New Zealand's big psychotherapy programme requires evaluation

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New Zealand is following the UK and Australia by developing a national psychotherapy programme, at the very time that the value of these programmes is being questioned. The New Zealand national psychotherapy programme was a centrepiece of the government's first "wellbeing" budget[1] delivered on 30 May 2019. The budget attracted international attention, and was viewed by Lord Layard "as a game changing event" for public policy, because it was focusing on the "wellbeing" of its citizens, beyond traditional bottom-lines such as productivity and economic growth.[2]

A key policy initiative was to try to improve population mental health by funding new frontline workers in doctor's surgeries, aiming to help 325,000 people per annum (approximately 6.5% population coverage) with mild to moderate anxiety and depression, by 2023/24.[1] The initiative follows the precedent set by Australia's Better Access programme and the UK's Improving Access to Psychological Therapies (IAPT) programme, which achieve population coverage rates of 4.7% and 1.5% respectively.[3] The scale and budget of the proposed New Zealand programme is therefore more ambitious than either the UK or Australian programme.

However, significant questions have been raised regarding the effectiveness of both the IAPT and Better Access programmes in reducing the population prevalence of anxiety or depression.[3] Hence, the New Zealand government should carefully analyse the relative strengths and weaknesses of IAPT and Better Access Programme, before implementing their own proposals.

Australia's Better Access programme has been criticised for not having conducted controlled trials before nationwide implementation.[4] There are also concerns that Better Access has no clear ongoing evaluation or benchmarking framework, inequitable access, an unclear model of care and uncertain quality of treatment.

The IAPT programme has several appealing design features, including the use of structured telephone-based cognitive behaviour therapy (CBT) (Australia's Better Access is face-to-face, and does not mandate a specific psychological model) and collection of routine outcome measures at each therapy session. The data collected (numbers of people seen, average number of sessions, treatment outcomes) is then sent to NHS digital for annual reporting and benchmarking purposes.[5]

We would suggest that New Zealand preferentially adopt these key components of UK's IAPT programme. Irrespective, it remains uncertain whether the New Zealand government's $455 million investment will actually reduce the population prevalence of anxiety and depression, based on the Australian and UK experience.[3,4] Hence, the New Zealand government should set aside specific resources to fund a robust, independent and ongoing research and evaluation framework (see Table 1) for both individual and population level outcomes.

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Table 1: Suggested evaluation framework for New Zealand anxiety and depression treatment programme.

Individual level outcome measures
• Embed routine session-by-session outcome measures at individual level for anxiety and depression—for example, the PHQ-9 and GAD-75 • Ongoing measure of disability, including work and social adjustment scales • Disorder-specific scales (eg, panic disorder severity scale, social phobia inventory, obsessive compulsive inventory) • Patient satisfaction levels with service provided • Quality of life measurement • Data should be linked individually between the psychotherapy programme, primary care data-sets, emergency department and hospital inpatient data-sets
Proposed clinical trial
• Stepped wedge cluster randomised controlled trial—short and long-term outcomes (one year post-intervention) • Detailed cost-benefit analysis
Annual report of service performance
• Benchmarking various services in terms of accessibility, efficiency and effectiveness
Population level outcome measures prior to and following implementation of the programme
• Population survey of wellbeing levels • Population prevalence survey of psychological distress—using Kessler K-10 • Detailed national survey of diagnosed anxiety and depression related disorders • Rates of antidepressant use • Rates of benefit utilisation (supported living payment) for mental health conditions • Rates of sick leave utilisation • Rates of emergency department presentations for anxiety, depression, drug and alcohol • Rates of hospital admissions for anxiety, depression, drug and alcohol • Rates of suicide • Rates of economic productivity

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