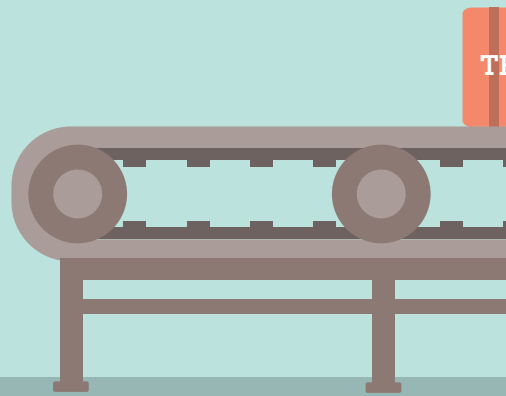
WORKING IN THE THERAPY FACTORY

THE IAPT MODEL DOMINATES MENTAL HEALTH SERVICES IN ENGLAND. *ELIZABETH COTTON* ARGUES THAT THE MODEL IS FLAWED AND DOWNGRADES THERAPY



The Industrialisation of Care[1] was published in June 2019 and forms part of the emerging critical literature that explores the industrial and political implications of England's largest mental health programme – Improving Access to Psychological Therapies (IAPT). The contributors to the book, of which I am one, argue that this model of a mental health service is based on internal resistance. When the entire talking therapies system has been moved towards an IAPT model, with a shrinking independent psychotherapeutic sector and limited sustainability of private practice, securing paid work as a counsellor is largely dependent on an acceptance of the IAPT model, whatever your views as a practitioner.

'There is a growing call for an inquiry into IAPT carried out by service users and their families'

a strategic downgrading of therapy, which is dangerous both for therapists and clients, exposing our real mental health crisis.

IAPT is one of the most quickly expanding sources of employment in the mental health sector. Other sources of paid employment, both inside and outside the NHS, are correspondingly drying up, which might go some way to explain the fear among clinicians of raising their concerns about the impact of the IAPT model on patient care. It might also explain why the IAPT model has been introduced without much

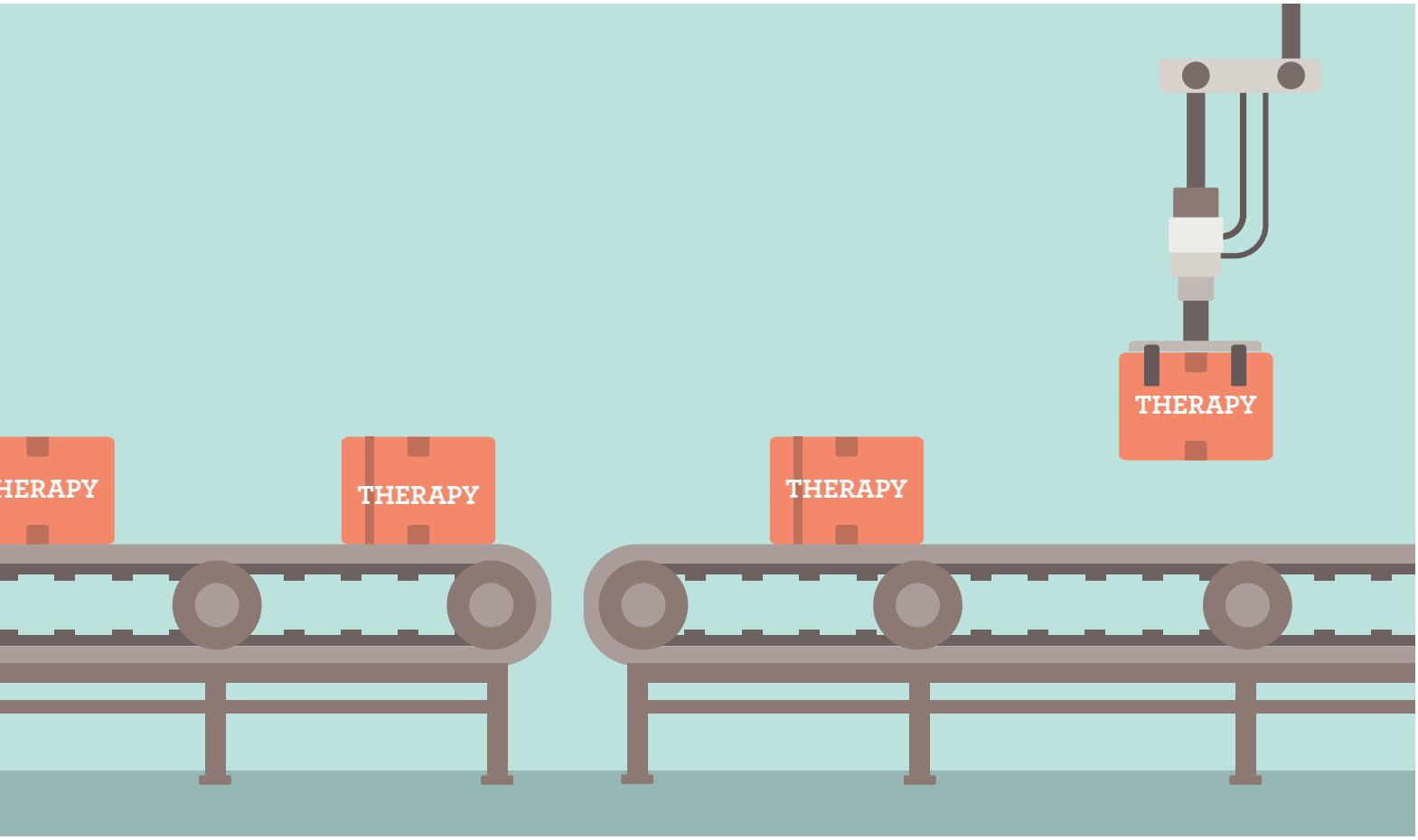
This is not to denigrate the work of people involved in IAPT, the vast majority of whom are qualified and experienced, providing what care they can. IAPT services are also diverse, with often heroic efforts by IAPT teams to protect the principles on which real care is based. But increasingly, whether you work in IAPT or not, this model of mental health dominates across services.

