

Adapting empirically supported treatments in the era of integrated care: A roadmap for success

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Abstract

The emerging era of integrated care represents a major opportunity for clinical psychology to migrate empirically supported treatments (ESTs) into the mainstream of public health. To succeed will require us to modify current ESTs to make them brief, cost-effective, patient-centered and acceptable to and easily learned by both the mental health and health-care professionals that will deliver them. Changes to the recently modified standards for designating ESTs are proposed that will facilitate adoption of a population health model of treatment development and testing, designed to promote rapid dissemination of empirically supported interventions that are a “good fit” for integrated settings. Defining characteristics of the “new look” for ESTs are examined.

KEYWORDS

acceptance and commitment therapy, brief interventions, effectiveness research, empirically support therapies, implementation science, integrated care, population health

1 | INTRODUCTION

The health and mental health care systems in the United States are currently in the midst of a radical transformation, in the form of transitioning to a “patient-centered medical/behavioral home” model of health care (Nutting et al., 2009). More important, there is growing emphasis on integrating behavioral services within all sectors of the health-care and social services delivery systems. This trend is most dramatic in the primary care system, which has been described as the “de facto” mental health system of the United States (Regier et al., 1993). As a result of the burgeoning pressure for service integration, new models of integrated behavioral care have been developed, tested for feasibility and effectiveness, and now are rapidly spreading across the entire health care system (cf. Robinson & Reiter, 2016; for a comprehensive treatment of this subject).

If the movement toward integrating behavioral services continues, clinical psychology will be in the midst of a sea change that has the potential to permanently alter the way

evidence-based psychological services are delivered in the United States. This presents us with a once in a lifetime opportunity to move psychological interventions into the mainstream of public health. However, every paradigm change opportunity like this also comes with a black box warning: Clinical psychology must address the theoretical and methodological challenges associated with designing, testing, and disseminating empirically supported interventions that are a good fit for integrated settings generally and health-care settings specifically. Although the ESTs of tomorrow may share some underlying features with the current generation of ESTs, they will very likely have many unique, defining characteristics as well.

In this article, we will examine the central issues related to the development, testing, and dissemination of empirically supported treatments for use in primary care. We have spent the last three decades working in the primary care setting, and that is our area of expertise. Our focus on primary care is done with the caveat that the service integration movement is influencing all sectors of the social/educational service

systems, including schools, nursing homes, assisted living facilities, jails, and juvenile detention facilities, to name but a few potential integrated care venues. It is also important to note that most integrated care settings possess common features that will significantly change the architecture of any evidence-based interventions that are to undergo widespread dissemination. To create new ESTs that are a “good fit” for the practical realities of integrated care settings, we must first understand the grounding principles of population-based health care in relation to the grounding assumptions that have guided the development of ESTs to date. This will allow us to isolate those assumptions that will need to be modified or changed to capitalize on this important opportunity. We will also propose several important modifications in the processes for designating empirically supported treatments. These changes for the most part are designed to incentivize research into population health versions of current ESTs and to create a more efficient pipeline for developing and disseminating evidence-based treatments into the health-care sector.

We strongly believe in the power of empirically supported treatments and appreciate the decades-long efforts of our highly esteemed colleagues that have worked long and hard to develop them. Without their seminal contributions to the field of clinical science, we would still be languishing in the dark ages of never-ending psychotherapies with questionable effectiveness. It is also important to remember that, even though there is considerable resistance to using ESTs in the practitioner community, the main tenets of evidence-based care (i.e., time-effective, outcome-focused treatment) are deeply embedded in the new mental health paradigm. This would not have been possible without the advent of the EST movement. Our hope in writing this article is that it will stimulate the community of clinical psychology to get in front of the health-care transformation movement and apply our formidable theoretical and empirical skills to help solve the problem of our current pandemic of mental disorders. This will require a rather pronounced shift in our treatment development and testing pipeline, with the goal of developing a “first to market” approach to treatment dissemination. We have no illusions that this task will be achieved quickly, but we can get through the growing pains of this transition if a consistency of purpose develops among clinical researchers, psychologists in practice and mental health policymakers.

2 | THE ALARMING DECLINE IN POPULATION MENTAL HEALTH

The mental and chemical health of the American citizenry is in an unprecedented nosedive. We now have a 27% annual prevalence of onset for Axis I conditions (Kessler & Wang, 2008), meaning that every year, more than one in

four Americans will develop a diagnosable mental or substance use disorder. Many more will struggle with sub-threshold symptoms and various problems in living that will dramatically affect their quality of life. The vast majority of people with mental health or substance use problems do not seek professional help for their problems but will continue to use a disproportionate amount of health-care services (Simon, Ormel, VonKorff, & Barlow, 1995). If they do decide to seek help, their first point of contact likely will be with a prescribing general medical professional, such as a physician, advanced nurse practitioner or physician assistant. Sadly, less than one quarter of all people with a mental health or substance use disorder will actually see a mental health professional.

The advent of empirically supported treatments has unfolded pretty much in the same time frame as the expanding rates of mental health disorders and addictions, suggesting that simply having ESTs available is not the same as delivering them en masse to the population. True, a few privileged, motivated people, living in the right urban area, with the right kind of health insurance, are lucky enough to find a clinician that actually knows how to deliver an EST for a specific problem, and they get the help they need. But for the remainder of people in trouble, for a wide variety of reasons, no empirically supported therapy is available (Harvey & Gumpert, 2015). Although there are an estimated 775,000 mental health providers in the United States, they mostly congregate in urban areas, leaving vast areas of rural and frontier America with severe mental health service shortages. Indeed, there are almost 70 million Americans in need of mental health care spread evenly according to population across urban, suburban, rural, and frontier areas (Kazdin & Blasé, 2011). At the same time, we are witnessing a universal trend involving a reduction in the use of, and expenditures for, psychotherapy services of any kind. This is associated with a rapid increase in expenditures for psychiatric medications of all classes, particularly antidepressants and antipsychotics (Olsson & Marcus, 2010). Even with these pronounced shifts, the unwavering truth is that the majority of people with mental health problems receive no care whatsoever (Wang et al., 2005).

The social and economic costs associated with untreated mental health and substance use problems are astronomical, including dramatic increases in unemployment, functional disability, and early mortality (Murray et al., 2013). Sadly, there is a massive “opportunity cost” associated with failing to address mental health or substance abuse problems in their early formative stages. Most of these cases present for care outside of the mental health system and are seen in primary care settings. An alarming percentage of mild-to-moderate subthreshold clinical presentations, if left untreated, tend to get more serious over time (Kessler &

Wang, 2008). By failing to provide an effective treatment response at the initial point of contact in primary care, we are breeding a generation of citizens with progressively worsening mental and chemical health issues. These festering mental health and substance abuse problems trickle down through families, leading to higher and higher prevalence rates from one generation to the next. Since the first large epidemiologic catchment study in the 1980s (Regier et al., 1993), every national replication study has shown an increase in prevalence rates across the board.

3 | EMPIRICALLY SUPPORTED TREATMENTS: PART OF THE SOLUTION OR PART OF THE PROBLEM?

