was the first to evaluate the efficacy, cost-effectiveness, and cost-utility of a group face-to-face psychological treatment for common mental health disorders in PC in Spain. The cost of adding the group psychological therapy protocol in the PsicAP was only a mean protocol represented an average increase of €27.4 per patient. The cost-effectiveness and cost-utility ratios indicate that this psychological treatment program can be efficiently and cost-effectively implemented in our health care system, while TAU is not cost-effective and its poor cost-utility ratio in improving the QoL is unacceptable. These results are consistent with the few studies in Spain that highlight the limitations of routine treatment and the cost-effectiveness of any psychological intervention (Aragonès et al., 2014).

Discussion

Relevance of the PsicAP trial

The PsicAP project, despite being inspired by the British IAPT, has some differences that give it its own personality. First, PsicAP was a clinical trial designed to validate the efficacy of a group transdiagnostic treatment in Spanish PC centres. By contrast, IAPT is a pragmatic health implementation project, where different levels of intervention (low and high intensity therapies) are offered for emotional disorders such as anxiety and depression, in a collaborative model involving a wide range of health care professionals. In the IAPT, individual, online, and face-to-face therapies are offered to patients diagnosed with an emotional disorder with a care model already implemented in routine practice and funded by the British government. In contrast to the IAPT, the PsicAP project—which seeks to serve the same clinical population as the IAPT—offers group treatment from a transdiagnostic model within a clinical trial. The results of other clinical trials using the IAPT system have shown similar results to those obtained in the PsicAP trial. A meta-analysis of 47 clinical trials performed by Wakefield et al. (2021) found large effect sizes between pre-post treatment for depression (d = 0.87) and anxiety (d = 0, 88), and a moderate effect on functioning (d = 0.55), results that are very similar to those observed in the PsicAP trial. Knapstad et al. (2019) found improvements in the psychological treatment arm compared to the TAU group, with an effect size of –0.88 in depression and –0.60 in anxiety. In that clinical trial, reliable recovery rates of 58.5% were observed in the psychological treatment group compared to 31.9% in the TAU group, with an effect size between groups of 0.61. As Table 2 shows, the recovery rates in the PsicAP trial were lower than in the study by Knapstad and colleagues. However, it should be noted that the PsicAP trial applied stricter criteria to define recovery, which was based on three symptoms (anxiety, depression and somatizations) versus only two (anxiety and depression) in the study by Knapstad in Norway. Interestingly, while those other reported only a medium effect size for anxiety (d = -0.60), the effect size in the per protocol group in PsicAP was large (d = -0.98). In short, these results support the international comparison of the results of PsicAP trial with previous meta-

analyses, showing similar effect sizes than those seen in other clinical trials (Cuijpers et al., 2019; Zhang et al., 2019).

Consider together, the results of both projects strengthen the idea that psychological treatments are effective and that these can be applied in routine practice in primary care to benefit patients. The data from the PsicAP trial suggest that group transdiagnostic psychological therapy could be even more beneficial in this setting due to its cost-effectiveness ratio, which would promote models of stepped mental health care, as recommended recently in the Australian model (Cross & Hickie, 2017). Finally, these data also suggest that clinical psychologists working in the PC setting should receive specific training in the application of this protocol and other empirically-supported therapies to ensure the proper implementation of evidence-based therapies. In the future, it would be interesting to determine the influence of specific factors—such as treatment duration, the qualifications and/or training of the therapists, patient characteristics, and the specific treatment approach—on the treatment outcomes.

The current situation in Spain

The growing body of evidence in support of psychological intervention in the PC setting has recently led to an increase in interest in using these approaches to treat common mental disorders in the PC setting in Spain. Since 2015, several non-legislative bills (NLB) have been approved in the parliaments of seven Spanish regions (autonomous communities) and in the national congress. These bills requesting that these governmental bodies include clinical psychologists in the PC setting to treat mental health disorders with evidence-based therapies. Steps have been taken in this regard, including the hiring of 21 clinical psychologists in 2017 withing the PC of the Madrid Health Department to deliver the PsicAP treatment protocol in routine clinical practice. This same treatment is currently being applied in the Autonomous Community of Navarra. A pilot experience was launched in Asturias, where several clinical psychologists were hired in various PC centres in Oviedo, Gijón and Avilés. Also, in 2017, a new care program for mental health and addictions was approved by the government of Catalonia to strengthen PC units with the addition of psychiatrists, clinical psychologists and nurses. In 2019, the Ministry of Health, Consumer Affairs, and Social Welfare published an official document known as the "Strategic Framework for Primary and Community Care", which emphasizes the need for the inclusion of clinical psychologists in primary care and the need to reform of the portfolio of services offer by these professionals to treat patients with anxiety and depression (Ministry of Consumer Health and Social Welfare, 2019). Other regions and provinces in Spain (Alicante, Lanzarote, and Murcia, among others) have also begun to add clinical psychologists to PC centres. Significantly, Andalusia recently approved the hiring of 25 clinical psychologists in primary care.

