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SERVICE MODELS, FORMS OF DELIVERY AND CULTURAL ADAPTATIONS OF CBT

The UK Northern Talking Therapies Practice Research Network: lessons from 10 years of generating practice-based evidence

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Abstract
Practice research networks (PRNs) have been proposed as a mechanism to support continuous service evaluation and improvement in the field of psychological therapies. In theory, PRNs could help to generate high quality practice-based evidence that has potential to inform and improve clinical care. However, in practice, many obstacles pose challenges to the sustainability and impact of such networks. The UK Northern Talking Therapies PRN is an exemplar that has generated over 20 scientific publications over a decade of successful clinical-academic collaborations. This article distils key lessons learned over that time, to guide and promote the wider adoption of PRNs in psychological services.

Key learning aims

(1) To describe the structure, functions and outputs from a practice research network (PRN).
(2) To identify factors contributing to the sustainability of a PRN in the context of publicly funded psychological services.
(3) To understand the relationships between evidence-based practice, practice-based evidence and the innovation cycle in psychological therapy services.

Keywords: CBT; innovation; NHS Talking Therapies; practice research network; practice-based evidence

Introduction

The challenges of implementing evidence-based practice (EBP) in routine service provision are widely recognised across healthcare professions (Rapport *et al.*, 2022). An important part of effective implementation is the generation of practice-based evidence (PBE) to evaluate how EBP works in routine services, which are often very different from the context in which the EBP was generated, such as in controlled clinical trials. Healthcare services can vary in many ways, such as in their financial resources, social relations and support, leadership, organisational culture and climate, organisational readiness to change and characteristics of patients. Moreover, clinical samples of patients accessing routine psychological services are diverse and often different from carefully selected clinical trial samples, which makes it difficult to know if treatments tested in trials will work similarly in routine care (Morrison *et al.*, 2003; Westen *et al.*, 2004). Hence, the

evaluation of routine health care delivery and outcomes using formal research methods is necessary for continuous improvement.

Practice research networks (PRNs) involve partnerships between practitioners and researchers and, when successful, combine the realities of routine care with methodological rigour to produce high quality research (Barkham, 2014; Castonguay and Muran, 2016). They can generate practice-based evidence by collecting routine care data, producing real-world evidence that can help to evaluate services and to identify areas for continuous improvement. In psychological therapies research, several PRNs conduct research based on the use of common outcome measures implemented across services; some examples include the Pennsylvania Psychological Association PRN (Borkovec *et al.*, 2001), the Penn State University training clinic PRN (Castonguay *et al.*, 2015), the Psychotherapy Practice-Research Network (PPRNet) in Canada (Tasca *et al.*, 2014), and the Northern Talking Therapies PRN in England (NTT-PRN) (Lucock *et al.*, 2017). Despite the potential benefits of PRNs, they are under-used in mental health settings (Audin *et al.*, 2001; McMillen *et al.*, 2009). McMillen *et al.* (2009) suggest this is due to challenges and barriers such as funding, maintaining sustainability, generating publishable scientific outputs, impact on practice, managing relationships within the PRN, maintaining productivity, and ethical and governance arrangements. The number of studies published by PRNs is reported to be low; for example, a survey of 86 primary care PRNs in the USA reported that 88% published fewer than seven studies (Tierney *et al.*, 2007). According to Parry *et al.* (2010), publication of outputs in local and international journals would be a hallmark of PRNs that can produce high quality evidence that can inform clinical care.

The present paper reports on the progress and achievements of the NTT-PRN 10 years from its inception in 2014. We evaluate the progress of the PRN against three criteria to assess the success of a PRN: (1) sustainability, (2) research outputs, and (3) impact on services. We also reflect on the role of innovation, challenges and successes, and look to the future role of the PRN. By describing the types of published research carried out so far, we will show how the PRN has moved beyond implementation of EBP to innovation, also addressing issues such as access and efficiency/cost-effectiveness. As in an earlier report of the activity of this PRN (Lucock *et al.*, 2017), we will make reference to the Exploration, Preparation, Implementation and Sustainment (EPIS) framework (Aarons *et al.*, 2011) which acknowledges the importance of inner and outer organisational contexts. The last two domains of this framework, implementation and sustainment, are of most relevance to the PRN as the sustainment phase refers to maintaining changes after initial implementation. The outer context within which the PRN operates in England is the NHS Talking Therapies programme, which is funded by the UK government and includes an electronic patient management infrastructure to support research, including routine outcome monitoring systems.

