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Evidence-based psychological treatments for mental disorders: Modifiable barriers to access and possible solutions

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Abstract

The prevalence of mental disorders is high and appears to be growing, yet the majority of individuals who meet diagnostic criteria for a mental disorder are not able to access an adequate treatment. While evidence-based psychological treatments (EBPTs) are effective single or adjunctive treatments for mental disorders, there is also evidence that access to these treatments is diminishing. We seek to highlight modifiable barriers to these problems at the patient, therapist, treatment, organization and government-levels of analysis. A range of solutions to each set of contributors is offered and domains for future research are highlighted. In particular, we focus on the need to continue to work toward innovation in treatment development while also solving the difficulties relating to the dissemination of EBPTs. Several relatively new concepts in the field will be discussed (implementation cliff, program drift, voltage drop and deployment treatment development) and we contrast America and England as examples of government-level processes that are in the process of major change with respect to EBPTs. We conclude that there is a need for people in our field to become more knowledgeable about, and get involved in, shaping public policy.

Keywords

mental disorder; evidence-based psychological treatments

We seek to highlight three critical problems facing our field. The first problem is that the prevalence of mental disorders is high and growing. The second problem is that the majority of individuals diagnosed with a mental disorder are not able to access an adequate treatment. The third problem is that while there is compelling evidence that evidence-based psychological treatments (EBPTs) are effective as single or adjunctive treatments for many mental disorders, there is evidence that access to these treatments is diminishing. We will then extend several excellent recent discussions of these problems (e.g., Gaudiano & Miller, 2013; Kazdin & Blase, 2011; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013; Shafran

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et al., 2009) by highlighting a range of modifiable barriers, as well as possible solutions, at 5 levels of analysis; namely, the patient, therapist, treatment, organization and government-levels of analysis.

The prevalence of mental disorder is high and growing

The National Comorbidity Study (NCS, 1990–1992; n = 8,098; 15–54 year olds) and its replication (NCS-R; 2001–2003; n = 9,282; 18+ year olds) are nationally representative surveys conducted in the United States of America (USA). According to the NCS-R, and reported by Kessler et al. (2005), 30% of people surveyed over a 12-month period, and 50% of the population over the lifespan, met diagnostic criteria for a mental disorder. In 2010, and involving 68,309 individuals in the USA aged 12 and older, the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (2012) reported that 18.6% of adults had a mental disorder, excluding a substance problem, and 4.1% of adults had a serious mental disorder. An additional 20.7 million adults were diagnosed with a substance use disorder. Forty percent of these individuals also had a comorbid mental disorder. A crossnational study conducted by the World Health Organization (WHO) included 6 less developed countries and 8 developed countries. The results indicate that the global pattern is for high rates of mental disorder, although there was some variability with lower rates in Asian countries (Demyttenaere et al., 2013). Similarly, a meta-analysis of 27 studies including over 150,000 people from 16 European countries estimated that about 27% of people were diagnosed with at least one mental disorder within the past 12 months (Wittchen & Jacobi, 2005). In terms of children and adolescents, an Institute of Medicine and National Research Council meta-analysis of over 50 studies from community samples across the world reported a prevalence rate of 17% for one or more mental, emotional, or behavioral disorder in youth, and about half reported significant functional impairment (O'Connell, Boat, & Warner, 2009). Although we need to keep in mind the limitations inherent to comparing two cross sectional studies, the results from the Global Burden of Disease study suggests that from 1990 to 2010 the disability-adjusted life years (DALYs) associated with 'mental and behavioral disorders' *increased* by approximately 36% (Murray et al., 2013). DALYs are the sum of years of life lost due to premature mortality and years lived with disability (Murray & Lopez, 1997). In sum, the evidence that has accrued across multiple studies conducted across multiple countries indicates that mental disorders are prevalent and that the number of people meeting diagnostic criteria for a mental disorder appears to be steeply growing.

Mental disorders are undertreated

SAMHSA estimated that in 2007 fewer than half of the individuals who need mental health care are receiving the care they need (SAMSHA, 2007). A similar pattern of results is evident from the NCS-R. Specifically, Wang et al. (2005) reported that approximately 60% of individuals with a mental disorder do not receive treatment and of those who do, only 32% of the treatments received fell into the 'at least minimally adequate treatment' category (p. 631). Also, Kessler et al. (2003) reported that only 52% of people diagnosed with major depressive disorder in the past 12 months received treatment and the treatment received was judged to be adequate in only 42% of cases.

Unfortunately, the trend toward under treating mental disorders is not limited to the USA. A national survey of 16–64 year olds in Great Britain over a 7-year period (1993–2000) reported that only a quarter of people with a mental disorder were receiving some kind of treatment in 2007, unchanged from 2000 (Jenkins et al., 2009). In Australia, based on the 2007 National Survey of Mental Health and Wellbeing, a nationally representative household survey of 8841 individuals aged between 16 and 85 years, only one-third of people (34.9%) meeting criteria for a mental disorder made use of any services for a mental health problem (Burgess et al., 2009). In the analysis of 16 European countries, only 26% of all cases had any consultation with professional health care services (Wittchen & Jacobi, 2005). Also, the WHO comparison of 14 countries reported that 35.5% to 50.3% of serious cases in developed countries and 76.3% to 85.4% in less developed countries received no treatment in the prior 12 months (Demyttenaere, et al., 2013).

Evidence-based psychological treatments (EBPTs) are effective

The Director of the National Institutes of Mental Health in the USA observed that '*while psychosocial interventions have received much less marketing attention than pharmacological treatments, the results are arguably more encouraging'* (p. 29) (Insel, 2009). Indeed, progress toward establishing EBPTs for most mental disorders has been excellent (Chambless & Ollendick, 2001; Layard & Clark, 2014; Silverman & Hinshaw, 2008). There are a range of rigorous review processes that have completed lists of evidence-based therapies including the American Psychological Association's Division 12 (www.psychologicaltreatments.org), SAMHSA's National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov) and the National Institute for Health and Care Excellence (NICE). NICE is particularly remarkable because, for each disorder, a panel of experts including clinicians, researchers and consumers is formed to carefully review the scientific evidence on the best treatment/s available for each physical and mental health problem. The treatments determined by the panel to be the frontline treatment/s for each condition are expected to be provided to the citizens of England within the National Health Service. Also, the National Health Service is often asked to report on the extent to which they are complying with NICE recommendations. NICE has concluded that EBPTs are frontline sole or adjunctive interventions for a broad range of mental disorders (Clark, 2011; Layard & Clark, 2014; Shafran, et al., 2009) and this conclusion was the basis for remarkable solutions to the difficulty of disseminating EBPTs within England, as we discuss in the 'Government-Level' section below.