It is certainly reasonable to assign blame for this dismal situation to misguided government policy, to lack of mental health funding, to the dramatic overprescribing of psychoactive drugs with questionable efficacy, or to exploitative insurance reimbursement practices (Harvey & Gumpert, 2015). Although the advent of ESTs has clearly succeeded in establishing psychological treatments as credible alternatives to drug therapy in the mental health specialty sector, there has been no corresponding large-scale adoption of effective psychological treatments in primary care or other community care settings (Insel, 2009). There are undoubtedly myriad factors that collectively account for these disappointing results.

One factor is a severe workforce shortage of clinicians capable of delivering ESTs in general, and in primary care specifically. Many graduate-level training programs do not teach any EST, much less than an array of them (Weissman et al., 2006).

Second, when ESTs are disseminated into community mental health settings, there is a noticeable decrease in their effectiveness, what has been called in implementation science the “voltage drop” (Chambers, Glasgow, & Stange, 2013). This may serve to decrease the allure of ESTs for community clinicians. One explanation for the voltage drop is that graduate training programs are not doing a good job of training their students how to deliver an array of ESTs. An equally plausible contributing factor is that the test tube environment of RCT efficacy trials simply identifies the top boundary of clinical effectiveness for a particular treatment under ideal conditions, and those ideal conditions seldom exist in the world of applied clinical practice. Thus, a drop in the effectiveness of an EST is a near certainty once it is introduced into the field.

As an example, consider the voltage drop problem encountered in the Improving Access to Psychological Therapies (IAPT) program in the United Kingdom. The

IAPT program is designed to deliver a broad range of ESTs to patients with various mood and anxiety disorders. IAPT therapists are certified for practice based upon highly specialized competency-based clinical training in various EST approaches (Clark et al., 2009). Aggregate clinical outcome data for 2015–2016, involving 490,395 patients treated with an EST, showed an overall average reliable change rate of 46.3%. (NHS Digital, 2016). This treatment success rate is far below what is normally shown in RCT-based efficacy studies of nearly every EST.

Third, although the current health-care environment is begging for brief, effective models of psychological intervention, the current efficacy, to effectiveness, to community dissemination cycle for an EST typically takes 15–20 years (Sundararaman, 2009), resulting in a serious market-timing problem. The gap created by our current inability to both rapidly design and deliver brief, effective psychological interventions has instead been filled by a widespread reliance on pharmacotherapy. In the ever-changing environment of healthcare transformation, we need to be more nimble in our ability to quickly adapt and disseminate ESTs.

Finally, we are certainly not the first authors to suggest that the architecture of most contemporary ESTs is not a good fit with the practical realities of community care contexts generally, and primary care specifically (Kazdin & Blasé, 2011; Weisz, Ng, & Bearman, 2014). Most EST approaches are complex, labor-intensive treatments that require therapists to undergo specialized postgraduate clinical training. For example, a financial analysis of the IAPT program revealed that the overall cost to deliver an EST to completion for one patient was roughly \$3,800 (Radhakrishnan et al., 2013).

The cost to deliver ESTs en masse to people that might benefit from them in primary care would be so large that an exponential increase in mental health funding would be required to address even a fraction of the need. Take, for example, the likely costs required to treat depressed primary care patients. If there are six full-time primary care providers in a clinical practice, an average of 150 medical visits will take place daily; or roughly 750 patient visits per week. If we just focused only on helping patients diagnosed with major depression and ignored every other type of behavioral health issue, we would identify 45 clinically depressed patients every week, assuming a 6% population prevalence rate. If we delivered a 12-session EST protocol for depression on an individual basis, we would be committing 540 hr of therapist time *per week*. In a 46-week work year, we would be committed to providing 24,840 hr of therapy. That would require the medical practice to hire over a dozen full-time psychologists just to deliver care for patients with major depression!

What is needed is for us to take a radically different approach to the design, testing, and dissemination of evidence-based psychological interventions in primary care. To do that, we need to understand the grounding principles of the movement toward integrated care.

4 | THE NEW RULES OF THE GAME: THE POPULATION HEALTH MODEL

When gearing up for a major paradigm shift, it is important to start with a big picture framework that will guide decision-making as we work our way down the ladder of specific strategies that will insure success. In this case, the framework for health-care redesign is known as *population health care*. Although many psychologists have heard of the term, few may understand the dramatic implications it carries for the development, testing, and dissemination of empirically supported treatments. Population health care incorporates a complex set of principles that, if implemented with fidelity across the delivery system, would improve the health and mental health of the entire population (Kindig & Stoddart, 2003). These principles are simple enough when considered separately, but deceptively complex when they are combined into a reengineering framework. Here are a few of the more seminal population health principles that begin to create a new framework for designing treatments that will work in healthcare settings.

- Health and mental health-care resources are finite, and there are not enough of them to give every person every medical service they might want or need.
- Because health resources are limited, delivery of health-care (and mental health) services must involve rationing.
- The rationing process should result in an equitable distribution of health-care resources across all segments and subgroups of the population.
- The health of the population is more likely to improve when a limited amount of services are delivered to a large segment of the community. Conversely, population health is threatened when a relatively small percentage of people consume most available healthcare resources.
- Health disparities (i.e., negative differences in the health status of any identified subgroup compared with any other subgroup or with the population as a whole) are the result of social, racial, ethnic, economic, behavioral, and resource allocation factors.
- Lack of timely access to appropriate health care, either because it is not readily available or because it is not delivered in a form that fails to engage potential recipients, is a major cause of adverse population health outcomes.

- To achieve optimal population health, subgroups that suffer health-care disparities must be identified and system-level resources redesigned and reallocated to address causal factors leading to disparities within those subgroups.
- Population-oriented services should emphasize first, preventative care; second an aggressive, evidence-based, stepped care approach to the treatment of acute conditions; and third provision of regular, ongoing chronic care to slow disease progression in those with chronic conditions.

The seeds of the health-care transformation movement in the United States lie in the recognition that the current health care system fails the test of quality imposed by the principles of population health care. As Starfield (2000) pointed out, although we have the most expensive health care system in human history, we actually have one of the worst health care systems in the civilized world when it comes to key indicators of population health.

Thus, the operational “footprint” of primary care is to provide frontline medical services, in short contacts, to a very large percentage of the population. Primary care is an accessible, first point of contact for all health-care needs, broadly defined. The care provided is comprehensive, continuous over time, and closely coordinated by the primary care provider. The primary care setting contains a “basket” of services available that makes it a “one-stop shopping” venue. The care provided is person-centered and focused on empowering the patient to engage in effective self-management of health risk and health protective behaviors. Research consistently shows that this approach produces better health outcomes, reduces hospital costs, and decreases population morbidity and mortality (Starfield, Shi, & Macinko, 2005).

5 | PHILOSOPHICAL AND TECHNICAL ISSUES

When redesigning ESTs to create a better fit with the integrated care context, it is important to understand what our grounding assumptions have been up to now and what must change if we are to achieve our stated objective. The goal here is not to criticize underlying assumptions or to argue that one assumption is right and the other is wrong. It is simply to recognize the close tie that exists between treatment architecture and our underlying assumptions about the goals, processes, and outcomes of psychotherapy.

For decades, mental health theory, treatment development, and research have been dominated by a philosophy that we will term the “case-based” approach. In the case-based approach, specialized clinical services are delivered

in an acute care model involving weekly or twice weekly therapy sessions. The goal is to eliminate or cure the patient's presenting symptom complaint(s). In this sense, the mental health therapist is functioning as a "specialist," much like a general surgeon does.