Context – NHS Talking Therapies for anxiety and depression

The *Improving Access to Psychological Therapies* (IAPT) programme was established in 2008 and later renamed as *NHS Talking Therapies Services for Anxiety and Depression* in 2023. This national programme introduced a new structure to the way in which psychological therapies were organised and delivered in England, supported by new government investment, and premised on national guidelines for the treatment of common mental health problems (Clark, 2018). Services are delivered within a stepped care service model, with brief 'low intensity' interventions being offered to people with mild-to-moderate anxiety and depression symptoms. These brief and self-help oriented interventions are delivered by Psychological Wellbeing Practitioners (PWPs) which was a new addition to the mental health workforce. 'High intensity' interventions are formal psychological therapies provided when patients are 'stepped up' from a low intensity intervention or when only a high intensity therapy is indicated by national guidelines (e.g. for post-traumatic stress disorder). The high intensity psychological therapies available in the programme are

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cognitive behavioural therapy, interpersonal psychotherapy, person-centred experiential counselling for depression, behavioural couples therapy, eye movement desensitisation and reprocessing, and brief dynamic interpersonal therapy.

The Northern Talking Therapies Practice Research Network (NTT-PRN, formerly known as Northern IAPT PRN) was set up in 2014, four years after full, national implementation of the IAPT programme, making best use of the infrastructure for routine outcome monitoring that is a mainstream feature of these services. The PHQ-9 measure of depression (Kroenke *et al*., 2001) and the GAD-7 measure of anxiety (Spitzer *et al*., 2006) are administered on a session-by-session basis to monitor treatment response. When the PRN was first set up, it consisted of practitioners, academics, and services that had already worked together on practice-based research, including some with a shared historic vision and experience in collecting PBE in psychological therapies and analysing large routine datasets prior to the national IAPT initiative (e.g. Barkham *et al*., 2001; Lucock *et al*., 2003).

The Northern Talking Therapies PRN

The NTT-PRN covered the north of England across three main regions – the North East, North West, and Yorkshire and the Humber – consisting of a population of 15.5 million in mixed urban and rural areas including 17 cities. The PRN initially involved three universities (Sheffield, Huddersfield, and York) and six Talking Therapies services. More details about the network's initial phase are reported by Lucock *et al*. (2017). At an initial meeting involving these organisations, a chairperson was nominated, and it was decided to build on existing studies already set up at the time, involving the participating services (e.g. Delgadillo *et al*., 2016). A website was set up (www.iaptprn.com), terms of reference agreed, and half-day conferences were held most years (six were held at various venues over the first 10 years with a gap during the COVID-19 pandemic). A process of accepting new members joining the PRN, universities, and IAPT services, was agreed with members. This involved email communications with all NHS Talking Therapies services in the northern regions of England, requesting interested services to nominate a local research lead who would complete an online survey to provide their contact details and to be included in regular email updates coordinated by the chairperson.

Sustainability of the PRN

Membership

The PRN has not only proved to be sustainable, but it has expanded over the last 10 years, with 20 services and six universities having joined the network by September 2024, thereby doubling the membership of both universities and NHS organisations. There is widespread acknowledgement of the importance of lived experience in all aspects of the research process of the PRN. Studies conducted by the NTT-PRN have included patients and people with lived experience of psychological treatment in the co-production, conduct and dissemination of research. Given that the topics of studies supported by the NTT-PRN are diverse, the inclusion of diverse patient representatives across different studies has been an effective and decentralised strategy for patient and public involvement.