Access to EBPTs is declining

In the USA there has been an ongoing analysis of the type of treatments that are being provided. An editorial by Druss (2010) in the *American Journal of Psychiatry* notes a 'sea change' in the provision of mental health services away from EBPTs from 1998 to 2007. Druss's editorial was prompted by the analysis of service use data comparing outpatient mental health care in 1998 (n = 22,953) and 2007 (n = 29,370), conducted by Olfson and Marcus (2010). The clear and puzzling trend was that spending on psychotherapy declined by more than a third, from $10.94 billion to $7.17 billion. This change was driven by a decrease in the average number of psychotherapy visits. Also, the use of only

psychotherapy, as well as psychotherapy and psychotropic medication together, declined (40.0% down to 32.1%). Declines also occurred in annual psychotherapy visits per psychotherapy patient (9.7 sessions down to 7.9 sessions), a finding that raises particular concern as it appears that 16 sessions are needed for one-half of patients to be classified into a 'recovered' category (Hansen & Lambert, 2003). In contrast to the declines observed for EBPTs, the use of only psychotropic medication increased (44.1% up to 57.4%). In 2011, antidepressants were the most commonly prescribed class of drugs (264 million prescriptions), medications for attention deficit and hyperactivity disorder increased by 17%, relative to 2010 ($7.9 billion in sales), and spending on antipsychotics was $18.2 billion. Together, this represents an increase of $2.1 billion over 2010 and 57 million prescriptions (Lindsley, 2012).

Note that across these studies the use of the term 'psychotherapy' varies. Olfson and Marcus (2010) use the term to refer to "a treatment technique for certain forms of mental disorder relying principally on talk/conversation between the mental health professional and the patient" (p. 1457). Olfson and Marcus (2009) use the term to refer to 1 visit or more that included a specific indication of "psychotherapy/mental health counseling". As such, we do not know the extent to which the treatments delivered are EBPTs. It is certainly tempting to speculate that it might be a small proportion.

This worrisome trend is not limited to the USA. The national survey of 16–64 year olds in Great Britain discussed above reported that the use of medications to treat mental disorders doubled from 1993 to 2000. In particular, antidepressant use rose from 0.16% in 1993 to 2.02% in 2000. Over the same period, the overall prevalence of mental disorders did not change markedly and the use of EBPTs did not increase significantly (Brugha et al., 2004). In an analysis of the 2007 English Adult Psychiatric Morbidity Survey, older respondents were less likely than younger adults to receive talking therapy and were less likely to have seen their GP in the last year about mental health, and they were more likely to receive benzodiazepines. Also, ethnic minorities were less likely to be taking antidepressants and were less likely to have seen their GP in the last year about their mental health (Cooper et al., 2010). In the Australian National Survey of Mental Health and Wellbeing described earlier, general practitioners were the most commonly reported providers of mental health services with 76% of those receiving any mental health care reporting using their general practitioner (Parslow & Jorm, 2000). It is unclear if general practitioners are trained in and have appointment slots that are long enough to deliver EBPTs with fidelity. Taken together, these studies point to the rise in medication use, the under treatment of mental disorders and that several groups are underserved by current mental health services, particularly elderly and minority individuals.

The rise in medication use and the decline in the provision of psychosocial treatments are of concern for a host of reasons. First, the outcomes from some widely used medications are not very encouraging (e.g., Insel, 2009). Second, there is evidence that medications, often off-label and with serious side effects, are being used to treat disorders for which the evidence base for EBPTs is well established (Comer & Barlow, 2014). Third, in some circumstances prescribing a medication may even send an unhelpful message. For example, instead of building skills and habits, a medication might serve to maintain or cover up the

symptoms (Mindell & Owens, 2009). Fourth, patient choice enhances treatment effectiveness (Geers et al., 2013). Given the decline in the provision of EBPTs, there is a decline in the range of choices available for patients. Fifth, there is evidence that psychosocial interventions can be more acceptable to patients relative to medication treatments (e.g., Vincent & Lionberg, 2001). This is important because a treatment that is acceptable is more likely to be associated with adherence. Sixth, most psychosocial interventions teach skills and include a 'relapse prevention' phase to increase the odds that patients will continue to use their skills after the course of treatment has finished. As such, EBPTs tend to produce durable effects, even up to 24 months following the end of treatment (e.g., Morin, Colecchi, Stone, Sood, & Brink, 1999). Seventh, given the high comorbidity with substance use problems (Grant et al., 2008), the prescription of certain classes of medications may increase risk for developing substance-related problems. EBPTs have no potential for such negative outcomes.

The findings reviewed in this section raise several domains for future research. There is a need for research to understand why EBPTs are declining while the use of pharmacotherapy is rising and to determine whether the latter can be accounted for by an increase in prescriptions via general practitioners rather than psychiatrists or perhaps others with prescribing privileges. It is also possible that direct-to-consumer advertising (e.g., via television) is playing a role (Donohue, Cevasco, & Rosenthal, 2007). Also, research is needed to determine how reimbursement policy or the availability of trained providers impacts the decline. Finally, there is a need for service use data from other countries to determine the extent to which of these trends are local versus global.

Modifiable Barriers

Barriers to using EBPTs can arise at various levels of analysis. We focus on five levels and summarize the main points in Table 1.

Patient-Level

There are many barriers to patients receiving an appropriate EBPT. One set of barriers that are often neglected are the practical problems like transportation problems and difficulty obtaining childcare, both of which need to be solved before an individual will be able to attend an appointment. Also, appointments for treatment may not be available at a time and in a place that is convenient for the patient, given their work, family and other responsibilities.

It is not easy to identify a treatment provider among the plethora of professionals claiming to offer to treat mental disorders. So there are many skills, and some knowledge, that patients need in order to identify a treatment provider, navigate the process of making an appointment and be on time to weekly appointments. All of these can be serious challenges for individuals with a severe mental disorder.