Proposals for future lines

All of these initiatives in Spain indicate a growing awareness and appreciation for the value of including clinical psychologist in the PC setting to offer improved access to psychological therapies for mental health problems such as anxiety and depression. However, many important challenges are facing us, both now and in the coming years, especially in the context of the COVID-19 pandemic, which is seriously affecting the mental health of the population, with the potential for long-term sequelae in the general Spanish population (Salari et al., 2020). Primary care is the first line of health care in the Spanish NHS and strengthening this area by adding more professionals and resources should be a key measure to reduce the hard impact of COVID-19, and the associated social crisis, which is expected to increase the prevalence of anxiety and depression disorders in PC, similar to what occurred after the 2008 financial crisis (Gili et al., 2014). Common mental disorders represent an important part of the care burden in PC, where most of these disorders are treated, even though some chronic cases are ultimately referred to specialised mental health centres. Given the available evidence, it is clear that we need to insist that the health authorities improve public health services to offer better mental health care, including access to evidence-based psychological treatments throughout Spain. The data show that psychological therapy is not only the most effective treatment approach—recommended by clinical guidelines as the first-line treatment—but they also appear to be highly cost-effective.

Acknowledgments

We thank all the members of the PsicAP Research Group for their participation in this great project. This work has been supported by the Spansh Foundation for Promotion and Scentific and Professional Developement of Psychology grant to primary investigator (PI) Antonio Cano-Vindel; by a grant from the Agencia Estatal de Investigación (PSI2012-36589) to Antonio Cano-Vindel and (PSI2014-56368-R) Juan A. Moriana; and by the IDIVAL (INNVAL 16/08 and PRIMVAL 18/03) grant to César González-Blanch.

References

Aragonès, E., López-Cortacans, G., Sánchez-Iriso, E., Piñol, J. L., Caballero, A., Salvador-Carulla, L., & Cabasés, J. (2014). Cost-effectiveness analysis of a collaborative care programme for depression in primary care. *Journal of Affective Disorders*, *159*, 85-93. https://doi.org/10.1016/j.jad.2014.01.021

Cano-Vindel, A. (2011). Bases Teóricas y Apoyo Empírico de la Intervención Psicológica Sobre Los Desórdenes Emocionales en Atención Primaria. Una Actualización [Theoretical Bases and Empirical Support for Psychological Intervention on Emotional Disorders in Primary Care. An update.]. *Ansiedad y Estrés*, *17*(2-3), 157-184.

Cano-Vindel, A., Muñoz-Navarro, R., Moriana, J. A., Ruiz-Rodríguez, P., Medrano, L. A., & González-Blanch, C. (2021). Transdiagnostic group cognitive behavioral therapy for emotional disorders in primary care: The results of the PsicAP randomized controlled trial. *Psychological Medicine*, 1-13. https://doi.org/10.1017/S0033291720005498

Clark, D. M. (2018). Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology*, *14*, 159-183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, *47*(11), 910-920. https://doi.org/10.1016/j.brat.2009.07.010

Codony, M., Alonso, J., Almansa, J., Vilagut, G., Domingo, A., Pinto-Meza, A., Fernández, A., Serrano-Blanco, A., Márquez, M., & Haro, J. M. (2007a). Uso de fármacos psicotrópicos en España. Resultados del estudio ESEMeD-España [Psychotropic medications use in Spain. Results of the ESEMeD-Spain study]. *Actas Españolas de Psiquiatría, 35*(2), 29-36.

