

Notes on the Increasing Access to the Psychological Therapies Programme

*'Don't it always seem to go that you don't know what you've got til it's gone'
Joni Mitchell*

Under the new Government mental health strategy (through D of H/NHS) for providing greater access to the psychological therapies there will be a massive explosion in training for therapists to offer cognitive behavioural therapy (CBT). As we are being constantly reminded, this is due to National Institute of Health and Clinical Excellence (NICE) guidelines for treatment of common mental health disorders like depression and anxiety. Although this may all be done with the very best of intentions, there are some serious anomalies and challenges for therapists not of the disorder/treatment persuasion. Most people will have noticed by now that the term 'Increasing Access to the Psychological Therapies' (IAPT) is, in fact, a misnomer. Although clearly written in the **plural** (implying inclusively) it actually privileges just one type of therapy. It would be more accurately defined as, 'Increasing Access to the Psychological Therapy', in the singular, or even IACBT. Instead of providing access to the rich diversity of psychotherapeutic practice available in the UK, as many of us might have imagined, the public will be denied this potentially rich resource of experienced and skilled support. The paradox is that something which initially was conceived as a response to satisfy the public's demand for alternatives to drug treatment and more access to the talking therapies, in practice actually restricts access. Many questions arise: how has the CBT model managed to create a situation of virtual monopoly over the IAPT programme? What is the background to this and if it continues, what will be some of the possible ramifications?

We believe that many person-centred practitioners may already be suffering from a kind of 'culture shock'; sensing that a crisis is occurring but unsure how to respond. Some of us may be feeling confused and disorientated - struggling to make sense of the changes going on around us. We may also be feeling ignored, excluded and alienated from the IAPT process, waiting like disinterested bystanders – detached from the whole thing and hoping for some common sense to prevail. This lack of overt dissent may well disguise a deep dissatisfaction, frustration and loss of confidence, despite the appeals to the impartiality of 'science' and 'evidence', with a process that many regard with growing suspicion and cynicism. It is hard for committed and responsible people to understand the convoluted nature of the IAPT process that seems for many of us to defy common sense explanations. The result is that we have an absurd situation that we are planning (at huge expense) to train thousands of therapists to deliver exclusively CBT, when there are probably tens of thousands of highly skilled counsellors and therapists, experienced at encountering and helping clients with difficulties concerning depression and anxiety, who are under-employed at present. Lewis Carroll couldn't have come up with anything more surreal. There are so many carts pulling horses that we might need to employ a team of carpenters and vets as an integral part of the IAPT. All this may be resulting in a distinctly unhealthy and risky disconnection for the profession and one which could have very unpredictable outcomes.

We feel that that from the outset the IAPT programme will be hobbled due to its almost exclusive reliance on CBT as the principle therapy mode with its unquestioning obedience to the ‘authority’ of the medical model. While at one level giving unprecedented access to the talking therapies, it will simultaneously deny the public its right to have any say in the choice of therapy it receives. That decision has already been made by the infallibility and impartial authority of the NICE. There seems to be no ‘Plan B’ if clients are dissatisfied with their CBT experience. With all the eggs in the CBT basket, many clients are being set up to fail; what provision, for instance, will be made for those who don’t like or can’t get on with CBT? What we could be doing here of course is something really radical (but apparently unthinkable) – like consulting with and educating the public as to the range of talking therapies that are available, instead of continuing to treat them like passive ‘patients’. Although it might seem like a matter of semantics, the shift from patient to client could be the beginning of the real empowerment process. However, by safely choosing to ‘stay in the box’ and continuing to view therapy as a form of **treatment** we are fatally narrowing our options. Also, by relying totally on medical model explanations, thereby avoiding differing interpretations of the nature of depression and anxiety, we will miss a perfect opportunity to really empower **clients**. Unfortunately by pretending that CBT is the only reliable or effective therapy, clients will be unjustifiably denied access to the full range of therapies. In this way sadly we are creating, perhaps unwittingly, a subtle form of disempowerment.

With the announcement of the IAPT programme, this should be a time of celebration for all the psychological therapies: an inclusive vote of confidence with everyone something valuable to contribute. This kind of recognition by the state is something that we as a collective (voluntary and unrecognised often) have been working towards for a long time. Over the years the public have been able to access a **range** of talking therapies through GP surgeries and charities like the local MIND network, innumerable other specialist and generic voluntary projects and so on. All of which have made a huge contribution to the nation’s overall mental health, and that’s partly why the public are demanding more. We could now be on the threshold of something really exciting and imaginative: a new vision for mental health. It is highly significant that the IAPT represents a move away from the reliance on medication and more invasive forms of treatment and has the potential to be so positive. Perhaps because we sense that this really is a historic opportunity to do something quite radical and it’s being wasted. At a time when the role of drugs in mental healthcare is being increasingly questioned and exposed, we are still choosing the security of ‘staying so safely’ in the box’ of the dominant medical model paradigm. We just can’t seem to take that risk of trying to think in a different way. It’s like our dependence on fossil fuels – when the oil runs out we’ve still got gas. We get trapped in a mind-set with no thought of exploring the role of renewables. This is part of the tragedy – what is being touted as the new Enlightenment is actually nothing of the sort. By opting so exclusively for medical model-based therapies the public is effectively being denied any contact with person-centred, humanistic and other relationally-based alternatives. Rachael Freeth puts it well:

‘I find it difficult to see how psychological therapy that is delivered through care pathways and protocols, and that has essentially become a commodity to be bought and sold in the competitive healthcare market place, can really effect the desperately needed healing of the deeper psycho-spiritual ills of our age. At present it seems that we are way off convincing the government and policy makers

that it is vital for there to be relational therapies as very much a part of the range of psychological therapies provided within healthcare services.’ 1

For the proponents of CBT the current situation must seem like a merited vindication of their efforts and position. For many others however this situation is highly problematic. We want to be careful here to separate the valuable role played by CBT in many instances, where it may well be appropriate for the needs of some clients. What we want to challenge is the **dominance** of CBT under the present arrangements for delivery of the IAPT scheme. Clearly CBT has a key role to play within the multiplicity of approaches to mental suffering. However this is not an argument to justify the dominance of CBT or for that matter any other single modality. One of the most serious consequences is that the massive expansion and promotion of CBT (under IAPT) will result in the strengthening of hegemony for the medical model, with its reliance on the psychopathology – diagnosis – treatment model. This will create the illusion (based on ‘evidence’) that this is the best of what is available and will obscure the existence of other viable models, with their alternative views of human nature and the human condition. Also, we believe that this will create a distorted **perception** that exaggerates the role of CBT and misrepresents the wide diversity of practice available within the therapy field. Government endorsement of CBT through NICE is a very powerful form of approval and has serious and far-reaching implications. It results in the **privileging** of one form over the rest - an implied superiority of one over all the others. This subtle process effectively ignores and silences oppositional voices by making invalid, irrelevant or rendering invisible all other legitimate therapy forms. By dominating the intellectual space it’s as though they no longer matter or have ceased to exist. It is difficult to avoid the conclusion that we are dealing here with the role played by politics and ideology in the creation of a virtual **monopoly** of interest and power. It is also difficult not to conclude that this is primarily an assertion of economic and business interests in controlling the market. From a political perspective it is not hard to spot dominant and subordinate discourses in operation. The dominant discourse seeking to justify or strengthen its position of advantage while at the same time marginalising voices of dissent. We feel strongly that the IAPT in its current manifestation represents a very serious threat to the legitimacy and viability of other therapy forms.

Concluding comments

We believe that it is vital to resist this process in order to preserve and protect the space for models like person-centred therapy, with their emphasis on actualisation, emancipation and authenticity which offer an alternative to pathologising, problem or solution oriented therapies, to survive. We know now from an ecological perspective how much diversity matters. Examples from nature remind us that when for example the rainforest is cut down and replaced by monoculture/agriculture then soon a desert

begins to form where once there was life. The failure to understand and appreciate the rich diversity of living systems and their complex interdependence and the amount of life they support inexorably leads to impoverishment and ruin. Forest clearance can be justified by short-term expediency and limited economic gain for a few; the longer-term result nevertheless is catastrophic. Once it's gone, it may be lost forever.

By agreeing to take up a post under the IAPT model within the NHS, one will be required to sign a contract to deliver the NICE guidelines. In doing this, we may risk compromising something that many of us consider at the heart and soul of therapy. That is, a view of the person-centred view of each unique being as capable of self directing towards greater integration and socialisation. An institutionalised model of stepped care is in no way an approach to helping people with varying needs and of varying complexity that sits within an alternative humanistic paradigm. Signing up for this will become a non-negotiable fact for workers on the front line of therapy provision. Participation in therapeutic work will only be tolerated if it involves the delivery of the NICE recommended/CBT treatment approach. There is no argument over this, the logic makes it clear that other approaches will not be tolerated and that, we argue is too great a compromise. To surrender or even abandon what we know works and is demonstrated through evidence based practice will only continue to add weight to the forces pushing for the expansion of the medicalisation of distress. What about the client-centred principles of growth, actualisation, emancipation from and through distress? Are these not valid outcomes and objectives of therapeutic endeavour?

We have expressed our concerns over the current move towards reducing choice for clients receiving therapy in primary care. The dominant position of CBT under the IAPT programme is in our view putting person-centred, humanistic and other psychotherapeutic approaches at a serious disadvantage. The medicalisation of distress, the commodification of therapy, the hierarchical nature of IAPT and the model of stepped care within which it is embedded is simply misleading clients into the false belief that they have an elevated chance of being treated into better health. We make the call here to join together in making a strategic and organised counter position against the current tide.

1 Rachel Freeth article '**The medical model**' in therapy today. November, 2007.

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