In addition, there are barriers related to having the motivation to seek out, and attend sessions and then adhere to the treatment recommendations, all of which are core to a successful treatment (Glenn et al., 2013). Many variables contribute to a lack of motivation

including that low motivation is a common symptom of mental disorders (American Psychiatric Association, 2013). Also, there is stigma associated with meeting diagnostic criteria for a mental disorder and receiving treatment (Hinshaw & Stier, 2008). This may diminish motivation to seek out and attend sessions. Beliefs such as 'I should be able to cope with this alone' and beliefs that the available treatment options are ineffective may also reduce motivation (Stinson, Tang, & Harvey, 2006).

Public awareness of the available effective treatment options is also lacking and is well-illustrated in a report which highlights that one of the leading reasons individuals with a mental or substance use disorder don't seek treatment is a fear of needing to take medication (Institute of Medicine, 2006).

Finally, diagnostic systems are regularly reviewed and updated (Kupfer, Kuhl, & Regier, 2013) and may be based on an entirely different system in the future (Hofmann, 2014; Insel et al., 2010). However, at this point, many EBPTs have been devised to treat specific disorders. Hence, receiving an accurate diagnosis may be another important patient-level variable in the process of receiving an appropriate EBPT. Indeed, it can take many years to receive an accurate diagnosis (Sorensen, Rawson, Guydish, & Zweben, 2003; Sundararaman, 2009).

We offer five pathways to begin to address these patient-level barriers.

Develop and test conceptual models—One valuable approach to address patient-level factors would be to devise and test conceptual models of the various barriers faced by patients. The conceptual model, in turn, constitutes a "road map" for organizing research and identifying solutions (Clark, 1999). As an example, the barriers-to-treatment conceptual model (Kazdin, Holland, & Crowley, 1997) addresses practical obstacles to children receiving treatment for behavioral problems. In a 4-year prospective study testing this model, 242 children referred for oppositional, aggressive and antisocial behavior were studied. The perception of few barriers reduced the risk of dropping out whereas the perception of obstacles associated with receiving the treatment, the belief that treatment is not very relevant, and poor alliance with the therapist increased drop out. The barriers-to-treatment model could be usefully applied across age groups and types of mental disorder and holds promise for the development of interventions that specifically target patient-level contributors. One such intervention—the Participation Enhancement Intervention—will be detailed in the 'Research on motivation' section below.

Barrier-specific research—With so many important patient-level barriers there is also a great need for research programs focused on specific barriers, and there have already been several promising efforts in this domain. For example, the INDIGO Research Network (International Study of Discrimination and Stigma Outcomes) is furthering our understanding of stigma. In one study, 700 people who met diagnostic criteria for schizophrenia across 27 countries were interviewed (Brohan, Slade, Clement, & Thornicroft, 2010). Participants reported that they felt a need to conceal their diagnosis and that the anticipation of discrimination stopped them applying for work, training or education and 55% reported that their diagnosis stopped them looking for a close relationship. Moreover,

47% of participants experienced discrimination from friends, 43% from family members, 29% whilst trying to find a job, 29% whilst trying to keep a job, and 27% whilst establishing an intimate or sexual relationship. In another effort, the World Psychiatric Association (Sartorius, 2006) published 11 principles, or 'lessons learned', to guide others in developing programs to combat stigma. Examples include that the program needs to be ongoing rather than short-term and that the goals must be broadly stated and have local relevance. Also, there are detailed overviews available articulating the multiple levels of work needed to reduce stigmatization (Hinshaw, 2007).

Improve diagnosis—There have been a range of approaches to reducing the time elapsed from the onset of a mental disorder to receiving an accurate diagnosis. First, there are interventions to improve mental health literacy in order to help people to recognize their symptoms earlier, receive an appropriate diagnosis earlier and receive an efficient treatment earlier (Jorm, 2012). For example, four weeks following a brief intervention designed to improve knowledge about mental health in a school setting, adolescents exhibited marked improvement on measures of mental health literacy (Pinto-Foltz, Logsdon, & Myers, 2011). While this study raises the possibility that brief interventions may encourage earlier help-seeking, the link between mental health literacy and help seeking needs to be addressed in future research. Second, Basco et al. (2000) reported on the use of validated diagnostic screening measures within community mental health settings. This approach clearly improved the accuracy of diagnosis. Third, screening in primary care also facilitated earlier detection and referral for mental health problems, particularly for children and adolescents, whose parents frequently talk about behavioral issues with their child's pediatrician (Trupin, 2011). For example, in Massachusetts, within a year of primary care physicians being required to screen children on Medicaid insurance for mental health problems at "well-child visits," mental health visits for the children increased markedly (Kuhlthau et al., 2011). In sum, the accruing evidence suggests that accurate diagnosis can be aided by improving mental health literacy, by using diagnostic screening measures and by integrating medical and mental health care.

Progress monitoring—While weekly progress monitoring is often a feature of EBPTs, there are good reasons why there is increasing emphasis on developing progress monitoring systems and monitoring outcomes (Persons, 2012), particularly for patients who are at risk for poor outcome (Newnham, Hooke, & Page, 2010). Indeed, the use of progress monitoring results in fewer patients deteriorating during or after treatment (De Jong et al., 2013). Also, the data collected from progress monitoring helps to adjust and advance treatment, helps patients to choose a service that has good outcomes and the data also helps those who fund the service (Layard & Clark, 2014; Radhakrishnan et al., 2013).

Research on motivation—Research has focused on tackling motivational barriers to patient's seeking and attending treatment. For example, motivational interviewing aims to reduce motivational barriers via a stance that emphasizes accepting the patient as an individual, avoiding argumentation, giving lectures or ultimatums and by focusing on the process of eliciting and shaping language in favor of change (i.e. change talk). Motivational interviewing includes a straightforward review of the perceived pros and cons of change

(Miller & Rollnick, 2002). Guided by the barriers-to-treatment conceptual model (Kazdin, et al., 1997) and drawing from motivational interviewing, Nock and Kazdin (2005) addressed the high drop out from interventions for children by developing a brief adjunctive intervention called the Participation Enhancement Intervention (PEI). This intervention involves three 3–15 minute doses focused on (a) providing parents with information about the importance of attending and adhering to the treatment, (b) eliciting motivational statements about attending and adhering to treatment, and (c) helping parents to identify and develop plans for overcoming barriers to treatment that may arise over the course of treatment. Compared to treatment as usual, PEI improved the motivation of parents who attended more sessions and adhered to treatment more fully.