Funding

The EPIS framework identifies inner and outer contexts as important in implementation of PBE. A key outer context facilitator for the PRN has been the centrally funded NHS Talking Therapies programme and the requirement for all services within the programme to deliver evidence-based psychological therapies and have an electronic patient management system including routine

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outcome monitoring (ROM), which consists of measures of anxiety and depression at each session. This avoids the costs of setting up, implementing and maintaining a ROM system which would involve overcoming typical barriers to the implementation of measurement, including concerns from practitioners (e.g. see Lucock *et al.*, 2015). Session-by-session measures provide opportunities to investigate phenomena such as early change, shapes of change, sudden gains, and provide a system for feedback on progress during therapy (Barkham *et al.*, 2023).

By contrast, funding is required to carry out high quality research and academic partners affiliated to the PRN have been successful in obtaining both small-scale pump priming grants (e.g. Delgadillo *et al.*, 2016) and substantial grants from charities and research councils to conduct pragmatic randomised controlled trials embedded in Talking Therapies services (e.g. Kellett *et al.*, 2023; Delgadillo *et al.*, 2018). This shows how success with appropriate funding is dependent on the demonstration of a PRN's capacity to complete, publish, and disseminate outputs from early-stage practice-based studies.

Collaborations

In addition to the successful clinical-academic collaborations within the PRN, links have been established with other researchers, networks, and organisations in the UK and internationally. The international collaborations are evidenced in co-authorship of studies including research partners in Germany (e.g. Delgadillo *et al.*, 2018) and the USA (e.g. Delgadillo *et al.*, 2022).

Leadership

A key facilitator of the sustainability and expansion of the PRN has been the commitment of network members to coordinate the activities of the network in a way that is not contingent on short-term or project-specific funding sources. Having a dedicated chairperson for the PRN supported the continuous renewal of the membership (i.e. ensuring continuous representation of clinical services, when their nominated members changed jobs), the organisation of network conferences, and the maintenance of online communications (website, newsletters, email updates). The long-term sustainability of a PRN requires the time-commitment of a chairperson who has some level of autonomy to dedicate time to the above tasks, and with a job role that is not contingent on short cycles of research funding (i.e. a tenured academic job provides a realistic platform to coordinate a PRN).

Research outputs – publications in peer-reviewed international journals

Over 20 studies have been published in international peer-reviewed journals since the inception of the PRN. These include different types of research, such as clinical trials of innovative digital health technologies (Delgadillo *et al.*, 2018; Delgadillo *et al.*, 2022), the development and evaluation of brief psychological interventions (Kellett *et al.*, 2023; Lucock *et al.*, 2018; Lucock *et al.*, 2022), reporting on longer-term outcomes and relapse rates after routine care (Ali *et al.*, 2017), evaluations of the effectiveness of group-based psychological interventions (Delgadillo and Groom, 2017; Delgadillo *et al.*, 2016), investigations of factors affecting clinical outcomes including the dose–response and early response effect (Robinson *et al.*, 2020), and predictors of treatment attendance and drop-out (Bowker *et al.*, 2024; Sweetman *et al.*, 2022). These involve a range of methodologies and share the characteristic that is most important in a PRN: practice-based research involving collaborations between researchers and clinicians. This collaboration is also reflected in the number of practitioners who were sufficiently involved in the research and preparing the manuscripts to be included as co-authors. These include psychological professionals and service managers, as well as academic researchers.

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Impact on services

The aim of health research is to improve clinical care, through effective interventions and improvements in the organisation, access and delivery of services. Although PRNs support practice-based research, which can immediately impact on routine service delivery, there are significant challenges in scaling up innovations and effective service developments and sustaining these changes over time. Some of the PRN studies are at the intervention development, pilot or feasibility stages, and require a stronger evidence base to support wider implementation (e.g. Lucock *et al*., 2022). For these developments, the next step is to apply for funding to support fully powered clinical trials that could influence future clinical guidelines.

However, some PRN studies have led to improvements in service provision and/or recommendations. Some examples are new clinical guidelines available on the PRN website for large group psychoeducational CBT (Delgadillo *et al*., 2016) and the widespread use of outcome feedback to identify 'not on track' cases (Delgadillo *et al*., 2018). The latter is an example of an evidence-based digital innovation that has been widely applied across NHS TT services and has also influenced clinical guidelines in other countries, such as the American Psychological Association (APA) professional practice guidelines on measurement-based care (Jensen-Doss *et al*., 2024).

