Medical approaches to suffering are limited, so why critique IAPT from the same ideology.

**Abstract**

Although Scott (2018) rightly questions the dynamics of the IAPT system and re-examines the recovery rates, finding quite shocking results, his recommendations are ultimately flawed. There is a strong critique of the diagnostic procedures in IAPT services, but the answer is not to diagnose more rigorously and to adhere more strictly to a manualised approach to psychotherapy. The opposite maybe required. Alternatives to the medical model of distress offer a less stigmatising and more human approach to helping people with their problems. Perhaps psychological therapists and the people they work alongside would be better served by a psychological approach rather than a psychiatric one.

**Main text**

Scott (2018) offers a re-examination of IAPT data obtained through General Practitioners (GPs) and offers his own expertise as a diagnostician as part of his role as an expert witness. He finds that the recovery rates in his sample are far below the statistics published nationally by the NHS. The data and outcomes provided in the study are both interesting and appalling at the same time; recovery rates of 23% in those that ‘complete’ therapy is simply not acceptable. Furthermore, Scott (2018) puts forward that even those that do complete therapy only 19.1% have had a therapeutic course of therapy (more than eight sessions). When all referrals to IAPT are considered the percentage of people meeting ‘recovery’ at discharge falls to 12%. In collecting his own data by assessing in a heavily medical manner Scott (2018) suggests that only 9.2% no longer meet diagnostic criteria at the end of IAPT treatment.

Scott (2018) obtained data from GPs rather than accessing the IAPT services electronic clinical records. Not all people want their GP informed of their contact with mental health services, which is one reason why most IAPT services offer a self-referral service. In addition, given the high volume of work services often do not prioritise discharge summaries; both these reasons may help explain why Scott’s (2018) sample only consisted of 29 people with pre and post outcome measurement.

Scott (2018) strongly adheres to a medical model of mental distress, and advocates that this approach should be expanded throughout IAPT services. He puts forward the recommendation that senior members of staff should be the first point of access and that they should use a structured clinical interview to correctly diagnose people’s presenting problems. He goes further and states that to decrease staff dissatisfaction and burnout that supervision should be focused on fidelity to a manualised version of cognitive behavioural therapy (CBT).

Although alarming, the statistics provided by Scott (2018) do contain several methodological issues and as such the findings cannot be generalised. Rather than directly focusing on these issues; it is assumed that other commentaries will take this approach, this commentary will adopt a wider approach based on the underlying ideology underpinning Scott’s (2018) critique of IAPT services.

In some ways I applaud the way in which fire has been fought with fire; in that Scott (2018) employs a diagnostic perspective on distress to challenge a system that claims a similar ideology. I also echo some of his thinking and decision making. I agree that having staff that are ill equipped in mental health assessment being the ones that conduct the brief, telephone assessments is not the way forward (see Binnie (2015) for further critique). However, apart from the notion that tighter or more dictatorial supervision is probably not the best way to reduce staff burnout, it is the staunch reliance on a medical or disease approach towards people’s suffering that I have the most difficulty with.

It has been put forward that the current psychiatric diagnostic paradigm has failed (Boyle and Johnstone, 2014); despite best attempts no biomarkers have been found (Kupfer, 2013); and issues of validity and reliability have been challenged consistently over the years (Kutchins and Kirk, 1999; Bentall, 2003). There are alternatives to the medical or disease model; rather than labelling and stigmatising people, basing services and therapies on people’s experiences enhances the role of conceptualising or formulating their difficulties and distress (BPS, 2000). This move away from a medical perspective and towards an experience based approach has recently been expertly reinvigorated with the publication of the Power, Threat, Meaning framework (Johnstone and Boyle, 2018). It is too early to tell if this new framework will be successful, but if services that are based on psychiatric diagnosis like IAPT are to be challenged then these challenges should be drawn from an opposing ideology, not by recommending that such services become more medical in their approach.

It may seem that criticising the psychiatric diagnostic system is merely an academic or conceptual pursuit. However, there are many real-world implications of the medical approach to distress and therapies, several of which are contained within Scott (2018). One is expressed in the sentence “clients could easily have a personality disorder for which their clinicians are neither trained to identify nor treat”. This implies that people have a personality disorder, that it is real, like a disease, not just a description of complex emotions and behaviours. It also implies that you shouldn’t go near these people unless you know how to recognise the disease and know how to ‘treat’ it. All that this can lead to is the further discrimination of people that have this unhelpful label applied to them and increases service level resistance to working with people rather than for their diagnosis. In reality, IAPT services do have to work with people that have complex and enduring problems, but rather than exclude them, services should be inclusive and offer additional training and supervision to staff members.

Scott (2018) perpetuates the idea that there are ‘off the shelf’ or manualised treatments that can be strictly applied when working with people. The statement “competence without adherence is meaningless” is not only discourteous to practitioners with a different mindset but also negates the existence of other more transdiagnostic ways of working. It is perfectly possible to be a competent cognitive behavioural therapist and at the same time eschew a reductionist, medical approach. As a supervisor I would not say that my prime function is the blind adherence to the propagation of evidence-based ‘treatments’; my prime function is to the needs of the supervisee and through them the needs of the people they serve.

Given the difficulties associated with non-attendance and drop out (see Binnie and Boden (2016) for a review) increasing the practice of administering the SCID at first contact is not advisable. Scott (2018) puts forward that “a standardised interview such as the SCID ensures that a clinician is looking for disorders so that nothing is overlooked”, however, by adopting this medicalising and formal approach it is likely that the human contact and relationship building so vital to all models of psychotherapy will be overlooked. People in distress and seeking help want to be heard and supported rather than formally interviewed.

Moving the narrative back to pragmatics it can be put forward that Scott’s (2018) recommendations although applaudable, are ultimately impractical given the financial restrictions on clinical practice. For one in five people referred to IAPT to have a standardised semi-structured interview (i.e. the SCID) administered by a senior therapist is not cost effective and/or would lead to bottle necks in the system. Given the paucity of information given at referral how this allocation of resources would be met is virtually impossible.

In conclusion, Scott (2018) is right to critique and re-evaluate IAPT. He has attempted to play them at their own game by challenging their ability to diagnose and has recommended that IAPT should put greater resources into a system based on the medical model. However, this isn’t a game worth playing, often by responding with like for like you give your opponent a platform, you give them gravitas. As psychological therapists and researchers we should not be promoting a psychiatric ideology. Other challenges from a non-medical perspective are far more likely to lead to change and hopefully create IAPT services that everyone can be proud of and, if required, would be extremely likely to recommend to friends and family.

The Author declareS that there is no conflict of interest

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