Therapist-Level

Therapist beliefs and preferences—Research on therapist-level barriers is critically important given the challenge of mounting a workforce skilled in the delivery of EBPTs and who deliver EBPTs with fidelity (Goldman, 2001; Shafran, et al., 2009; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Therapist-level barriers include the belief that EBPTs have an adverse impact on the therapeutic relationship (Jensen-Doss, Hawley, Lopez, & Osterberg, 2009), are too structured and technique focused (Addis, Wade, & Hatgis, 1999) and that the treatments would not necessarily lead to better outcome (e.g., Becker & Jensen-Doss, 2013). Also, some practitioners have a preference for eclectic, flexible approaches incorporating strategies drawn from multiple theoretical orientations (e.g., Baumann, Kolko, Collins, & Herschell, 2006). However, there are several limitations to this literature. The studies are characterized by low response rates and are focused on EBPTs for a limited range of problems (i.e., substance use problems, disorders of childhood). Also, much of this research has been conducted with doctoral level psychologists. There is a need to study beliefs and attitudes among the broader range of mental health professionals who deliver EBPTs. A final limitation is the use of measures to assess therapist beliefs that have not been validated despite the availability of at least two validated measures, the Evidence-Based Practice Attitude Scale (EBPAS) (Aarons, 2004) and the Therapy Procedures Checklist (TPC) (Weersing, Weisz, & Donenberg, 2002).

To the best of our knowledge only one study to date has examined if therapist-level barriers are associated with treatment outcome. Wiborg, Knoop, Wensing and Bleijenberg (2012) reported that a stronger belief that treatment manuals threaten freedom and flexibility of the therapist was related to less effective outcome from CBT for chronic fatigue syndrome. Also, there is very little research on the increasingly important issue of therapist response to legislative mandates to administer evidence-based treatments (Rieckmann, Bergmann, & Rasplica, 2011).

Cognitive biases—In a very interesting review of therapist-level barriers, Lilienfeld, Ritschel, Lynn, Cautin and Latzman (2013) focus on sources of resistance to EBPTs among clinicians. These authors suggest that therapists tend to believe they can perceive patients' problems and treatment outcome objectively and without bias. They also point out that therapists tend to be confident in their view of human nature and then use these beliefs to provide a rationale for selecting interventions with little or no empirical support. There is

also a tendency to confuse invalidated treatments (i.e., treatments that don't work) and unvalidated treatments (i.e., treatments that have not yet been examined). Lilienfeld et al. (2013) offer a range of solutions derived from cognitive and social psychology including that therapists can be educated about cognitive biases, such as the tendency to favor information that confirms our beliefs (confirmation bias), perceiving causal relationships when there are none (illusory correlation) and the tendency to perceive biases in others but not ourselves (bias blind spot). Additionally, Lilienfeld et al. (2013) point to 'diffusion research' that suggests that messages tend to be devalued if the people delivering the messages are perceived to be outsiders. Finally, they highlight the relevance of the attitude change and persuasion literatures that would suggest that asking skeptical clinicians to try one EBPT may be one path forward in promoting therapist attitude change.

Training—Lack of training in EBPTs (e.g., Weissman et al., 2006) and lack of time to review the new literature independently (National Research Council, 2010) are additional key problems to therapists being equipped to deliver EBPTs. In the USA, approximately 65% of programs that train the largest number of graduating students each year who intend to be mental health practitioners did not require training in EBPTs (Weissman, et al., 2006). Also, Shafran et al. (2009) highlight how little we actually know about how to best train providers of EBPTs. Although these authors review evidence suggesting that ongoing supervision clearly improves outcome, they note that the dose and style of supervision remains to be established. Specifically, Shafran et al. (2009) point to the need for research on precisely *how* to provide the training (e.g., manuals, expert workshop, longer term courses with supervision, web-based programs) and to establish *how much* training is needed for different types of EBPTs. Also emphasizing the importance of supervision, Gyani, Shafran, Layard and Clark's (2013) survey of 636 therapists in England found that research has little influence over therapists' choices. Instead, therapists reported being more likely to be influenced by clinical experience and supervision. Training is a ripe, and critically important, domain for innovation in the coming decade (Levenson, 2014).

Specialists and generalists—Comer and Barlow (2014) raise concerns about the move toward training generalist practitioners to provide EBPTs. The authors mount a compelling case for the need to establish a tradition of also training specialist providers of EBPTs for (a) the most complex treatments and (b) for the disorders with low prevalence rates. They also raise the interesting possibility that telehealth may help improve access to these specialist teams.

Treatment-Level

Identifying the appropriate EBPT—There is evidence that medications are being prescribed, often off-label and with serious side effects, for disorders for which an EBPT is well established (Comer & Barlow, 2014; Comer, Mojtabai, & Olfson, 2011; Comer, Olfson, & Mojtabai, 2010; Olfson, Crystal, Huang, & Gerhard, 2010). Hence, there is a need to increase the ease and incentive for correctly identifying effective treatment options. We have already highlighted the detailed review of EBPTs by APA, SAMSHA and NICE. An additional search via the National Guideline Clearinghouse (http://www.guideline.gov) and the Guidelines International Network (http://www.guideline.gov) identifies a wide range of

other sources of practice parameters and empirically guided practice guidelines. With this proliferation in the sources of information, some diffusion of focus and confusion seems inevitable. Hence, there is a need to simplify and establish a definitive source of EBPTs, perhaps a source that is equivalent to the US Food and Drug Administration, albeit for EBPTs (Olfson & Marcus, 2010). In England, the NICE guidelines fulfill this role and have been the impetus for important government-level initiatives that will be discussed below.

Continuing to innovate—While progress toward establishing EBPTs for most mental disorders has been excellent, much work remains. The effect sizes can be small to moderate, gains may not persist, and there are a small proportion of patients who derive little or no benefit. Hence, there is an ongoing need for innovation to develop new treatments and to continue to improve existing treatments. This is a domain in which our field has been active and successful, as illustrated by the examples below.

Clark (1999) and Salkovskis (2002) proposed four steps for developing an effective treatment for mental disorders. The first is to fully grasp the phenomenology of the disorder via *clinical practice*. The aim of clinical practice is to carefully listen to patients and watch for phenomena that are not consistent with existing theory and to then carefully consider whether such phenomena reflect processes that have not yet been recognized. These clinical observations are then used to inform a *theory* of the maintenance of the disorder and are subjected to *experimental investigation*. If the research confirms the importance of the new process, its place in the *theory* of the maintenance of the disorder is confirmed. The validated theory can then be used as a map to guide the development of a specific targeted treatment in which the maintaining processes are reversed.

