

## **Our Big Fat Multi-Million Pound Psychology Experiment**

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NOTE: this paper is one of two submitted by the Midlands Psychology Group, in response to an invitation to comment on a summary of initial findings from the Doncaster trial of the Improving Access to Psychological Therapy demonstration. For the other paper, see:

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Contact:

[Midlands.Psychology.Group@hotmail.co.uk](mailto:Midlands.Psychology.Group@hotmail.co.uk)

Website:

<http://www.midpsy.freeuk.com/>

## **Our Big Fat Multi-Million Pound Psychology Experiment**

‘The ‘Improving Access to Psychological Therapies’ [IAPT] Programme is a multi-million pound effort to test the Layard hypothesis’, (Richards & Suckling, in this issue).

### **Who are the participants?**

In making their case for the IAPT experiment, Richards & Suckling and the Centre for Economic Performance (2006) quote the ‘respected’ Psychiatric Morbidity Survey to outline the scale of mental health problems: one in six of us would be diagnosed as having depression or chronic anxiety disorder (CEP, 2006); and anxiety and depression constitute about 97% of the total prevalence of mental health disorders (Richards & Suckling).

In a previous survey (Office of National Statistics, 2000) the prevalence of ‘neurotic disorder’ was calculated on the basis of lay interviews. Neurotic disorders were assessed by first stage interviews, carried out by ONS interviewers who had been on a one-day course of ‘survey-specific training’ (p.10). Psychosis and personality disorder, on the other hand, were assessed by second stage interviews, carried out by ‘specially trained psychologists’ (p.9). The report goes on to caution that ‘lay interviewer administered measures tend to provide higher prevalence rates for disorders than those that are clinician administered’ (p.13).

The question of who the participants are in the IAPT experiment is never clearly explained. Richards & Suckling specify 'mild to moderate depression and anxiety'; the CEP refers to 'crippling depression and chronic anxiety' (p.1). Elsewhere we are told IAPT is about providing services to 'people with 'common' mental health problems such as anxiety and depression' (CSIP, 2007a). This problem and its relationship with NICE guidelines is explored in an editorial in the British Medical Journal: 'People with mild to moderate depression or the associated mixed anxiety and depressive disorders constitute most of those whose care might be influenced by [NICE] guidelines... These are mostly subthreshold disorders where identifying the presenting difficulty as a treatable pathology may be inappropriate', Middleton, Shaw & Feder (2005, p.267).

NICE also acknowledges in its Guidelines for Depression: 'the most significant limitation [with the evidence base] is with the concept of depression itself. The view of the Guideline Development Group, is that it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans' (p.10, NICE 2007). It is interesting but also worrying, that services plan to implement recommendations that NICE suggests have limited validity.

### **Psychological therapy as the independent variable**

Let's pretend that there are illnesses called depression and anxiety. Let's pretend that our participants are people diagnosed with mild to moderate depression and anxiety, that they have all been diagnosed with the same screening tool by the same expert psychiatrist. We

are now planning to increase the psychological therapy available to these people in order to increase wellbeing and decrease incapacity benefit payments.

In our experiment, the independent variable is the psychological therapy. But do we mean psychological therapy *wholesale*, or one psychological therapy in particular? Most people working in mental health services are aware that NICE recommends CBT for both depression and anxiety. However, there are problems with the NICE guidelines: '[There are] significant limitations to the current evidence base... These include very limited data on both long-term outcomes for most, if not all, interventions... In part, these limitations arise from the problems associated with the randomized control trial methodology for all interventions...' (NICE, 2007, p.10). Middleton, Shaw & Feder (2005) offer further appraisal of the evidence base: '[The] contrast between clear evidence based recommendations for the management of severe depression and uncertainty, because of poorer evidence, about the management of mild or moderate depression is the central weakness of the guidelines... Until research has established who is likely to benefit from active treatment, practitioners will continue to be tempted to respond to requests for help by allowing such negotiations to result in a medical diagnosis. This may satisfy the practitioner's desire to do something and the patient's search for help. What it does not do is reflect the evidence base', (p.267).

### **CBT as the independent variable**

Let's pretend that the NICE guidelines are in fact conclusive and that we can say with certainty that CBT does indeed substantially increase well-being over the long-term, and

helps people back into work. Which type of CBT shall we choose? The NICE authors, McIntosh, Cohen, Turnbull, Esmonde et al (2004) explain that: ‘The nature of psychological therapies [has] (sic) changed and what was described in the 1970s as cognitive behavioural therapy and that described in the 1980s and onwards, may have been describing quite different interventions’ (p.45). Indeed, far from CBT being a standardized, distinct technique, Tarrier, Haddock, Barrowclough, & Wykes (2002) suggest that in practice, CBT may actually be indistinguishable from ‘interpersonal psychotherapy’ which is informed by a very different theoretical viewpoint.