The sustained impact of PRN supported research on practice is also subject to the contextual factors that may act as barriers or facilitators. For example, the feedback research and implementation has benefited from the ROM system already implemented across all NHS TT services, whilst the SMArT intervention (Lucock *et al*., 2022), which is at an earlier stage in developing a robust evidence base, has met with barriers to wider implementation because of the emphasis in NHS TT services on recovery and treatment completion rather than long-term improvement and relapse prevention.

The role of innovation in the PRN

Innovation is seen as critical to health services, to ensure its sustainability and deliver better health outcomes (www.england.nhs.uk/ourwork/innovation) and is necessary to improve effectiveness, efficiency, and access to services. It can refer to either the implementation of what has worked elsewhere in a different context, or it can refer to developing new interventions, products, models of care delivery, etc. Literature on this topic has mostly focused on the role of PRNs as an infrastructure to evaluate outcomes and processes of routine clinical care, supporting continuous service improvement. However, the outputs associated with the NTT-PRN demonstrate that PRNs can also help clinical services to generate innovations. Examples are the development of new interventions based on psychological theory (e.g. relapse prevention based on implementation intentions theory; Lucock *et al*., 2018), the use of digital health technology (e.g. feedback technology based on routine outcome measures; Delgadillo *et al*., 2018), and the development of brief and more accessible low intensity versions of traditional psychotherapeutic interventions (e.g. guided self-help based on cognitive analytic therapy; Kellett *et al*., 2023).

Related to the above point about funding, PRNs can offer an infrastructure that enables the development and evaluation of innovative treatment approaches and technologies, which in turn provides a solid case for attracting competitive research funding. In other words, innovations that are enabled by a PRN form the necessary track record to attract research funding, which in turn helps sustain the activities of the PRN. In this way, as illustrated in Fig. 1, practice-based evidence and evidence-based practice should be seen as complementary approaches that support innovation and which can inform and continuously improve clinical care.

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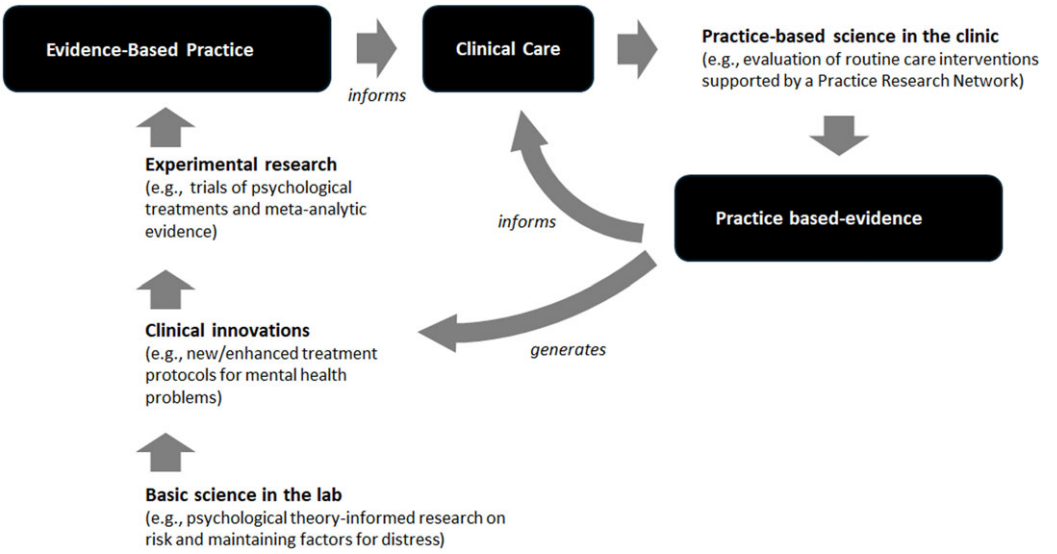

Figure 1. Synergies between basic science, evidence-based practice, practice-based evidence and innovation.