The Stage Model of Treatment Development (Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014) captures a different but complementary slice of the treatment development process by describing a reciprocal, iterative and recursive interplay between basic science (Stage 0), treatment generation and refinement (Stage 1), efficacy testing in research settings (Stage 2), efficacy testing in the real world (Stage 3), effectiveness testing (Stage 4) and then implementation and dissemination (Stage 5). Our view is that there has been some excellent Stage 2 work in our field. Stage 2 is 'Efficacy testing in *research settings with research-based providers*'. A next and much needed step is to move to Stage 3 or *'Efficacy in the real world research that is conducted in community settings, with community-based providers'*, while maintaining the high level of control necessary to establish internal validity. Moving through Stages 3 through 5 more rapidly is important because there is currently a 15–20 year lag between treatment discovery and incorporating new treatments into routine practice (Sorensen, et al., 2003; Sundararaman, 2009).

To give one example of the utility of these two models for generating a novel, effective and efficient treatment, consider the example of posttraumatic stress disorder. The treatment development process began with an interplay between theory (Ehlers & Clark, 2000), experiments to test the hypotheses that comprise the theory (Ehlers et al., 2002) and treatment development (Ehlers et al., 2003). The new treatment was then disseminated into a real world setting (Duffy, Gillespie, & Clark, 2007) and is being upscaled across England

(Layard & Clark, 2014). Similar examples are available for several other multiple disorders (Layard & Clark, 2014).

Transdiagnostic and/or modularized treatments—We also need to solve the 'too many empirically supported treatments problem' (p. 68) (Weisz, Ng, & Bearman, 2014). A brief glimpse of any of the databases listing EBPTs reveals that there are potentially dozens of EBPTs. It is highly unlikely that any one therapist will be able to master them all. One relatively new approach—the transdiagnostic approach—holds potential for contributing to solving this problem. The transdiagnostic approach involves targeting treatment at a transdiagnostic process, defined as a common process that occurs across more than one mental disorder (e.g., Barlow, Allen, & Choate, 2004; Fairburn, Cooper, & Shafran, 2003; Harvey, Watkins, Mansell, & Shafran, 2004; Kring & Sloan, 2009). The advantages of a transdiagnostic approach are threefold. First, if a transdiagnostic process contributes to the maintenance of symptoms across multiple disorders, then one potentially powerful approach would be to focus treatment on that process rather than on the large number of discrete disorders currently listed in the DSM. Second, comorbidity is the norm. Hence, a significant clinical dilemma is which disorder/s to prioritize for treatment. Treating transdiagnostic processes, or processes common across the comorbidities, provides one path forward to improve outcomes. Third, as already mentioned, a transdiagostic approach may reduce the current heavy burden on clinicians, who must learn multiple disorder-focused protocols, often with common theoretical underpinnings and interventions (Harvey, et al., 2004; Mansell, Harvey, Watkins, & Shafran, 2009).

There has been progress in developing transdiagnostic treatments that target transdiagnostic processes across the anxiety disorders and depression in adults (Craske et al., 2011; Farchione et al., 2012; McManus, Shafran, & Cooper, 2010; Norton, 2012), across anxiety, depression, and conduct problems in youth (Bilek & Ehrenreich-May, 2012; Fraire & Ollendick, 2013; Weisz et al., 2012), across all of the eating disorders (Fairburn et al., 2009) as well as for schizophrenia (Bentall et al., 2009), bipolar disorder (Ellard, Deckersbach, Sylvia, Nierenberg, & Barlow, 2012) and sleep problems (Harvey, 2008, 2009; Harvey, Murray, Chandler, & Soehner, 2011). Also, specific treatments targeting transdiagnostic processes, such as rumination (Nolen-Hoeksema & Watkins, 2011) and perfectionism (Egan, Wade, & Shafran, 2011), have also been shown to be effective (Riley, Lee, Cooper, Fairburn, & Shafran, 2007; Watkins et al., 2011).

A particularly successful transdiagnostic treatment—the Modular Approach to Therapy for Children with Anxiety, Depression, or Conduct Problems (MATCH)—provides an approach to treating anxiety, depression, and conduct problems in youth (Weisz, et al., 2012). In an evaluation of MATCH, a total of 84 community clinicians were randomly assigned to 1 of 3 conditions for the treatment of 174 clinically referred youth aged 7 to 13 years old. The three conditions were: usual care, standard manualized disorder-focused treatment (i.e., cognitive behavioral therapy for depression, cognitive behavioral therapy for anxiety, and behavioral parent training for conduct problems) and a modular treatment that integrates the procedures from the 3 separate treatments and includes detailed guides for therapists as to the conditions under which the various elements should be administered. The best outcome was observed for the modular treatment (MATCH). MATCH produced significantly steeper trajectories of

improvement relative to both usual care and to standard manualized disorder-focused treatment. Notably, outcomes from the disorder-focused manualized treatments did not differ significantly from the outcomes of usual care (Weisz, et al., 2012). This study was conducted across outpatient settings (i.e., not in a university/medical school setting) and 40% of the therapists were social workers, 24% were psychologists, and 36% of the therapists had various other qualifications, which is a much more representative sample of mental health providers than is typical in treatment research conducted in university settings.

A similarly impressive example is the demonstration that CALM, a modularized CBT treatment for the anxiety disorders, which is delivered via a computer and assisted by an Anxiety Clinical Specialist. CALM was superior to usual care across 1004 adult patients and 17 primary care clinics (Craske, et al., 2011). The Anxiety Clinical Specialists for this study were: 6 social workers, 5 registered nurses, 2 masters level psychologists and 1 doctoral level psychologist. The advantage to CALM was sustained for 18 months for individuals with generalized anxiety disorder and social anxiety disorder, and for 12 months for individuals with panic disorder.

This research on MATCH and CALM represents an encouraging ‘new wave’ of Stage 3 and 4 studies, as defined by the Onken et al. (2014) Stage Model of Treatment Development. These studies also demonstrate the potential utility of transdiagnostic and modular treatments.

