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IAPT causes split between Frankie and Johnny.

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Summary

Opinion about the wisdom of introducing IAPT across the country is divided. Some of the arguments are discussed in the light of the first IAPT outcome report. Issues addressed are: medical philosophy, levels of expertise, value for money, and unanswered questions.

The introduction of IAPT schemes into the landscape of clinical psychology has brought with it a storm of controversy rarely seen since Eysenck vs psychoanalysis. Sim Roy-Chowdhury (2010) has referenced most of the key contributors and has calmly weighed up the issues. Here, I wish to discuss the recent exchange of letters between Frank McPherson (CPF 211) and John Marzillier (CPF 209) in the light of the first report on the outcome of the IAPT demonstration projects in Doncaster and Newham.

Frank chides John for getting his priorities wrong. He believes that improving access to psychological therapy amongst the masses is more important than ensuring that our credentials as psychotherapists are impeccable, a view that could result in a situation in which therapy is reserved for 'the select few'. I think that both writers have a point - and both would probably agree that wider access to psychological therapy through the NHS is a good thing if it improves a person's quality of life, doesn't cause harm, and is at least considerably cheaper than referring the same person to Harley Street. And I believe that the state has a justifiable interest in getting people off incapacity and other benefits into suitable employment. In my experience, few people prefer to be disabled by their psychological problems rather than work, assuming they feel confident enough to do so and there is a sufficient financial incentive.

The reality we face is that many people have life problems they want to deal with - but this does not necessarily imply that we should employ more and more therapists at the taxpayer's expense or that it is always desirable for people to seek therapy privately. In ideal circumstances, a person may prefer to solve their problem on their own or with their community. After all, our success as a species is grounded in our ability to analyse problems and learn from experience. However, I suspect that some of our ancestors were smart enough to carve out a nice niche for themselves by offering to solve others' problems for them. These shamans and priests, by exploiting human insecurities, probably knew how to prime their peers into imagining problems that only they had the answers to (no doubt demanding three animal sacrifices a week over five years). We ought to question the assumption, shared by Frank and John, that so many people actually need professional therapeutic help. For instance, 'assertiveness therapy', an approach used in CBT from its beginning, is now commonly subsumed under 'education and training', and taught individually or in groups in evening classes and other venues. And we certainly ought to question IAPT's assumption that we need therapy because we are 'ill'. It is extremely disappointing that the language adopted in the IAPT literature is psychiatric. I naively imagined, perhaps along with John and Frank several decades ago, that we were beginning to break away from the medical model. The outcome data for IAPT chiefly relate to 'illness' and not to quality of life. A person's 'caseness' is decided by cut-off points on scales of psychiatric symptoms.

Nevertheless, we have to accept the fact that many people think they need therapy, perhaps because they think they are ill. As modern shamans, we profess to know something about helping them when they are at a loss. But this help could be fairly simple and straightforward (step 2 in IAPT terminology). Many of us, with the help of a manual,

can assemble a flat-pack chest of drawers into a piece of furniture without being trained as carpenters or needing to call one up. It would be arrogant to assume that people can't work things out for themselves. Psychologists have done a wonderful job in making their ideas and techniques widely available in manuals and self-help books.

But there will always be people who have a look in their eyes of incomprehension or terror when handed a screwdriver. A craftsman or craftswoman is needed. The key question is how skillful does that person need to be? How far can we adopt the methods of Henry Ford by training up workers who are unable to build a motor car but can fit in the seats? This remark does not betray an elitist attitude but simply expresses realism about achieving results. Here, I agree with John that a manualised approach to therapy, a manual that tells you how to fix in seats, has strict limitations. It is extremely difficult to know which manual to pull off the shelf when you are faced with a new client. Techniques are fairly easy to learn but which technique to use, and when, is far more tricky. I am ready to be convinced by the evidence produced by IAPT but I am doubtful that we can get away with little expertise, just as I am doubtful that surgeons can be replaced by podiatrists.

Let us therefore turn to the first report on the IAPT demonstration sites (Clark, Layard, and Smithies, 2008). IAPT services use a stepped care approach. If a 'low intensity' intervention suffices, a person is not stepped up to a 'high intensity' intervention. The economic argument for training a large number of new therapists is that they don't require a lengthy training (and are therefore cheaper) and that this is perfectly reasonable because a very high proportion of people referred for therapy can manage a flat-pack chest of drawers. If they can't, there is another set of 'high intensity' therapists, given a longer training. If that fails too, there is the back-up of an 'elite core' of applied psychologists who have invested even more time in training - the high priests of the whole enterprise.

It is very revealing that a high proportion of people referred to the IAPT services in Doncaster and Newham never really get engaged with what's on offer. Perhaps this is generally true of NHS therapy and counselling. Amalgamating the figures from the two centres, about 15% were considered unsuitable, a further 20% had no sessions or only one, and of those who received two or more sessions, 30% dropped out or refused further therapy.

The mean number of sessions in Doncaster for people receiving two or more was 4.9, equivalent to 2.6 hours of contact, including the initial assessment. This seems to be considerably shorter than the length of therapy in most randomised controlled trials (RCT) for CBT. I am quite happy to call it facilitated self-help, especially as most of it occurs over the 'phone. Only 2.1% of cases were stepped up to a higher level. Either they have some amazingly competent therapists in Doncaster or something is being missed. In my own practice, I do see a minority of people very briefly, and for them, a good self-help book can be incredibly valuable and effective, with little extra help. But let us not kid ourselves that it is possible to make a good assessment and formulation in a very brief period of time for a person whose problems are even the slightest bit complex. After 40 years of practice, I am constantly made aware that I often miss important information or get my formulation completely wrong.