Indeed, if we took the assumptions of the case-based model as truth (rather than assumptions), we would be hard pressed to believe that an EST could ever be developed that would be a good fit for most primary care settings. Fortunately, our assumptions can be empirically tested with respect to the scientific predictions they generate. If the predictions prove false or inconclusive, we can modify any particular underlying assumption until it produces a better fit with the observed data. In the sections that follow, we will examine four key philosophical and technical challenges that must be addressed in the quest to design ESTs that are a good fit for integrated care contexts.

6 | HOW MUCH THERAPY IS ENOUGH?

The dose-effect assumption underlying the case-based model is that therapeutic benefits accrue additively and linearly over the course of treatment; that is, the more therapy a person receives, the more benefit is bestowed. If this assumption is true, brief treatment models comprised of only a few sessions should not be nearly as effective as longer multisession protocols. What does the evidence generated by psychotherapy research suggest? Although it is true that some research suggests that people gain more benefit the longer they participate in therapy (Barkham, Rees, Stiles, Hardy, & Shapiro, 2002; Hansen, Lambert, & Forman, 2002), other research suggests that there is a nonadditive, nonlinear dose-effect relationship. Specifically, a disproportionate amount of therapeutic benefits tend to accrue in the earliest stages of treatment (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2010; Barkham et al., 2006; Harnett, O'Donovan, & Lambert, 2010; Howard, Kopta, Krause, & Orlinsky, 1986).

For twenty years, randomized clinical trials of ESTs for a wide variety of mental disorders have revealed that a large percentage of treatment responders exhibit "sudden gains" in therapy (Hardy et al., 2005; Masterson et al., 2014; Safer & Joyce, 2011; Tang, DeRubeis, Hollon, Amsterdam, & Shelton, 2007; Wilson, 1999). Effectively, the patient exhibiting sudden gains no longer meets symptom criteria for being considered a "case." If sudden gains occurred in a routine clinical practice, the patient and therapist would likely agree to terminate treatment at the point and schedule a booster session for a future date. The median session at which sudden gains have been observed in RCTs varies between three and five. In one study (Hardy

et al., 2005), 31 of 76 clients responding to cognitive therapy for depression exhibited sudden clinical gains. In another study, early changes in symptom trajectory were significant predictors of long-term outcomes in cognitive behavioral therapy (Lewis, Simons, & Kim, 2012). Another remarkably consistent finding is that patients who exhibit sudden gains tend to retain those gains over the long term (Safer & Joyce, 2011; Tang et al., 2007). Terrence Wilson, in this journal nearly 20 years ago, stated that sudden gains in therapy are real, account for a significant percentage of positive clinical outcomes, and should be studied more closely (Wilson, 1999). For present purposes, this well-documented clinical phenomenon suggests that some patients do indeed benefit very rapidly from therapy. There may be subgroups of patients for whom more treatment is better and other groups for whom less treatment is better. At present, there is no clear predictor of who will exhibit sudden gains in therapy and who will not.

There is a long tradition of psychotherapy research testing the effectiveness of very abbreviated versions of full-length ESTs (see Barkham, Shapiro, Hardy, & Rees, 1999 for an early example of this line of research). One of us (PR) was the architect of an abbreviated treatment protocol for depressed primary care patients, which was examined in a large RCT (Katon et al., 1996). These patients received 2.0–3.0 hr of CBT interventions known to be effective in treating depression, delivered in once-weekly 30-min sessions. Results indicated that 70% of the patients receiving this "skinny" EST protocol exhibited 50% or greater reductions in self-report and interview-based symptoms of depression. The magnitude of clinical change observed in patients receiving the skinny protocol was directly comparable to that observed in RCTs of longer treatments for depression. More recently, an abbreviated version of a well-established EST for combat-related PTSD was tested with a cohort of primary care patients, with a very similar pattern of positive results (Cigrang et al., 2015). Another study compared cognitive behavioral therapy treatment protocols for depression lasting 2, 8, and 16 sessions (Barkham et al., 2002), with no differences noted between the three protocols in terms of pre- to post-treatment changes in depression. There was a nonsignificant trend favoring longer treatment in producing a higher percentage of patients exhibiting reliable change, particularly among patients exhibiting lower levels of interpersonal functioning.

Another promising line of research has been to directly test "generic" ultra-brief CBT interventions delivered in primary care. These investigations have shown a robust, stable clinical response in patients with a wide range of different types and severity of mental health problems receiving on average between two and three half-hour-long visits (Bryan, Morrow, & Appolonio, 2009; Bryan et al., 2012;

Ray-Sannerud et al., 2012). It is interesting to note that although it has long been assumed that functional status and social integration take longer to restore in therapy than symptom relief, all three of these dimensions have been shown to change in parallel in response to ultra-brief primary care-based CBT interventions (Bryan et al., 2012). A meta-analysis of very brief primary care interventions suggested that a variety of different approaches seem to work with both mood and anxiety disorders (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010). In conclusion, we suggest that there is no a priori reason to reject the notion of designing ultra-brief versions of ESTs for application in primary care and other community contexts.

7 | HOW DO WE INCREASE THE SPREAD OF EFFECTIVE INTERVENTIONS?

A major underlying assumption of the population health approach is that “preferred interventions” are those that can be efficiently disseminated to a large percentage of the community with a minimum amount of resources. Primary care providers typically see about 80% of the members of a covered population for at least one visit annually, contrast this high population penetration rate with the accessibility of the case-based approach. The percentage of the general population that will receive a mental health service in any given year is 3%–5%. Models of care designed to serve only 3%–5% of the community are going to be dramatically different than models seeking to serve 20% or 30%. Recall that the current population rate of mental health disorders hovers around 30%, and so the task at hand is to develop empirically supported interventions with enough “reach” to create a 30% population penetration rate. Reach requires that we modify our treatment approaches so that they can be delivered to a much broader segment of the population. This likely will require us to develop briefer and less resource-intensive models of intervention that can be delivered in a wide variety of formats (i.e., Internet, video-teleconferencing, phone-based counseling by nurses or lay health workers).

8 | HOW DO WE OPTIMIZE TREATMENT UPTAKE?

Treatment uptake involves the extent to which community-based clinicians accept the usefulness of and express a willingness to deliver a particular EST. It also involves the willingness of patients to agree to be recruited into, and to adhere to the requirements of, the treatment. Treatments with high levels of provider and patient acceptability

should result in high rates of patient recruitment, low drop-out rates, and fidelity to the treatment model by care providers. From a population health perspective, treatment uptake is the single most important feature of a community-based intervention, even more important than the actual clinical impact of that intervention. It does not matter how effective an intervention is if large numbers of community clinicians would not deliver it or if large numbers of patients are not willing to complete it or both.

One of our most vexing treatment uptake problems is the lack of adoption of ESTs by a large segment of community-based mental health therapists (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). From the perspective of community clinicians, ESTs are complex, difficult to learn, and are not supported by insurance precertification practices that tend to stringently control the number of therapy sessions that will be paid for (Harnett et al., 2010; Yates, 2011). ESTs require both intellectual rigor and astute, ongoing clinical decision-making on the part of the therapist and the associated mental “wear and tear” can create problems with professional burnout. In the IAPT program, 68% of therapists delivering EST services reported significant problems with burnout, even while professing to strongly believe in the effectiveness of these treatments (Steele, McDonald, Schroder, & Mellor-Clark, 2015).