More ‘spoons’—In the USA, only 700,000 mental health professionals, concentrated in highly populated, affluent urban areas, are available to treat the 75 million people with a mental disorder whose geographical distribution includes poor and rural areas (Kazdin & Blase, 2011; Kazdin & Rabbitt, 2013). This acute problem is likely to hold for many other countries. Hence, there is a need to develop more ‘spoons’ (Yates, 2011) for delivering effective treatments to a broader range of patients via the internet, telephone, smartphone, self-help book, text message as well as by television and radio (Kazdin & Blase, 2011) and perhaps also via home visits. More transportable treatments including ehealth - interactive computer programs and apps – are also being developed (Andersson, 2009; Teachman, 2014). Identifying ‘weak treatments’, such as advice from a physician or nurse, and nontraditional service providers are other important approaches that are being adopted to reach more people in need (Kazdin & Blase, 2011; Kazdin & Rabbitt, 2013). Finally, because mental and physical illness are often closely connected and many people are already comfortable seeking treatment from their primary care physician, the provision of services for mental disorders are being integrated within primary care (Wakefield & Dupuy, 2014). Screening and treatment for depression, smoking reduction and drug and alcohol problems are being prioritized and the services are provided by psychologists and social workers.

Organization-Level

Administrative Logistics—The barriers to accessing and implementing EBPTs within organizations are relatively understudied. However, we do know that disillusionment/ skepticism that a new treatment will help is one identified organizational barrier (Roche & Freeman, 2004). Lack of administrative support and staff time are other key organizational

barriers (Willenbring et al., 2004). Also, using the Organizational Social Context (OSC) questionnaire, Aarons et al. (2012) found that organizational climate within community mental health clinics was associated with individual clinician attitudes toward utilizing EBPTs and clinicians working in more stressful environments were less likely to use EBPTs when mandated by agencies or states. These data are very useful for informing potential organizational restructuring to promote increased access to, and utilization of, EBPTs.

Implementation Cliff and Voltage Drop—Our field is already aware that treatments developed in university settings are too rarely disseminated for delivery within practice/community based organizations— a phenomenon known as the 'Implementation Cliff' (Weisz, et al., 2014). Even when the treatments are disseminated there may be some loss in the benefits to patients—a phenomenon known as the 'Voltage Drop' (Chambers, Glasgow, & Stange, 2013). For example, Weisz, Kuppens, Eckshatin, Ugeto, Hawley and Jensen-Doss (2013) conducted a meta-analysis of 52 studies conducted in clinical settings in which the effect size difference between EBPTs and usual care was 0.29. While this represents a drop relative to the outcomes seen in research settings, the probability was still 58% that one randomly selected patient would have a better outcome after an EBPT relative to a randomly selected patient who receives usual care. One possible explanation for this drop in benefit is that 'program drift', which refers to deviation from manualized protocols, decreases benefit (Chambers, et al., 2013). Another possibility is that there is a lack of 'fit' between the interventions developed in university settings and the organizations that deliver most mental health treatments or the patients treated within the organizations. Two examples of efforts to improve the 'fit' will now be described.

First, the Replicating Effective Programs (REP) framework (Kilbourne, Neumann, Pincus, Bauer, & Stall, 2007) was developed by the U.S. Centers for Disease Control and Prevention. REP outlines four phases that guide the process of ensuring dissemination of treatments into real-world organizational settings. Phase 1 is the Pre-Condition Phase during which the needs of the patients within the organization are established and an effective intervention that fits with local organizations and/or the target group is identified. This is also the phase for packaging the intervention and identifying implementation barriers. Phase 2 is the Pre-Implementation Phase during which delivery is customized and logistics are planned. Phase 3 is the Implementation Phase during which training, weekly supervision, building partnerships with the local organizations and process evaluation take place. The focus of Phase 4 is Maintenance and Evolution. The goals are to ensure sustainability of delivering the intervention within the local organization and then packaging the intervention to be ready for national dissemination (Kilbourne, et al., 2007). In sum, the REP framework helps break down and ensure coverage of all the important issues so the 'fit' and uptake of a new intervention is maximized. The value of REP has been demonstrated in multiple RCTS (Kilbourne, et al., 2007).

Second, Weisz et al. (2014) have proposed 'deployment treatment development' in which interventions are developed and tested with the patients and the therapists who will receive and deliver the intervention and within the organizations in which they will be delivered. This strategy is in contrast to the usual method in which the treatment is developed within a university or research setting and later tested for applicability to real world settings.

Similarly, the dynamic sustainability framework emphasizes understanding the changing context of healthcare involving continued learning and problem solving. The goal is to ensure ongoing adaptations of interventions to fit the context and to aim for ongoing improvement as opposed to diminishing outcomes over time (Chambers, et al., 2013). This model is particularly relevant in contexts that are in the midst of rapid change, such as the health system in the USA, as will be discussed in the Government-Level section below.

Government-Level

To illustrate the critical role of government-level factors, we focus on two countries—the USA and England. These countries have been selected because (1) they have both have undergone relevant and significant, albeit very different, changes in the provision of mental healthcare services over the past decade, (2) data has been collected on trends in delivering EBPTs in both countries and (3) they represent two very different approaches to health care.

USA—In 1960, national health care spending was 5.4% of the gross domestic product. In 2007, the 16.2% that was spent on national health care was far more than any other developed nation and the rise is unlikely to be attributable to the aging or growing population (Peterson & Burton, 2007). Surprisingly, this level of funding does not seem to have translated into better outcomes. In fact, the USA is 37th for life expectancy (Kulkarni, Levin-Rector, Ezzati, & Murray, 2011) and 31st for infant mortality (Heisler, 2012), two common metrics used to gauge the health of a nation. The rise in costs have been attributed to ‘resources being increasingly allocated in response to profit opportunities rather than medical need’ (p. 550) (Kuttner, 2008).

Also, until recently, 45 million Americans did not have health insurance. The percentage of uninsured had been rising because the costs associated with buying insurance had been steadily rising. In particular, health insurance is typically provided through one’s employer. Hence, when people become unemployed or underemployed they may lose their health coverage and they may be unable to afford to buy their own insurance.