Challenges

The PRN has encountered several challenges during the last 10 years. Dependence on 'soft funding' (i.e. time-limited research grants) is a common issue that risks making long-term initiatives precarious. The PRN has relied on relationships, a shared vision, and commitment to PBE, to make it resilient to the ebbs and flows of research funding. Many other similar initiatives, funded by the NHS, regional health providers, and pump-priming funding from universities, have disappeared over time because they did not survive the perils of dependence on short-term funding sources. Another challenge is ensuring that the constituent organisations making up the membership of the PRN are kept up-to-date and involved in network activities. This requires a lead person or core team to coordinate communications and events to keep the momentum and interest going, and to renew the membership in situations of staff turnover in clinical services. Given the importance of openness and collaboration in a PRN, it is important to keep everyone involved and ensure they have a stake in the network; for example, ensuring that all affiliated clinical services know about upcoming opportunities to participate in new projects, such as multi-centre clinical trials.

Discussion

This paper has described the sustainability and expansion of the NTT-PRN, 10 years after it was first set up. At the time of its inception, the aims were relatively modest: to generate practice-based evidence to influence psychological therapies services in England and support the development of a research culture within its constituent services. The early strategy was to build on pre-existing collaborations and expertise (practitioners and researchers including those with expertise in data science and experimental psychology), focusing on routinely collected outcome measures, and starting with modest, achievable aims (Lucock *et al.*, 2017). We would recommend this strategy to others planning to set up similar networks. The PRN has not only been sustained for a decade, but it has surpassed these early expectations by expanding the organisations involved, both psychological therapies services and universities, and successfully completing high quality practice-based research. The quality of the research is evidenced by the number of publications in international journals. At its outset, the PRN was framed as a vehicle through which PBE could be

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implemented (Aarons *et al*., 2011). The types of research supported by the PRN show how it has also been possible to use this as a vehicle for innovations for the field of psychological therapies, beyond the context of the English NHS.

We have highlighted how the ROM system used by all NHS TT services provides an infrastructure for research and evaluation of service innovations. Indeed, there are PRNs linked to NHS TT services in other regions of England and which have produced several academic publications; for example, the Thames Valley Talking Therapies Network (e.g. Thew *et al*., 2024) and the North and Central East London Network (e.g. Saunders *et al*., 2020). Indeed, the volume and quality of research across NHS TT services is impressive and we recommend other localities look at similar approaches to share ideas and support EBP initiatives. This paper highlights factors that will support more widespread use of PRNs in psychological therapies services, and how they can be sustained over time, so our hope is that we will see an expansion of such networks. In the UK we are fortunate to have an infrastructure for routine outcome measurement which is a major facilitator and has also supported other networks in NHS TT services.

Regarding future plans, maintaining the PRN is a priority; for example, establishing links with other similar regional networks to support large scale multi-centre studies. We hope this paper will inspire other groups to set up similar networks. Areas for improvement in the future include service user/lived experience input in identifying research priorities and developing strategies for wider implementation and impact on service provision.

In summary, the following factors have been found to be important in the sustainability and success of the PRN: (1) committed leadership that is not contingent on short-term funding; (2) multi-disciplinary collaborations that have the expertise to carry out high-quality and innovative programmes of research; (3) formal terms of reference that establish a shared vision and commitment to generating PBE; (4) processes that ensure that affiliated members are kept up-to-date with network activities; and (5) the democratic inclusion of all affiliated organisations, offering them support and opportunities to get involved in projects.

Key practice points

(1) The sustainability of a PRN depends on the following factors being in place: committed leadership, multi-disciplinary collaborations with expertise to carry out high quality practice-based research, a shared vision and commitment to generating PBE, processes that ensure that all affiliated members are kept up-to-date with network activities and research opportunities.
(2) When these factors are in place a PRN can produce high quality practice-based research which leads directly to service improvements.
(3) PRNs can support service innovation, by developing and evaluating new interventions and services.
(4) For clinicians, PRNs provide a way of engaging in practice-based research that is likely to have an impact on their services and can provide an important career development opportunity.

Further reading

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