On the patient side of this equation, there is an equally unsettling picture about the uptake of ESTs as well. In fact, treatment refusal rates for ESTs are in the vicinity of 20% even when the treatment is provided free of charge by trained therapists (Clark et al., 2009; Radhakrishnan et al., 2013). Another 20% of patients initially agree to participate but do not make it to the first session, or drop out after the first session (Fernandez, Salem, Swift, & Ramtahal, 2015; Olfson et al., 2009; Radhakrishnan et al., 2013). The rate of premature termination is variously estimated to range from 20% to 45%, and dropouts are even a significant problem in the randomized clinical trials (Olfson et al., 2009; Swift & Greenberg, 2012). By the time we account for treatment refusals, therapy dropouts, and treatment nonresponders, the net effectiveness of even well-established ESTs is in the range of 20% (Radhakrishnan et al., 2013). Perhaps this is one reason why community-based mental health clinicians are not sold on the value of retraining themselves to deliver ESTs.

Although there are many potential causes of premature termination, one likely contributor is a lack of correspondence between the goals of the client that is seeking help and the far more ambitious goals of the typical EST. Whereas ESTs seek to eliminate the symptoms of distress and to reduce the likelihood of relapse, most clients just want to feel better. Analysis of large insurance data sets show that even modest reductions in the level of symptom distress strongly predict early treatment discontinuation (Brown & Jones, 2005). This preference for emotional

relief results in an overall average of five therapy sessions attended, and with a modal number of one session attended (Gibbons et al., 2011)! Indeed, a significant percentage of patients fail to make it to the first session, after agreeing to participate in treatment (Fernandez et al., 2015), even though dropouts are less likely to meet criteria for reliable change when compared with patients who complete treatment (Cahill et al., 2003; Hansen et al., 2002). Perhaps feeling better, although not completely better, is a good enough treatment result for the typical patient (Baldwin et al., 2010; Barkham et al., 2006).

9 | HOW DO WE MAXIMIZE THE IMPACT OF LIMITED MENTAL HEALTH RESOURCES?

Resource constraints are also an important population health consideration when designing empirically supported interventions. It is important to realize that only 7% of the health care dollars in the United States is spent on funding specialized mental health and substance abuse services (Levit et al., 2008). The remainder goes into funding primary and specialty health-care services. Even as the era of integrated primary care services unfolds, there is unlikely to be a huge change in this funding picture. Community mental health resources will likely remain limited, with increasing expenditures for psychoactive drugs and declining expenditures for psychotherapy services (Gibbons et al., 2011; Levit et al., 2008). Insurance companies do not like to pay for longer, more expensive treatments if there are shorter ones that are even close to being equal in effectiveness (Yates, 2011). Insurance companies routinely use various medical necessity, co-insurance, and deductible practices that are known to suppress service use (Simon, Grothaus, & Durham, 1996). Out of financial necessity, we will need to develop brief, inexpensive interventions that can be spread across as large a segment of the population as possible. Because of severe resource constraints, new models will also need to appeal to and effectively “recruit” health-care professionals to function as surrogate mental health providers.

10 | A ROADMAP FOR SUCCESS: GROUNDING PHILOSOPHIES

In this section, we will describe some modified grounding principles and associated strategies that might promote the development and testing of a new generation of empirically supported interventions widely applicable in community settings. This achievement would put empirically supported behavioral interventions on the radar of public policymakers, who currently see few options other than the widespread

proliferation of drug therapies as a solution to the mental health pandemic. The new standards recently put forth by the Division 12 task force represent an attempt to address many deficiencies in the old approach; indeed, some of those deficiencies are on our list as well. The proposal to reserve a “very strong” recommendation only for treatments that have been tested in at least one field-based effectiveness study is certainly a very positive step forward. In the sections that follow, we will describe some additional steps that we can take as a profession to capitalize on the integrated care opportunity.

11 | ADOPT AN INTERDISCIPLINARY SCIENCE PERSPECTIVE IN TREATMENT DEVELOPMENT

In designing new interventions, we need to integrate evidence from the fields of public health, descriptive epidemiology, and health services research into the process. Among other impacts of adopting a more expansive definition of clinical evidence, we might likely begin to rethink who we should be designing treatment packages for.

For example, epidemiologic research shows that, even though a greater percentage of the general population is accessing traditional mental health care for their problems, by far the highest rate of growth in care seeking is occurring in the healthcare sector (Wang et al., 2005). Health services’ research shows that psychologically distressed primary care patients use double the amount of ambulatory health services every year, compared to matched nondistressed controls (Preville, Potvin, & Boyer, 1998; Simon, Ormel, et al., 1995). The outcomes of primary care-based treatment for most mental health conditions are about the same as the rate of spontaneous remission (Simon, Lin, et al., 1995). Primary care providers have ubiquitous access to drug treatments for every conceivable kind of problem. The problem is that (a) a large percentage of the patients who receive drugs for mental health purposes do not actually have the condition in a severe enough form to benefit from drug therapy and (b) a very large percentage of patients drop off their drug treatments due to side effects or perceived lack of benefit (Simon, Lin, et al., 1995). This information is coming from research conducted outside the field of clinical psychology, but collectively it creates a clear picture of the population health dilemma we face.

12 | THE NEW EVIDENCE-BASED CARE QUESTION

In using an interdisciplinary evidence approach, we may come to rethink what we mean by an empirically

supported treatment. Right now, the question we have been answering is as follows: “Which treatment(s) are known to work best with which specific mental health or addiction-based conditions or both?” The population-based care question would be: “Which treatment (s) works best, in the shortest possible time, with the least resources used, with the lowest refusal and attrition rates, when delivered by mental health and non-mental-health providers (with different levels of training) in a variety of different community settings, and with patients suffering from medical and mental health conditions of varying levels of severity?” If we spent the next decade answering this question for just the most common garden-variety health problems seen in community settings, it would be one for the ages, as far as the public health impact of clinical psychology is concerned.

13 | BEGIN WITH THE END IN MIND

Big shifts in direction begin when members of a shared community adopt a new vision of what their mission is and how it will be achieved. It is useful to begin by asking ourselves a simple question: “What if everything went right, and brief, acceptable, effective psychological interventions were available to the average person, in the average integrated care setting, on the average day. What would that look like? And how could we promote that reality?” First, psychologists would become a core member of the health-care team and function as the first point of contact for people seeking help. Second, all members of the health-care team would be able to deliver reasonably effective, technically simple psychological interventions in situations where direct access to psychological services is limited. They would use simple, easy to understand intervention concepts routinely. They would also be interested in learning more interventions to help other people in practical ways.

14 | EMPHASIZE SCOPE OVER PRECISION

Big shifts in approach require us to be willing to make uncomfortable adjustments in core philosophies that support what we are currently doing. One important dialectical process in clinical psychology is the tension between precision of concepts and scientific methods versus the scope of their application. As many may remember from their psychological assessment courses in graduate school, as we increase the precision of our knowledge, we decrease its scope of application. The current

working environment in psychotherapy research heavily favors precision over scope. Because precision is a top priority, layers and layers of research methods have evolved over time that heavily favor treatment development in academic, research-oriented settings. In the right context, the overall prevalence of mental disorders is so low that specialized, resource-intensive treatment can be delivered to all that need them. But in a scenario where one quarter of the community will experience a mental health disorder within any given 1-year period, a precision-based, resource-intense approach to treatment will continually fall short of expectations. This is analogous to requiring the developers of flu vaccines to go through the normal FDA field testing and approval cycle before they can distribute their vaccines. By the time the demands of the traditional approval process are met, a new strain of flu will already be in existence, and the “approved” drug will be useless. To get the flu vaccine out for the year it is needed, the testing process required is less precise. It is far more important to get a vaccine to market than it is to verify that it is the best possible vaccine. Interventions on a public health scale typically involve far more scope than precision, and the mental health pandemic requires a public health approach.