Individuals with a mental disorder have been significantly overrepresented among the uninsured. In 1996, 1 in 5 people diagnosed with a serious mental disorder did not have insurance, compared to 1 in 10 of those without a serious mental disorder (McAlpine & Mechanic, 2000). Moreover, only one fifth of the group with a serious mental disorder received a mental health service in 2004–2006 compared to one half among those who had coverage (Garfield, Zuvekas, Lave, & Donohue, 2011). Clearly, there was a great need for change, particularly for individuals with a mental disorder. Two relatively new laws hold promise for improving the situation.

Parity: In 1996 (with updates in 2005 and 2007), the mental health parity laws were established to prohibit differences in coverage for ‘mental disorders’ relative to ‘medical disorders’. These laws were needed because insurance companies and/or employers commonly set lower limits on mental health coverage relative to services for physical health problems (Sarata, 2011). While the Parity laws are an important advance, there is concern about their effectiveness. Teich and Buck (2007) completed an analysis of the Mercer National Survey of Employer-sponsored Health Plans in 1997 and 2003. One-third of

employers reported no difference in coverage for mental and physical health problems. However, for the remaining two thirds, the differential benefits appear to be increasing. Also, from 1997 to 2003 the limits on coverage for mental health treatment rose. Teich and Buck (2007) concluded that 'it is unlikely that universal parity in employer-based plans will be achieved through a legislative strategy' (p. 343). Moreover, Barry et al. (2003) reported that the only benefit that was equal with general medical insurance was coverage for prescription drugs, a likely contributor to the rise in drug treatments over EBPTs that has already been noted. Hence, two challenges ahead include (1) realizing the potential of the parity laws, particularly for the provision of EBPTs and (2) determining parity in the context of EBPTs because they are not easily comparable to treatment for any physical illness (Sundararman, 2009).

Patient Protection and Affordable Care Act (ACA): The goal of the ACA, which became law in 2010, is to improve access to affordable health insurance and to create coverage that is more affordable for those who are already covered. The law includes requirements: to increase access to health insurance coverage, to expand requirements for and restructure the private health insurance market and to establish state based 'exchanges' to provide a method for purchasing private insurance. Also, access to Medicaid and Medicare is being expanded and reorganized (Redhead, Chaikind, Fernandez, & Staman, 2012). Medicaid is a government program that provides health services to individuals who are very low income. Medicare is a government program that provides heath services to individuals who are older than 65 years of age. Importantly, insurance companies have been barred from denying coverage based on pre-existing conditions or rescinding individuals' coverage because of illness, including mental disorders.

It is estimated that 3.7 million currently uninsured individuals with a severe mental disorder will gain coverage once the ACA is fully implemented in 2019. There will be 1.15 million new users and many will be insured by Medicaid (Garfield, et al., 2011). To state this a different way, from 2009–2015 ACA funding is expected to contribute to the caseloads of mental health professionals increasing them in the order of 19 million to between 34 million (assuming mandatory funding levels) and 44 million (assuming appropriation of authorized funding levels) (Leighton et al., 2010). With this increase in the utilization of mental health services, the need to provide the optimal treatments is particularly critical (Garfield, et al., 2011). Also, there is a great need to rapidly mount a workforce who are skilled in the delivery of EBPTs (Goldman, 2001; Thomas, et al., 2009). In fact, funds are available to support such initiatives (Chor, Olin, & Hoagwood, 2014).

State-based initiatives: There are also important state-based government-level efforts. For example, in California, the Mental Health Services Act was passed in 2004 as a result of a ballot initiative known as Proposition 63. The ballot proposed to add a 1% tax to those with an annual personal income above $1 million and to use the revenue for mental health services. The ballot achieved broad support and has provided much needed funds for a broad range of important mental health initiatives such as improving access to services, the development of prevention programs, providing supported housing, and integrating mental health with other services (Feldman, 2009). For example, the important and successful

Prevention and Recovery from Early Psychosis (PREP) program was developed with these funds (Hardy et al., 2011). Discussion as to whether the same path may yield the same positive outcome in other states is being considered (Bambauer, 2005).

Veterans Health Administration (VA): A comprehensive and encouraging effort is in progress within the Veterans Health Administration (VA), which operates the largest integrated health care system in the USA. The VA has implemented national dissemination and training initiatives to ensure EBPTs are available for mental and behavioral health conditions to veterans in the USA (Karlin et al., 2010; Ruzek, Karlin, & Zeiss, 2012). For example, as of May 2010, the VA had provided training to over 2,700 VA mental health staff in the delivery of Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE) for PTSD, with impressive outcomes (Eftekhari et al., 2013; Karlin, et al., 2010). In addition, this initiative has yielded documented robust effects from VA therapists trained to deliver cognitive behavior therapy for insomnia (Karlin, Trockel, Taylor, Gimeno, & Manber, 2013; Manber et al., 2012) and cognitive therapy for depression (Karlin et al., 2012). Although more progress still needs to be made, these efforts at the government level show promise for the increased provision of services and more widespread dissemination of EBPTs in the USA.

England—Layard, Clark, Knapp and Mayraz (2007) published an economic analysis that concluded that the costs of providing EBPTs for the millions of people in England with an anxiety disorder or depression ‘would be fully covered by the savings in incapacity benefits and extra taxes that result in more people being able to work’ (p. 90). More specifically, the cost would be recovered within two to five years. Based on this analysis, between 2008 and 2011 the government invested 173 million pounds sterling per year above existing spending to establish the Improving Access to Psychological Therapies (IAPT) program. Key to convincing the government to increase spending in this domain were the NICE recommendations that EBPTs should be frontline treatments for anxiety and depression, along with the data that these treatments were not available to the public. As a result, IAPT has trained more than 3,600 new therapists in the EBPTs for anxiety disorders and depression recommended by the NICE guidelines (Clark et al., 2009) and by 2013 IAPT was treating approximately 400,000 patients each year, nearly half of whom had recovered by the end of treatment and many more benefited (Layard & Clark, 2014). Further cohorts of therapists are receiving training in an ongoing roll out of the program (Clark, 2011) and the program is being extended to youth (Shafran, Fonagy, Pugh, & Myles, 2014) as well as to mental disorders beyond anxiety and depression (Layard & Clark, 2014). The preliminary data from two specific demonstration sites, involving almost 5,500 treated patients indicates marked improvement in clinical outcome and employment status and these gains were maintained at 10 month follow-up (Clark, 2011). A broader analysis of the first year of operation for 32 IAPT services, involving 19,395 patients who received at least 2 sessions of treatment, indicated that 40.3% of patients had reliably recovered and 63.7% had reliably improved (Gyani, et al., 2013). The 2013–2014 data from IAPT is also looking very promising. Of those who finished a course of treatment, 60% showed reliable improvement and 13% of patients who were taking a medication at the start of treatment were no longer taking it after treatment (Community and Mental Health team, 2014). In terms of

employment outcomes, 16% of patients with an initial employment status of ‘long term sick or disabled or unemployed had a status of ‘employed’ after treatment. Moreover, 14% of those with an initial status of ‘long term sick, disabled, or in receipt of benefit payments’ had moved to a status of ‘unemployed and seeking work’ (Community and Mental Health team, 2014). It is notable that these data verify the assumptions on which the IAPT program was based—IAPT is reducing unemployment and improving outcomes for people with a mental disorder.

