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Mini Review

Ensuring IAPT Makes A Real-World Difference

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Key Messages

- Over the last decade over £3billion has been spent on the UK Government's Improving Access to Psychological Treatment programme, without any independent assessment of outcome.
- IAPT claims a 50% recovery rate but other evidence suggests that only the tip of the iceberg recover.
- Expansion of IAPT beyond its remit of depression and anxiety disorders should be halted, until it has been demonstrated that it adequately performs its' core task.

Introduction

Alarmed that less than a third (31%) of those with mental health problems were receiving treatment, Layard and Clark [1], successfully lobbied the UK Government for the provision of an Improving Access to Psychological Therapies (IAPT) service. In 2012 the influential Journal Nature claimed that the Service was 'world beating' [2]. The Service claims a 50% recovery rate and an expansion of provision to a quarter of those suffering from depression and anxiety disorders by 2020/2021 (IAPT Manual 2018) [3] with an average waiting time of less than 6 weeks for those who attended 2 or more treatment sessions [May 2019 IAPT data] [4].

No Added Value

Whilst the aims of IAPT are perfectly laudable, there is no evidence that it:

a) outperforms pre-existing services – Mullin, *et al*. 4 collected data on 11,000 patients undergoing counselling, approximately three quarters of whom suffered from depression (69.4%) or anxiety (75.1%) and half (49.5%) from interpersonal problems. The CORE-OM [5] self-report questionnaire was used to assess patients at the beginning and end of treatment and Mullin, *et al*. report that between 5 and 6 out of 10 recovered. IAPT has used different psychometric tests to evaluate the effect of treatment, the PHQ9 [6] and GAD7 [7] and cite a similar 50% recovery rate.

b) delivers a service in which patients fare any better than on a GP waiting list – Gilbody [8] looked at how GP patients with a PHQ-9 score of greater than 10 fare with usual treatment; over a four-month period, their mean PHQ-9 score reduced from 16 to 9 (the usual treatment included, antidepressants 85% and IAPT 13%; 6% had been in contact with secondary care) but this improvement is no different to the improvement made by IAPT treated clients - in the evaluation of a large stress group implemented by an IAPT service by Burns [9], the changes on the PHQ-9 were of a reduction from 16 to 10 during treatment.

c) makes a difference in patients with severe comorbid illness – Serfaty [10] compared the efficacy of CBT delivered by High Intensity IAPT therapists with treatment as usual in patients with advanced cancer and found no difference. These authors concluded that IAPT-delivered CBT should not be considered as a first-line treatment for depression in advanced cancer and that the use of such services in patients with severe comorbid illness deserved careful scrutiny.

The Need For Robust Evaluation

In the evaluation of a new drug there is an insistence on independent assessment by those without allegiance to the manufacturers. Yet blind independent assessment using a 'gold standard' diagnostic interview such as the SCID [11] has never been conducted on a sample of IAPT clients. Rather IAPT has for a decade been allowed to mark its' own homework using psychometric tests. But completion of a questionnaire for a therapist introduces demand characteristics - a wish to please therapist and to feel time has not been wasted, resulting in a possible artificial lowering of post-test scores. Further patients tend to present at their worst, often in crisis and are therefore likely to regress to the mean with the passage of time.

IAPT is A Misnomer

It says on the tin that IAPT is improving access to 'psychological therapies', but 71% of IAPT clients [12] have a low intensity intervention e.g guided self-help, as their first encounter with the service. Studies supporting the efficacy of low intensity interventions have not involved independent assessment. Psychological therapies as recommended by NICE refer to treatments that have been examined in randomised controlled trials with independent assessment of outcome in a significant proportion of studies and in which on average one in two people have recovered i.e 50% have lost their diagnostic status. These psychological therapies are not however the mainstay of IAPT's service provision. Indeed, in IAPT there is no attempt to gauge treatment fidelity, that is whether appropriate treatment targets have been identified and a matching treatment strategy deployed. In IAPT there is infinite treatment flexibility, as treatment is dictated by 'problem descriptors. But there is

no reliable diagnosis, and no fidelity to an evidence-based treatment protocol.