15 | ADOPT A RAPID FAIL APPROACH TO TREATMENT DEVELOPMENT

A key principle in system transformation and continuous quality improvement is the “80–20” rule, which holds that the first 80% of benefit in a system redesign is gained with the first 20% of effort. Getting the last 20% of results requires the remaining 80% of effort. In most cases, 80% is sufficient to realize most of the important goals of a redesign. Following this approach to treatment development would allow us to design, test, and quickly implement intervention principles in community settings that are pretty simple and straightforward. But, they would have enormous “carrying power” in a public health sense if the principles fit the social context and are easy for entry-level mental health technicians as well as non-mental-health professionals to learn and use.

Academic psychologists might chafe at the idea of not being in the “first position” with respect to testing and developing new treatments, but this is a “first to market” design challenge we face. It is an “80–20” rule type situation. As a profession, we must shift to a “rapid fail” mentality, meaning that new principles and techniques are implemented very quickly, often ahead of a complete set of scientific data to support them. It is a catastrophe if an ultra-brief treatment that initially looks promising turns out to be a disappointment.

16 | COMMUNITY-BASED TREATMENT DEVELOPMENT

One way to accelerate treatment development is to place a greater emphasis on the use of community-based innovations and less rigorously controlled field studies to function as a main “incubator” for treatment development (Weisz et al., 2014). This could take the form of involving practice-based research networks in the testing of a new approach or conducting pragmatic clinical field trials. A hidden benefit of placing more emphasis on practice-based research methods is that treatment development happens more quickly. This means that new clinical processes and techniques that are being discovered in field settings can be tested directly, without first waiting for efficacy studies, which generally take much longer to complete and publish.

Regardless of how effective a treatment is shown to be in the laboratory, there is no guarantee that it will prove acceptable to community-based clinicians or to the patients who must agree to participate in, and complete, the intervention. Thus, a key step in designing a new treatment is to vet it with the professionals who will deliver it and the patients who will receive it. This would take the form of convening focus groups of community clinicians and patients that would likely receive the treatment. The practice of end-user-based treatment design will almost certainly identify important barriers to treatment uptake and solutions to these barriers can be integrated into the redesign of the intervention. The desired outcome is to disseminate treatment models that have both high levels of uptake and documented clinical effectiveness.

17 | ADOPT TREATMENT BENCHMARKING PRACTICES

The traditional practice of requiring randomization into an active treatment and control/comparative treatment condition has had the effect of quelling effectiveness research in community-based practice settings. In most community settings, the mission of the agency or practice group is to provide immediate mental health care to patients seeking help, and practice-based research is deemed to be of secondary importance. These settings would be gold mines for treatment development research if we adopted a new evidence standard that, for lack of a better name, we will call “outcome benchmarking.” For example, there are a multitude of well-controlled treatment studies of major depression showing that people in the control condition improve at a much lower rate than people in an EST. We also know that 60%–65% of depressed patients receiving an EST will be classified as treatment responders. This means they will have a score under an established threshold on either a

self-report or interview measure of depression. So, we know two important things that basically define an effective treatment: the cutoff scores for a treatment to be considered a success and the percentage of treatment responders needed to meet or exceed existing ESTs for the same condition.

In practice, large-scale attempts to disseminate empirically supported treatments to the public, such as IAPT (Clark et al., 2009), use the outcomes benchmarking concept to guide therapist decision-making and as a basis for reporting clinical outcomes at the program level. In IAPT, a treatment “success” occurs when the index patient achieves a self-report-based symptom score below a clinical threshold on self-report measures of both depression and anxiety.

A new, more efficient treatment development strategy would be to “benchmark” new treatments by requiring them to meet or exceed previously established thresholds for moving from “case” to “noncase” status. For example, imagine that there is a new therapy for depression that takes only two sessions, but it has been developed in an agency setting where there is no financial or logistical support for a proper effectiveness study. The agency mission is to provide immediate care to all people that seek service, so there is no avenue available for random assignment into experimental treatment or wait-list groups. But the agency does keep entry and exit point depression scores for all patients seen at the clinic, such that each consecutive newly identified depressed client will get the new treatment as well as associated entry and exit point depression scores. Every mental health clinician in the agency has undergone an in-service training in how to administer this new approach, and they have access to a written session-by-session outline. But we do not actually know how any particular clinician is delivering the treatment. After 100 clients have received treatment, the agency finds that, at point of entry, all the clients exceeded the threshold score for moderate-to-severe depression. At point of exit, only 8% of clients failed to complete the new treatment; further, 67% of clients that completed the two-session treatment had depression scores that classified them as treatment responders, using the outcomes benchmarking method. The question to be asked is “Is this two-session treatment empirically supported?” One answer is “I’m still waiting for the required RCT-based efficacy and effectiveness studies.” The second answer could be “There is a clear demonstration of effectiveness using the outcomes benchmarking strategy; this new treatment has empirical support.”

18 | CONTEXT MATTERS

The long-standing overemphasis on precision has eroded our appreciation of the role context plays in determining the form and function of clinical interventions. In practice,

precision-oriented approaches view context as a variable to be controlled. For example, in multisite clinical trials, one required set of preliminary analyses is to show that the results of competing experimental treatments do not vary significantly by site. Context is so far in our rearview mirror at this point that the only real arguments we have about it are whether the benefits of empirically supported treatments will generalize to patients in community mental health settings. This has led to a relative disinterest in context as an important variable in treatment design. The assumption seems to have been that, as ESTs generalize well to the community mental health context (with proper staff training and supervision), they most likely will generalize to all contexts. But treatment researchers will soon discover that context does matter, if they pay attention to the four new parameters of the new evidence-based treatment question. In fact, we should be ready and willing to design and test treatments geared specifically for specific integrated care settings, such as a primary care clinic or a school nurse service. We would argue that every treatment is (and should be) designed to fit a specific context. The more contexts your treatment can be modified to fit, the better your treatment is. The consumers of empirically supported treatments deserve to know what contexts the treatments they are receiving have been tested in.

19 | PROPOSED MODIFICATIONS IN THE NEW STANDARDS FOR EMPIRICALLY SUPPORTED TREATMENTS

In this section, we will describe some practical modifications to the newly proposed standards for designating empirically supported treatments. Our agenda is pretty straightforward. We want to put incentives in place to stimulate and reward the design and testing of brief, psychological interventions that will rapidly get to market and gain widespread adoption in key community settings. Clinical psychology brings to the table a unique combination of knowledge about the processes underlying mental health conditions, how to address/resolve them clinically, and how to research the effectiveness of clinical interventions. If we realign the incentives, more members of the psychotherapy research community may get interested in designing and testing brief, population-based treatment models.

20 | ADD A POPULATION VALUE INDEX TO EST STANDARDS

One proposed strategy is to add a new parameter to the existing standards, a population value index (PVI). The

PVI would require researchers to demonstrate that a candidate treatment possesses the key features of a population-based intervention, as described in this article. Suggested elements of the PVI are presented in Table 1. PVI metrics would provide an estimate of a treatment's demonstrated ability to meet or exceed population health parameters.