At the Doncaster Demonstration Site, guided by NICE recommendations, they have specifically chosen low and high-intensity variants of cognitive behavioural therapy, under the framework of the stepped care model. Richards & Suckling explain the difference between high and low intensity variants as follows: ‘High-intensity treatments usually involve considerable therapist input akin to traditional therapy models. In contrast, low-intensity treatments emphasise patient self-management with much less contact between mental health workers and patients, for example by the use of guided self-help’.

NICE also specifies that ‘Healthcare professionals providing psychological treatment should be experienced in the treatment of the disorder and competent in the delivery of the treatment provided’ (p.19). This is echoed in the Depression Report: ‘Therapy is not like anti-depressants; it differs according to who provides it. We know how well it can work if it is provided by properly qualified people, and most studies suggest it is much

less effective if given by less qualified people' (CEP, 2006, p.8). However, this may be at odds with Professor Richards' own vision of depression management in primary care, which involves developing teaching for new non-professionally affiliated mental health workers.

### **Stepped care and collaborative care as independent variables**

Let's pretend that we are clear about exactly what sort of CBT we are providing, exactly how long it is going to last, and that we can be sure that this is provided in exactly the same way each time and that our CBT is therefore both reliable and valid.

But perhaps the independent variable is not psychological therapy, or CBT, but rather *access* to psychological therapy, or perhaps *delivery* of psychological therapy. Richards & Suckling assert that these are important aspects influencing the success or otherwise of psychological therapies: 'Although the evidence for the efficacy of some psychological therapies is strong, the evidence for their organisation is less so'. The IAPT expert reference group (ERG) 'made the pragmatic recommendation that the stepped care approach... should be used' (CSIP, 2007b). However, Richards & Suckling acknowledge that, 'Although based on the common sense proposition that it is as harmful to over-treat as under-treat common mental health disorders, NICE guidelines provide little evidence to support the implementation of stepped care'.

In order to test out different models of access to and provision of psychological therapies, the Doncaster and Newham sites have specifically, 'adopted different operating

principles: the London site a specialist ‘replacement/referral’ model familiar to specialist mental health services; the Doncaster site a ‘collaborative care’ model more common in the US and in UK primary care’ (Richards & Suckling). We are being asked to ultimately draw conclusions and make comparisons about the effectiveness (and efficiency) of stepped/collaborative care vs replacement/referral models of care, before we’ve even got any definitive answers about the effectiveness of CBT or other psychological therapies. It is difficult to see how we can draw any conclusions about the Doncaster Site experiment, when there are so many variables at play.

### **The Doncaster Demonstration Site as a case study**

Tarrier, Haddock, Barrowclough, & Wykes (2002) are highly critical of the use of anything other than randomised control trials to evaluate the efficacy of psychological therapies. They argue that ‘the RCT is the primary source of evidence for the efficacy and effectiveness of any treatment.’ Furthermore, they highlight the methodological problems in evaluating any therapy and how non-specific factors, such as a therapist’s theoretical orientation, can have a greater effect on therapeutic outcome than the specific therapeutic techniques themselves.

Let’s pretend, then, that this is not an experiment to test the Layard hypothesis. We are, instead, conducting a case study of the Doncaster Site, to look at what happens when psychological therapy is made more widely available. Indeed, a team from the Sheffield, led by Professor Glenys Parry, has been awarded a contract to evaluate these pilots by the NHS National Collaborating Centre for Service Delivery and Organisation. Funding for

this study started on 1<sup>st</sup> December 2006 and will last for three years. A draft evaluation report will be written in the final year (2009), to allow stakeholders to comment. The final report will be published in conjunction with the SDO in 2010.

Let's pretend that we actually know the results of our study already and that it has been so successful that we now feel in a position to expand on these developments. Actually, we don't need to pretend because CSIP is pretending on our behalf. On 10 May 2007, CSIP published its plans for the next stages of IAPT. They report: 'It is important that we build on the success of the demonstration sites and continue to develop our evidence base. To address this, the Department now seeks to extend the scope and range of the IAPT programme in 2007/08 to support the case for further service expansion by demonstrating that the benefits of the new service can be replicated across the country' (CSIP, 2007c, p.7).

Let's pretend...

Actually, let's stop pretending.

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