Codony, M., Alonso, J., Almansa, J., Vilagut, G., Domingo, A., Pinto-Meza, A., Fernández, A., Usall, J., Dolz, M., & Haro, J. M. (2007b). Utilización de los servicios de salud mental en la población general española. Resultados del estudio ESEMeD-España [Mental health care use in the Spanish general population. Results of the ESEMeD-Spain study]. *Actas Españolas de Psiquiatría, 35*(2), 21-28

Cromarty, P., Drummond, A., Francis, T., Watson, J., & Battersby, M. (2016). NewAccess for depression and anxiety: Adapting the UK Improving Access to Psychological Therapies Program across Australia. *Australasian Psychiatry, 24*(5), 489-492. https://doi.org/10.1177/1039856216641310

Cross, S. P., & Hickie, I. (2017). Transdiagnostic stepped care in mental health. *Public Health Research & Practice*, *27*(2), e2721712. http://dx.doi.org/10.17061/phrp2721712

Cuijpers, P., Quero, S., Dowrick, C., & Arroll, B. (2019). Psychological Treatment of Depression in Primary Care: Recent Developments. *Current Psychiatry Reports*, *21*(12), 129. https://doi.org/10.1007/s11920-019-1117-x

De Girolamo, G., Alonso, J., & Vilagut, G. (2006). The ESEMeD-WMH project: Strenghtening epidemiological research in Europe through the study of variation in prevalence estimates. *Epidemiology and Psychiatric Sciences*, *15*(3), 167-173. https://doi.org/10.1017/S1121189X00004401

Gili, M., García Campayo, J., & Roca, M. (2014). Economic crisis and mental health. SESPAS report 2014. *Gaceta Sanitaria*, *23*(1), 103-108. https://doi.org/10.1016/j.gaceta.2014.02.005

González-Blanch, C., Umaran-Alfageme, O., Cordero-Andrés, P., Muñoz-Navarro, R., Ruiz-Rodríguez, P., Medrano, L. A., Ruiz-Torres, M., Dongil Collado, E., & Cano-Vindel, A. (2018). Psychological treatment of emotional disorders in Primary Care: The transdiagnostic treatment manual of the PsicAP study. *Ansiedad y Estrés*, *24*(1), 1-11. https://doi.org/10.1016/j.anyes.2017.10.005

Haro, J. M., Palacín, C., Vilagut, G., Martínez, M., Bernal, M., Luque, I., Codony, M., Dolz, M., & Alonso, J. (2006). Prevalence of mental disorders and associated factors: Results from the ESEMeD-Spain study. *Medicina Clínica*, *126*(12), 445-451. https://doi.org/10.1157/13086324

Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Knapstad, M., Lervik, L. V., Sæther, S. M. M., Aarø, L. E., & Smith, O. R. F. (2020). Effectiveness of Prompt Mental Health Care, the Norwegian Version of Improving Access to Psychological Therapies: A Randomized Controlled Trial. *Psychotherapy and Psychosomatics, 89*(2), 90-105. https://doi.org/10.1159/000504453

Kobori, O., Nakazato, M., Yoshinaga, N., Shiraishi, T., Takaoka, K., Nakagawa, A., Iyo, M., & Shimizu, E. (2014). Transporting cognitive behavioral therapy (CBT) and the improving access to psychological therapies (IAPT) project to Japan: Preliminary observations and service evaluation in Chiba. *Journal of Mental Health Training, Education and Practice 9*(3), 155-166. https://doi.org/10.1108/JMHTEP-10-2013-0033

Layard, R., & Clark, D. M. (2015). Why more psychological therapy would cost nothing. *Frontiers in Psychology, 6*, 1713. https://doi.org/10.3389/fpsyg.2015.01713

Ministry of Health, Consumer Affairs, and Social Welfare (2019). *Strategic Framework for Primary and Community Care*. Publication center.

Moriana, J. A., Gálvez-Lara, M., & Corpas, J. (2017). Psychological treatments for mental disorders in adults: A review of the evidence of leading international organizations. *Clinical Psychology Review*, *54*, 29-43. https://doi.org/10.1016/j.cpr.2017.03.008

Muñoz-Navarro, R., Cano-Vindel, A., Ruiz-Rodríguez, P., Medrano, L. A., González-Blanch, C., Moriana, J. A., Capafons Bonet, A., & Dongil-Collado, E. (2017). Diagnostic and referral hierarchical model of common mental disorders in primary care centers. The PsicAP clinical trial approach. *Ansiedad y Estrés*, *23*(2-3), 124-129. https://doi.org/10.1016/j.anyes.2017.10.002

Naeem, F., Pikard, J., Rao, S., Ayub, M., & Munshi, T. (2017). Is it possible to provide low-intensity cognitive behavioral treatment (CBT Lite) in Canada without additional costs to the health system? First-year evaluation of a pilot CBT Lite program. *International Journal of Mental Health*, *46*(4), 253-268. https://doi.org/10.1080/00207411.2017.1345039