Several of the PVI factors would relate to directly to treatment impact per se. The *durability* component would reflect the candidate treatment's long-term impact on symptoms and functional impairment. A higher estimate would indicate that a large percent of treatment responders continue to show reliable change over time. Interventions with low durability scores, like medication-only treatment of depression, put a drain on community resources by requiring a high percentage of treated patients to be "reworked" using new treatment resources. The *treatment velocity* score creates an accurate estimate of the impact trajectory of a treatment, allowing us to estimate the number of sessions required to produce reliable improvement or reliable recovery. This allows us to optimize the intervention so that we are neither undertreating nor overtreating the index problem. The *net effectiveness* factor of the PVI is an estimate of the treatment's overall clinical success rate, considering treatment refusal, dropout, response, nonresponse, and relapse rates in a combined formula. This is a pivotal statistic in determining the likely population impact associated with a community-based intervention. Treatments with high *community impact* scores will have demonstrated their effectiveness in a variety of community settings, thus expanding the number of service access points for eligible patients.

Other PVI factors would concern patient and provider factors that limit or facilitate the impact of the treatment on the population. A high *acceptability* score would be associated with low rates of patient refusal, low patient dropout rates, and high rates of treatment completion. The *reach* indicator reflects the ease with which a treatment can be learned and implemented by non-mental-health professionals or mental health professionals with relatively low levels of training. Treatments with greater reach will be constructed so as to minimize the additional time and money needed to train community-level providers.

A major contributing factor to reach is a demonstration of treatment effectiveness using alternative and *flexible delivery* formats. More flexible treatments would be amenable to delivery via a variety of digital and Internet applications (e.g., telehealth, e-health, or mobile application technologies), allowing them to be disseminated to patients in remote or resource poor areas.

From a policy and planning perspective, it is important to make an economic case for the community-wide dissemination of empirically supported therapies. Traditional approaches to economic analysis typically include some estimate of the *cost to treat* one patient and the incremental

TABLE 1 Elements of a population value index

Component	Description	Significance	Target
Net effectiveness	Treatment outcomes considering treatment refusals, dropouts, responders, nonresponders, and relapse among responders	Provides estimate of likely overall population impact of intervention under ideal conditions	High percentage of patients accept entry into treatment and finish it, with high percentage showing reliable change, low number needed to treat ratio, low relapse rates
Stepped care	Low- to high-intensity versions of the intervention are available for community dissemination	Allows patients to select a level of treatment intensity that suits their preferences; creates continuum of care options for providers	Demonstration of effectiveness of both low-intensity and high-intensity treatment options
Treatment velocity	Trajectory of session to session treatment gains	Provides measure of suitability for brief versus long-term interventions; identify percentage of patients likely to exhibit sudden gains; help identify characteristics of patients exhibiting sudden gains	High percentage of patients exhibiting rapid changes in symptom levels and functional status in low-intensity treatment; comparable outcomes between low- and high-intensity versions
Durability	Long stability of changes in symptom and functional status as a result of intervention	Measure of long-term intervention impact; estimate of amount of “rework: time required to achieve stable improvement”	Stable gains in symptom distress and functional status in large percentage of patients treated over time
Acceptability	Extent to which treatment is designed to fit the needs and preferences of the recipient client	Increases uptake of treatment in community leading to increased population health impact	Low rates of patient refusal and patient dropout, high rates of treatment completion
Flexible delivery	Treatment can be adapted without loss of efficacy for nontraditional modes of delivery, such as telehealth, e-health, or mobile application technologies	Allows treatment to be delivered in low resource areas or to populations with demonstrated barriers to receiving traditional care	Demonstration of equivalent levels of patient acceptability and treatment outcomes when flexible delivery models are compared to traditional modes of delivery
Community impact	Extent to which candidate treatment has been tested in the mental health and non-mental-health community settings where it will be disseminated	Increases “goodness of fit” between the implementation context and the intervention protocol	High levels of intervention effectiveness in multiple community settings; evidence of comparable outcomes when delivered by mental health and non-mental-health providers
Reach	Evidence of treatment uptake and application by non-mental-health-trained helping professionals	Increases the spread of an intervention by enlarging workforce capable of delivering it	Low costs associated with training provider extenders; high use of, and adherence to, provider extender treatment protocols
Cost to treat	Measure of costs associated with delivering a typical unit of treatment to one patient, including direct and indirect costs	Used as one metric to determine viability of intervention from a community resource level	Low, or very low, cost needed to treat one patient, compared with existing cost to treat one patient
Cost-effectiveness	The aggregate economic and clinical value of providing the intervention on a community-wide basis, given the additional resources consumed	Important part of “business proposition” of a community-based intervention; policymakers favor intervention initiatives with high cost-effectiveness ratios and with low total cost outlays	Low number needed to treat, low cost to treat, high acceptability and reach with high net effectiveness

(Continues)

TABLE 1 (Continued)

Component	Description	Significance	Target
Cost offset	Treatment costs are paid for by a commensurate reduction in social/health service use by successfully treated patients	Makes community dissemination of an EST a “net zero” funding decision for policymakers; leads to a “go” decision to fund community implementation;	Evidence of a direct relationship between positive treatment outcome and reduction in social and health services, with imputed cost savings that pay for the intervention
Penetration rate	Percentage of community that accesses the intervention	Estimate of likely population impact of disseminating an intervention	Very brief intervention, low treatment refusal rate, high treatment completion rate

cost-effectiveness of adding the new intervention, and its associated costs, into the community. Cost-effectiveness means that adding the new intervention results in a disproportionate amount of clinical benefit when compared to the costs and outcomes associated with the existing community intervention. Another highly meaningful economic indicator is *cost offset* where the cost of delivering the community-based treatment is offset by a corresponding reduction in resources consumed by successfully treated patients for various social or health-care services, such as disability pension, emergency room visits, or the costs of incarceration. The cost offset proposition was the determining factor in the decision by the British Government to fund the IAPT program (Clark et al., 2009). Finally, a *penetration rate* score would provide a summary metric estimating the dissemination potential of a treatment and, as such, would include both provider factors (e.g., time and training required for a provider to learn and deliver the treatment with fidelity), patient access to the treatment (e.g., location, time and cost, patient perception of stigma associated with treatment), and costs factors.

The establishment of specific methods and targets for each of these areas would provide guidance for the design of research studies and completion of data analysis. For example, treatment velocity could be measured by analyzing aggregate treatment trajectory on a session-by-session basis, specifying the cumulative percentage of treated patients that meet criterion for reliable recovery or reliable improvement in each successive treatment session. The target might be to show that 50% of treated patients show reliable improvement by the fourth session or earlier (i.e., velocity factor). Another research strategy might involve using “treat to target” criteria to discharge patients from a clinical trial once they have demonstrated statistically reliable change, regardless of where the patient is in the treatment protocol. It would then be possible to accurately describe the trajectory of clinical response to a treatment on a session-by-session basis, across a representative sample of patients. This type of precise clinical evidence would not only impress system-level decision-makers, but also it would also give them the

concrete information needed to evaluate the logistics and anticipate the costs of delivery relative to the benefits of community-wide dissemination initiatives.