What Are The Results At The Coal Face?

In a paper published in the Journal of Health Psychology last year [13] I reviewed the trajectory of 90 of IAPT's clients, some of whom had treatment before a personal injury and some of whom afterwards. I assessed them using a standardised diagnostic interview, review of records and supplied IAPT documentation as part of my role as an Expert Witness to the Court for over 25 years. I found that overall the recovery rate from DSM defined disorders was less than 10% (9.2%) but there was some variation by disorder, PTSD 16.2%, depression 14.9%, disorders excluding PTSD and depression 2.2%. It made no difference to outcome whether they were treated pre or post personal injury. In this paper I also reported the overwhelmingly critical voices of the IAPT clients. The documentation reviewed also contained the following letter from a GP to IAPT:

'I was extremely worried seen last week by colleague of yours issued with a number of leaflets on managing anxiety and depression not had the motivation to read the leaflet concerned that this approach should be used to people who are already depressed and lack motivation next appointment was arranged in by telephone in 3 weeks further intervention would have been more appropriate she appears to have lost confidence in the system'.

The Journal of Health Psychology published 3 rejoinders to my paper in the same issue of the Journal, all agreed that IAPT was not the 'gold standard' and there was a pressing need for independent assessment of outcome. It can be rightly objected that such a study drawing on data furnished in a medico-legal context is far from ideal, but it was not solely reliant on the diagnostic interview but also based on GP records and furnished IAPT data. Yet clearly there is a need for an independent reliable study to replicate these findings.

The results are also open to a charge of bias but in my trilogy of Simply Effective CBT books [14] published between 2009 and 2014 I made no criticism of IAPT. It was not until 2015 that I became increasingly aware of the extent of IAPT's treatment failures and it was not until 2017 that I first voiced my findings in print [15].

The Need To Radically Transform IAPT

There are a number of pressing needs:

a) Clinical Commissioning Groups, The Care Quality Commission, the National Audit Office, NHS England, the media and patients need to be made aware that IAPT offers its' services without any independent objective assessment of its provision. Further that these bodies and patients are being misled by powerful marketing.

b) There should be an independent assessment of a sample of IAPT clients, by clinicians without allegiances using 'gold standard' diagnostic interviews. Importantly loss of diagnostic status for at least 8 weeks should be a primary outcome measure, to prevent a revolving door.

c) IAPT should not be allowed to expand its work, as it is doing to medically unexplained symptoms and long-term physical conditions until it has at least demonstrated that 50% of patients with depression and the anxiety disorders lose their diagnostic status for a period of at least 8 weeks.

d) Given the haemorrhaging of clients in IAPT, the telephone assessments should be abandoned, reliable comprehensive diagnostic interviews should be conducted and re-administered at the end of treatment.

e) Outcomes should be adopted that make sense to the patient such as no longer suffering from the disorder for an extended period of time. Point assessments using psychometric tests should be seen as an unreliable metric for discharge.

It may be that implementation of the above will result in fewer people being treated and in longer waiting lists but these operational matters should not be allowed to obscure whether the mental health services in general and IAPT in particular are making a real world difference to patients life's. IAPT has already cost over £3billion, it surely cannot be allowed to continue without appropriate independent audit?.

Contributor and sources

Dr. Michael J Scott is a Consultant Psychologist, working in Liverpool, he is the editor of a 4 Volume work on Traumatic Stress and author of 12 books on cognitive behaviour therapy and numerous papers. In both his clinical practice and work as an Expert Witness he has become aware of the effects of IAPT service on patient's lives. His findings were published in a Special Issue of the Journal of Health Psychology last year together with commentaries by three authors and a response. Dr Scott began his career working in a GP practice in Toxteth, Liverpool where he was involved in a randomised controlled trial comparing individual and group CBT to a waiting list condition, he subsequently worked at 3 other GP practices.

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Patient involvement

Patients experiences are reported in detail in 'IAPT – the Need for Radical Reform' published in the Journal of Health Psychology last year, the results of this study have fuelled this paper.

Conflicts of Interest

I have read an understood the policy on declaration of interests and can report that I have no conflict of interest.

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