In Newham, the average number of sessions was 8.2 (equivalent to 7.2 hours, including assessment) and 74% of the treated sample received specialist CBT (of whom roughly 31% had been stepped up to this level). The reason for these differences between the two sites is not apparent.

The results of therapy are reported as change in 'caseness' and reduction in symptom questionnaire scores. Slightly over 50% were no longer 'sick' (in the language of the

report) at the end of therapy and this reduced to slightly over 40% at follow up (in fact, only a reduced sample was available for follow up measurement). While a reduction in score is important, we can't really deduce from it how a person judges their life overall - are they content with their lot, is their social life any better, are they reconciled to living with their disagreeable relatives, offspring, or job? To what extent are they managing their lives without psychotropic drugs? (Data collection of this type was incomplete). SSRIs were the most commonly taken medications and these can produce unpleasant side-effects such as weight gain and sexual dysfunction. Quite apart from the cost of drugs, can a person no longer be considered a 'case' if still taking them?

The distribution of scores at post-treatment was not reported but it would appear that the mean score at follow up was uncomfortably close to the criterion for caseness for the PHQ-9 (i.e. 9.75, cut-off 10) and exceeded the cut-off for the GAD-7 (8.4, cut-off 8). It would be helpful to know how many of the people who remained cases at post-treatment improved a bit, remained the same, or got worse. The results overall are really not that impressive. The authors of the report were also content with an increased rate of employment of around 5% in the treated group. Again, this does not sound like a major achievement, and I am unclear how it compares with the normal rate of going on and off benefits.

Is it value for money? One way of calculating the cost of therapy is to divide the total funding for the two projects by the number of therapy hours provided for people who attended two or more sessions. This does not take account of all the people who have not yet completed therapy (and other development costs) but it does include the cost of providing therapy for the 50-60% who didn't really benefit. On this crude measure, therapy costs £368.33 per hour in Doncaster and £704.48 per hour in Newham. Even for Harley Street, these prices are a bit steep. Come to me in Lewisham and it will cost you less - as it would for other accredited therapists on the BABCP website.

Frank might consider my evaluation of the evaluation a bit too harsh. It ignores the fact that the government has been persuaded to accept the idea of providing therapy universally across the country as it would for any other health need. It may indeed form an imperfect rootstock on which more appetising fruit can be grown in future. Over the course of its relatively short history, clinical psychologists have excelled in getting their foot in the door, prising it open, and spreading their influence. IAPT is undoubtedly an achievement and also an opportunity to prove that there is an alternative to mind-numbing medications. The risk is that it will sell itself short and spoil the brand.

I expressed my doubts in a letter to Lord Layard in October 2005. These were: 1. Will people referred to IAPT share the same characteristics as those who took part in CBT RCTs? For instance, are they not more likely to have drug and alcohol problems, physical illnesses, lifelong personality and relationship difficulties, and concerns about housing, racial harassment, or immigration status? Having worked in central London for most of my career, I have seen rather few textbook cases. 2. If people suitable for IAPT therapists are selected from a much larger pool of referrals, what will happen to the remainder? Won't this overburden the already stretched secondary, tertiary, and specialist services? And ditto for people who fail with IAPT - they will have to be passed on somewhere else. 3. There is a risk that protocol-driven therapy will produce a dumbing-down in skills, a loss of clinical flexibility, and a depreciation of independent professional judgment. For instance, the requirement that ratings of progress are completed every session is fine for rational, cooperative people but might be contraindicated for all sorts of reasons in others. Or strict contractual time-limits might be paralysing for some individuals who become over-anxious about endings. 4. What is the career ladder for existing clinical and counselling psychologists whose work in IAPT is predominantly clinical? Will they have to switch to administration and management in order to get promoted? The same question will be asked by IAPT therapists. There is a high probability that they will turn towards

higher paid private work if advancement is frustrated. Lord Layard sent me a friendly acknowledgement of my letter but didn't answer any of these questions.

Having worked long ago with Isaac Marks in setting up the first psychiatric nurse therapist training schemes at the Maudsley Hospital in 1972 (Marks, Hallam, Philpott, and Connolly, 1976), I do not have any misgivings about its long-term impact on mental health services. As far as I can see, nurse-therapists have been entirely beneficial. The first course was an intensive, full-time, 18 months, hands-on training in a clinic created for people with a variety of anxiety problems, including OCD. We demonstrated results that matched the published CBT outcome literature. In the case of IAPT, a number of new sites have been rolled out quickly on an ambitious scale before it has really proved itself, and with less highly trained personnel. Consequently, I am less sure of its ultimate fate. On balance, the risk has probably been worth taking and any teething problems will be resolved. I hope so, otherwise we will have to fight to re-establish the credibility of CBT.

Clark, D. M., Layard, R., and Smithies, R. (2008). *Improving access to psychological therapy: Initial evaluation of the two demonstration sites*. LSE Centre for economic performances, Working paper No 1648. www.iapt.nhs.uk

Marks, I. M., Hallam, R. S., Philpott, R. & Connolly, J. *Behavioural psychotherapy: An advanced clinical role for nurses*. London: RCN Research Series, 1976.

Roy-Chowdhury, S. (2010). *IAPT and the death of idealism*. Clinical Psychology Forum, 208, 25-29.