Candidate treatments without the required level of PVI evidence could still be designated as “strong” based upon the modified Division 12 standards (Tolin, McKay, Forman, Klonsky, & Thombs, 2015), but could then be designated as “of unknown effectiveness, cost-effectiveness or dissemination-readiness in community, school or health-care settings.” Conversely, candidate treatments that produce strong PVI evidence could be designated as “very strong” and as having “known effectiveness, cost-effectiveness, and dissemination-readiness” in community settings. We believe the *highest rating of any* empirically supported treatment should be reserved for treatments that have met the traditional Division 12 criteria AND have achieved a very high PVI score.

Adopting these standards would not result in researchers having to start over or to completely revamp their research programs. Indeed, several important elements of the PVI could be extracted from the data of existing randomized controlled efficacy trials. Other requirements of the PVI, however, would incentivize researchers to balance efficacy studies with field-based activities designed to increase the likelihood of treatment uptake. For example, convening focus groups of community clinicians or patients likely to receive the candidate treatment would help create a better correspondence between treatment architecture and the preferences of providers and patients. Further, field-based research could test interventions adapted for use by entry-level, nonlicensed mental health workers as well as non-mental-health-trained professionals (e.g., physicians, nurses, teachers, outreach workers). This would likely create a much bigger interest in the principles of implementation science, in which the thrust is not only passive dissemination efforts, but rather actively engaging community stakeholders in the design and implementation process. As we have already discussed, this is a complex process that is yet to receive adequate emphasis in the design of empirically supported treatments; however, it is profoundly necessary for new generation of ESTs.

21 | ADD A CONTEXT SPECIFIC “TAG”

In keeping with the theme that we will increasingly need to adapt existing empirically supported treatments to fit the demands of new settings, the more settings a candidate treatment is tested in (in various forms), the stronger should be the grading assigned by the review committee. A second related proposed change is to specifically designate the community contexts in which the candidate treatment has been tested, for example, academic research setting, primary care, school-based clinic, or inpatient medical setting. Instead of requiring just one field-based study to achieve a “very strong” recommendation, we might want to elongate the grading scale so it encourages researchers to test their treatments in multiple community settings to achieve the strongest endorsement.

22 | TWO PATHWAYS TO CITIZENSHIP

Currently, it is possible for a treatment to be designated as empirically supported without providing data from an effectiveness study, but a treatment cannot be designated as empirically supported if it only produces data from multiple effectiveness studies. We believe this skew favoring efficacy over effectiveness data needs to change. To open up the treatment development process even further, we propose that there should be two pathways to becoming an empirically supported treatment. One pathway would be to follow the existing standards, which favor production of efficacy studies and require less in the way of effectiveness research. The second pathway would involve creation of a parallel set of standards for field-derived treatment approaches. In this pathway, a field-based treatment approach could be designated as empirically supported without having to produce evidence from a randomized, controlled efficacy study. This would likely stimulate more practice-based research efforts. The two-path solution might also create a better interchange of ideas between the academic and practice-based communities.

We realize there are many conceptual and methodological issues associated with forming a parallel designation process for field-based treatments. How many qualifying effectiveness studies should be required? What are the requirements of a “good” effectiveness study? How many, and what kind of, methodological controls are required? What is the “exchange ratio” between efficacy and effectiveness studies? Does it take two good effectiveness studies to equal one good efficacy study? In cases where non-mental-health providers are involved, does demonstration of an intervention training protocol satisfy the standard of

demonstrating treatment fidelity (rather than video-taped or live review by trained raters)?

From a population health perspective, the result of a field effectiveness or practice-based research trial is the single most accurate index of the likely population impact of an intervention. The theoretical importance of effectiveness research has been recognized for close to two decades now, without seeming to gain any real traction in the treatment development and testing process. One laudable result of launching a separate designation pathway is that it would force us to clarify many currently hazy aspects of the key parameters of good treatment effectiveness research, which in turn, might stimulate the more widespread use of this approach in the treatment development cycle.

23 | DEFINING FEATURES OF THE NEW-LOOK EST

To conclude, it might be useful to take a “sneak peek” at what may become the defining features of the next generation of empirically supported therapies. As we have discussed, there are already clinical trials within the EST research community demonstrating that it is possible to produce positive clinical outcomes using low-intensity versions of ESTs. Indeed, there are several viable frameworks for translating ESTs into concrete public health interventions, such as the RE-AIM model (Chambers et al., 2013). RE-AIM takes an iterative approach to disseminating, testing, and redesigning community interventions based in a continuous quality improvement approach to evaluation and redesign.

24 | NEW OUTCOME TARGET: FUNCTIONAL STATUS AND WELL-BEING

From a population health perspective, designing interventions that reduce or eliminate symptoms is warranted to the extent that such symptoms significantly impact the patient’s functional status and quality of life. In many life situations, symptoms are going to be present because of the very nature of the situation, so the goal of the intervention shifts to preserving functional status and quality of life. Levels of symptom distress and functional status have been assumed to be nearly isomorphic, so treating symptoms is in effect targeting functional status. However, it now appears that functional status and quality of life are only modestly correlated with levels of symptom distress; changes in one domain do not necessarily predict changes in the others (Vatne & Bjørkly, 2008). In reality, life is one big

“symptom generator” and a defining quality of the new-look EST is to be more accepting of the presence of symptoms of distress, while teaching the patient to live a valued life, even in the presence of symptoms of distress.

25 | THE FAMILY DENTIST APPROACH

One huge advantage offered by integrated care settings is that patients will typically receive services on an ongoing basis, sometimes over the course of an entire lifespan. This feature will allow us to shift from the single episode of care approach characteristic of the case-based approach to an intermittent care across the lifespan approach. This approach is what our late mentor and friend, Neil Jacobson, called the “family dentist” model of care. Sometimes we go in to see the dentist for a routine check-up; other times we go in because a tooth is really hurting. Depending upon the reason, the treatment approach may change slightly, but the underlying message about following the principles of good oral hygiene will always be same, and the dentist will be there for us in the future. Similarly, any patient can receive repeated brief episodes of a mental health intervention spread across the lifespan. The goal is really to teach the self-care principles needed to allow the patient to function as his or her own therapist, anticipating that new problems in living will arise, and the same intervention principles that worked before might very well work again.

26 | TRANSDIAGNOSTIC INTERVENTIONS RULE

New-look ESTs will likely be based in transdiagnostic intervention principles that can be efficiently deployed in a variety of community contexts. Transdiagnostic models obey the principle of parsimony by explaining a host of seemingly different “disorders” by specifying a much smaller set of common underlying psychological processes. For example, in the acceptance and commitment therapy (ACT) model of psychological flexibility, human suffering and psychopathology are proposed to originate in two common processes: experiential avoidance and cognitive fusion (Hayes, Strosahl, & Wilson, 2011). Similarly, there are three main intervention pathways targeting experiential avoidance and fusion, any one of which might be sufficient to produce a positive clinical outcome: increasing openness to and acceptance of distressing private experiences, promoting present moment awareness and improving perspective taking, and engaging in values-based patterns of living (Strosahl, Robinson, & Gustavsson, 2012). The shift in focus from

complex, disorder specific treatment packages to transdiagnostic intervention principles has been called “process-oriented cognitive behavior therapy” (Hayes & Hofmann, 2018). The main goal of a process-oriented approach is to get back to the basic, fundamental principles underlying workable versus unworkable behaviors, allowing common behavioral interventions to be customized to fit the demands of a particular person seen in a particular context. From our experience, non-mental-health-trained health-care professionals and lay workers are likely to be interested in learning a limited set of transdiagnostic principles with a very wide range of clinical applications.