National Institute for Health and Care Excellence (NICE) (2011). *Common mental health disorders: identification and pathways to care*. https://www.nice.org.uk/guidance/CG113

Organization for Economic Co-operation and Development (2015). *OECD Health Data: Pharmaceutical market, OECD Health Statistics (database)*. https://doi.org/10.1787/Data-00545-En

Parés-Badell, O., Barbaglia, G., Jerinic, P., Gustavsson, A., Salvador-Carulla, L., & Alonso, J. (2014). Cost of disorders of the brain in Spain. *PLoS ONE*, *9*(8), e105471. https://doi.org/10.1371/journal.pone.0105471

Polanin, J. R., & Snilstveit, B. (2016). Converting between effect sizes. *Campbell Systematic Reviews*, *12*(1), 1-13. https://doi.org/10.4073/cmpn.2016.3

Richards, D. A., & Suckling, R. (2009). Improving access to psychological therapies: Phase IV prospective cohort study. *The British Journal of Clinical Psychology*, *48*(Pt 4), 377-396. https://doi.org/10.1348/014466509X405178

Roca, M., Gili, M., García-García, M., Salva, J., Vives, M., Campayo, J. G., & Comas, A. (2009). Prevalence and comorbidity of common mental disorders in primary care. *Journal of Affective Disorders*, *119*(1-3), 52-58. https://doi.org/10.1016/j.jad.2009.03.014

Rovira, J., Albarracín, G., Salvador, L., Rejas, J., Sánchez-Iriso, E., & Cabasés, J. M. (2012). The cost of generalized anxiety disorder in primary care settings: Results of the ANCORA study. *Community Mental Health Journal*, *48*(3), 372-383. https://doi.org/10.1007/s10597-012-9503-4

Ruiz-Rodríguez, P. (2019). *Análisis de coste-efectividad y coste-utilidad del tratamiento cognitivo-conductual de los desórdenes emocionales en Atención Primaria frente a tratamiento convencional* [Cost-effectiveness and cost-utility analysis of the cognitive-behavioral treatment of emotional disorders in Primary Care compared to conventional treatment]. Universidad Complutense de Madrid.

Ruiz-Rodríguez, P., Cano-Vindel, A., Muñoz-Navarro, R., Wood, C. M., Medrano, L. A., Moretti, L. S., & PsicAP Research Group (2018). Cost-Effectiveness and Cost-Utility Analysis of the Treatment of Emotional Disorders in Primary Care: PsicAP Clinical Trial. Description of the Sub-study Design. *Frontiers in Psychology*, *9*, 281. https://doi.org/10.3389/fpsyg.2018.00281

Ruiz-Rodríguez, P., Cano-Vindel, A., Muñoz Navarro, R., Medrano, L., Moriana, J. A., Buiza Aguado, C., Jiménez Cabré, G., & González-Blanch, C. (2017). A systematic review and critique of the economic impact and burden of common mental disorders in Spain. *Ansiedad y Estrés*, *23*(2), 118-123. https://doi.org/10.1016/j.anyes.2017.10.003

Salari, N., Hosseinian-Far, A., Jalali, R., Vaisi-Raygani, A., Rasoulpoor, S., Mohammadi, M., Rasoulpoor, S., & Khaledi-Paveh, B. (2020). Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. *Globalization and Health*, *16*(1), 1-11. https://doi.org/10.1186/s12992-020-00589-w

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology*, *60*(1), 1-37. https://doi.org/10.1111/bjc.12259

Whiteford, H. A., Ferrari, A. J., Degenhardt, L., Feigin, V., & Vos, T. (2015). The global burden of mental, neurological and substance use disorders: An analysis from the global burden of disease study 2010. *PLoS ONE*, *10*(2), e0116820. https://doi.org/10.1371/journal.pone.0116820

World Health Organization (2017). *Depression and other common mental disorders: Global health estimates*. World Health Organization. https://doi.org/WHO/MSD/MER/2017.2

Zhang, A., Borhneimer, L. A., Weaver, A., Franklin, C., Hai, A. H., Guz, S., & Shen, L. (2019). Cognitive behavioral therapy for primary care depression and anxiety: A secondary meta-analytic review using robust variance estimation in meta-regression. *Journal of Behavioral Medicine*, *42*(6), 1117-1141. https://doi.org/10.1007/s10865-019-00046-z