Many other lessons have been learned from this important program. First, recovery was higher where there were more highly trained and experienced therapists and where patients received more sessions, and at least an average of eight sessions per person were delivered (Gyani, et al., 2013; Layard & Clark, 2014). Second, following the landmark Omagh PTSD dissemination study (Gillespie, Duffy, Hackmann, & Clark, 2002), IAPT also instituted routine session-by-session outcome monitoring. By adopting the same kind of session-by-session monitoring system, the IAPT program has managed to obtain pre and post treatment data on approximately 96% of the people who received treatment (Community and Mental Health team, 2014). As discussed under patient-level barriers, progress monitoring is important for adjusting and advancing treatment, helps patients to choose a service that has good outcomes and helps those who fund the service know if their investment is paying off (Layard & Clark, 2014; Radhakrishnan, et al., 2013).

There are many differences between the USA and English systems. In particular, universal health care in the England, via the National Health Service (NHS), is a single entity. Treatment providers are typically employed within the NHS. Hence, it is likely to be easier to institute uniform training standards within the NHS relative to in the USA where there are many treatment providers operating independently. In the latter, ensuring nationally agreed upon standards of care is much more difficult. Also, the NHS is nonprofit so all services are free to patients and funds within the NHS are spent on health care. In contrast, most sectors of the USA system are ‘for profit’, which means that not all funds are channeled back into health care. Nonetheless, there are several features of the IAPT program that are translatable to the USA. In particular, a first step would be to establish a tradition of country-wide cost-effectiveness analyses focused on the costs and savings of providing EBPTs. Careful consideration would need to be given to the outcomes that policy makers and the public in the USA care about, such as demonstrations of loss of productivity or reduced potential for violence. A second step, would be to establish an FDA equivalent for EBPTs. FDA is an acronym for the U.S. Food and Drug Administration and is the authority that reviews new treatments for mental disorders—typically drug treatments—and judges whether or not they should be available to the public. This is suggested because, in England, the NICE guidelines were a key step in establishing IAPT.

Summary and Conclusion

The number of people affected by one or more mental disorders is large and growing, the majority of people with a mental disorder are not getting treated and, even among those who do get treated, the majority are not receiving a minimally adequate treatment, far or less an EBPT. We highlighted that the amount and quality of evidence for EBPTs as effective sole

interventions for a wide range of mental disorders is a puzzling contrast to data indicating that the availability of these treatments has steeply declined. Barriers and possible solutions are summarized in Table 1. In the assessment of the authors, the principle domains during the period ahead include (1) helping patients identify good providers of EBPTs, (2) training many more providers to be able to deliver EBPTs and (3) convincing governments to devote more resources to EBPTs.

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Abbreviations

EBPTs	evidence-based psychological treatments
SAMHSA	Substance Abuse and Mental Health Services Administration
NICE	National Institute for Health and Care Excellence
WHO	World Health Organization
DALYs	disability adjusted life years
REP	Replicating Effective Programs
ACA	Patient Protection and Affordable Care Act
IAPT	Improving Access to Psychological Therapies
NHS	National Health Services

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Highlights

- Mental disorders are highly prevalent and accessing adequate treatment is difficult
- Evidence-based psychological treatments (EBPTs) are highly effective
- Barriers and solutions to accessing EBPTs are discussed at five levels of analysis
- There is a need to continue to work toward innovation in treatment development
- There is a need to help patients identify EBPTs providers and train more providers

Table 1

Summary of modifiable barriers to accessing EBPTs and possible solutions

Modifiable Barriers	Possible Solutions
Patient-Level	
Problems such as transport, childcare, appointments at a convenient time and place, identifying a skilled therapist, attending sessions on time and overcoming stigma	Develop and test conceptual models of patient-level barriers to guide barrier-specific research and to guide treatment development efforts
Motivation to attend sessions and to adhere to treatment recommendations	Continue to translate research on motivation into interventions
Beliefs that treatment is not helpful and lack of awareness of EBPTs	Prioritize outcomes monitoring and publish the outcome data publically so it can be accessed by patients
Receiving an accurate diagnosis	Continue efforts to improve accuracy and speed of diagnosis
Therapist-Level	
Therapist beliefs such as EBPTs have an adverse impact on the therapeutic relationship, are too structured and technique focused and EBPTs do not necessarily yield a better outcome	Provide training in cognitive biases such as confirmation bias, illusory correlation and bias blind spot
Therapist preferences for eclectic, flexible approaches incorporating strategies drawn from multiple theoretical orientations	Conduct research on *how* to provide the training such as manuals, expert workshops, longer term courses with supervision, web-based programs
	Conduct research to establish *how much* training is needed for different types of EBPTs
Treatment-Level	
Difficulty identifying the appropriate EBPT	Establish a definitive source for identifying EBPTs
Room for improvement in current EBPTs	Continue to innovate
The ‘too many empirically supported treatments’ problem	Transdiagnostic and modularized treatments
	Develop more ‘spoons’ to deliver EBPTs
Organization-Level	
Disillusionment/skepticism that a new treatment will help	Improve organization climate and reduce stress for treatment providers
Lack of administrative support and staff time	Develop innovative approaches to reduce the implementation cliff, voltage drop and program drift such as REP and deployment focused treatment development
Stressful environment	
Government-Level	
Providing coverage for mental illness at the same rate as coverage for physical illness	Experts in EBPTs getting involved in advocacy and the development of policy to ensure EBPTs are offered as frontline treatments
Health care structure and policy	More fully document the short and long term cost effectiveness of EBPTs, particularly highlighting the potential cost savings
Lack of providers trained in EBPTs	