27 | EMPHASIZE CLIENT CHOICE AND EMPOWERMENT

Achieving maximum buy-in for, and acceptance of, psychological interventions by members of the community requires us to adopt a “patient-centric” approach to treatment development. Rather than telling patients what their treatment is going to be, we need to ask them what they are ready to work on, after being exposed to a menu of viable self-management skills. Giving clients the option to learn some skills, but not others, based in their preferences, will create more “ownership” over the therapy process, decrease therapy dropouts, and improve treatment engagement. The number one goal of the new-look EST is to recruit the highest possible number of eligible patients and to maximize the number that complete treatment.

This feature of the new-look EST will actually be as important as the actual effectiveness of the intervention itself. We must be willing to trade some level of treatment efficacy in exchange for gains in treatment uptake on the part of both community therapists and the patients they treat. For example, an intervention is shown to result in a 65% success rate among patients that complete the treatment, but 20% of eligible patients refuse the treatment and another 25% drop out of it. The “population effectiveness” of this intervention is $.65 \times 55\%$ or 35.75%. An alternative treatment is 50% effective, but only 10% of eligible patients refuse it and only 10% drop out. The population effectiveness of this treatment is $.50 \times 80\%$ or 40%. In this case, the second-best treatment may well be the first best treatment.

28 | BRIEFER IS BETTER

For a wide variety of reasons, brief and ultra-brief interventions are going to become the new normal in integrated care settings. Brief interventions are associated with lower rates of treatment refusal and therapy dropouts (Sledge, Moras, Hartley, & Levine, 1990). They are

far cheaper to deliver and are more likely to be accepted and used by non-mental-health-trained health-care professionals. Not only do we know that abbreviated, highly condensed versions of ESTs produce robust clinical outcomes in primary care patients (Katon et al., 1996), but they are also more cost-effective (Von Korff et al., 1998). Brief treatments preserve precious mental health resources, allowing them to be distributed across a much broader segment of the community.

29 | EVIDENCE-BASED KERNELS

The return to brief interventions will also result in a renewed focus on identifying common intervention principles that underlie seemingly different therapy approaches. In behavioral psychology, Embry and Biglan (2008) describe these fundamental interventions as “evidence-based kernels.” They identified over 50 examples of intervention initiatives in the public sector that were designed around fundamental units of behavioral intervention. Compared to the vast number of treatment packages and techniques in circulation, the number of evidence-based kernels is probably relatively small. This is actually “good news” from a population health perspective, because it is easier to transmit a small number of very important principles. It is thus no surprise that a variety of studies applying the kernel approach in community settings show that they can be taught quite easily to non-mental-health professionals, with positive results on the target problem of concern (Embry, 2011).

As a practical example of disseminating evidence-based kernels, we teach doctors and nurses to talk with their patients about what their patients are approaching and what they are avoiding in daily life, including positive and negative emotional experiences, and to set goals that encourage approach behavior in areas that patients identify as being excessively influenced by avoidance. Our mantra is “It is all about approach and avoidance. You have to get patients to approach the things in life that matter to them, rather than avoiding them.” This evidence-based kernel distills thousands of pages of clinical theory, research, and practice focused on experiential avoidance and psychopathology, exposure therapies, habit formation, and value-based goal setting.

30 | MODULARIZED INTERVENTIONS

If we are going to let patients take a more central role in selecting what they do and do not want to learn in therapy, it is very likely going to require us to make a major change in the way therapeutic concepts are packaged. Sequentially

unfolding treatments, which require patients to attend multiple sessions over time in order to be exposed to more complex concepts, lose a significant percentage of patients before those concepts are introduced. An alternative approach is to modularize the core concepts of a treatment, so that each module is covered in a free standing treatment session. Patients can then pick any number of treatment modules and arrange them in any order they would like, based upon their preferences. There is already data suggesting that modularized treatment packages produce better clinical results and result in lower dropout rates than standard, sequentially unfolding treatments (Katon et al., 1996; Weisz et al., 2012).

31 | MODELS THAT EXPAND REACH

There is growing recognition that there are far too many people in need of mental health interventions for us to have any chance of meeting the need using the existing mental health workforce. This means that the population impact of mental health outreach programs will largely be determined by the extent to which mental health paraprofessionals or non-mental-health-trained professionals can offer effective interventions in the trenches. This issue has normally been linked to providing mental health services in low resource settings, where there is no illusion that a mental health system exists (Patel, Chowdhary, Rahman, & Verdelli, 2011). It is time we turn this same lens on the mental health pandemic in the US, because many of the same strategies in treatment development will apply. One recently published model is called the common elements treatment approach (CETA; Murray et al., 2014). It is a process-oriented approach that uses a set menu of evidence-based behavioral interventions designed to be customized for clients presenting with different types of mental health concerns. CETA elements include interventions such as motivational interviewing to promote engagement, psychoeducation, cognitive restructuring, and live and imaginal exposure, as well as risk assessment and safety planning. Research has shown that these basic behavioral interventions can be taught to lay health workers with very limited educational backgrounds, who can then apply them effectively in community settings where no formal mental health resources exist (Murray et al., 2014; Nadkarni et al., 2017).

32 | FLEXIBLE DELIVERY FORMATS

Population health interventions emphasize both uptake and reach. When interventions are designed with these two qualities in mind, the result is a simple to understand

approach that can be delivered in multiple formats. In the case of the new-look EST, those flexible delivery formats might involve internet-based delivery of brief evidence-based interventions that can be supported by a mental health or health-care professional. Alternatively, in remote and rural areas where it is not feasible to come to a health-care center on repeated occasions, the new-look EST could be delivered right in the patient's home via any number of video-conferencing technologies and software packages. For patients that are willing to come for face-to-face contacts, alternative formats might include a single or half day workshop, an open-ended modularized group or classroom series or delivery of the intervention within a group medical appointment. The simpler the new-look EST is in design, the more flexible the delivery formats can become.

33 | SUMMARY

In this study, we described some of the issues facing clinical psychology in general, and empirically supported treatments specifically, in the new era of integrated care. This era is going to be a game changer for the theory and practice of clinical psychology as we know it. As psychologists increasingly migrate to job positions in primary care clinics, hospitals, schools, and other community settings, they face an unprecedented set of situational constraints on their ability to deliver evidence-based treatments in the way those treatments have traditionally been delivered. To succeed, we will be forced to adapt our treatments to fit the realities of these new practice contexts. We believe this challenge is also a unique opportunity for clinical psychology to "flex its" muscles" by focusing maximum energy on the development of a new generation of brief, empirically supported treatments that can be delivered by both mental health and non-mental-health professionals in a wide variety of community contexts.

As a profession, we have a chance to change the way that the average person thinks about psychological struggles and what to do about them. We can deposit a powerful message of hope inside the gargantuan network of social, educational, and health services in the United States. We can give all of the natural helpers out there a different way to talk about human suffering, a way that is both scientifically sound and far more empowering. It would be gratifying indeed to see our clinical and research colleagues band together and make this a bell weather moment for clinical psychology.

CONFLICT OF INTEREST

The authors have no conflict to disclose.

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