The IAPT model was introduced by the UK Government as a strategic attempt to cut the cost to the UK economy and the benefits bill.[2] If you combine the statistic that 50 per cent of disability benefits are paid on the basis of mental illness[3] with IAPT's claims of 50 per cent recovery rates, it explains, in my view, why IAPT has such political traction in the age of austerity.

The creation of an 'evidence' base for the IAPT model has caused the wholesale downgrading of therapy, such that services can employ people who are not clinically trained,[4] many of whom are working online. In my opinion, the introduction of IAPT has led to a standardisation and manualisation of services. A so-called 'uberisation' of mental health is therefore about to take place, which makes the sector vulnerable to the large-scale digitisation of therapy, both as a modality and as a condition of work.[5]

The IAPT programme provides short-term, results-oriented, cognitive behavioural therapy and has been introduced as a 'talking therapy' that efficiently addresses individual psychological states. The 'evidence' base for its effectiveness has been established through the widespread use of performance data, drawn from a system that has itself become highly contested, in terms of both the relevance of what it measures (such as waiting times) and the accuracy of its claims (such as a 50 per cent recovery rate).[6]

The IAPT model is based on a system of patient assessments that use tightly scripted



questionnaires, allowing only minimal freedom of discussion between therapist and patient. Though most service users have complex needs, the superficiality of the assessment and performance data collection process enables clinicians to refer them to short-term interventions that are not, for example, designed to treat depression. Clinicians can also make claims about recovery that do not relate to the actual mental health problems of service users.

The economic argument for rolling out the IAPT model has prevailed across the UK's mental health policy because of the relatively low cost of IAPT services, compared with long-term talking therapies and specialist services that require experienced clinicians. Although campaigners legitimately argue that the financial case for IAPT has excluded any consideration of the real costs to the UK economy of not treating mental illness adequately, including costs to acute, police and prison services, the direct costs of IAPT have dominated the debates about how to provide mental health services. As a result, despite the genuine concerns about the ethics and quality of care provided through IAPT that have been expressed by service users, particularly many disability and mental health networks, this downgraded model of 'talking therapy' now dominates across the UK's mental health service.

A strategic consequence of IAPT has been to enable the opening up of the mental health sector to private, third-sector and non-clinical providers. Every week, new contracts and digital services are commissioned in healthcare, with an increasing emphasis on wellbeing and mental health interventions.[5]

The delivery of the new welfare programmes has been carried out almost exclusively by large, private contractors; the majority of assessments have been performed by staff who do not hold senior qualifications or who are not clinically trained. The 'new' mental health jobs created in these programmes do not require clinicians[6] and, in my view, this workforce strategy represents a clear move towards generic and non-clinical jobs in the sector.

Much is now being made of digital healthcare, including grand claims for digiceuticals and the use of app technologies to measure health levels, including mental health. Digital healthcare has also been supported by successive health ministries. The benefits of this technological alternative to complex long-term treatments provided by clinicians are, in my view, empirically exaggerated,[7] but they are heavily supported by the normative logic of austerity on which decisions about mental health are based.

'IAPT has led to a standardisation and manualisation of services'

We are now entering a period where the large, digital health companies are about to make a lot of money. Many are developing healthcare products that ride the wave of 'solutionism' of government policy by providing services that are mechanised, scripted and online. The emergence of digiceuticals and digital therapeutics as a model offers digital 'treatment', based on software and clinically trialled 'evidence', and prescriptions, without face-to-face contact with a clinician. The second part of the uberisation of therapy relates to the dramatic growth in online platforms in healthcare. Platform companies, made up of software and databases of workers and clients, often providing services online, are

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the big employers of the future. In a way, this is nothing new – just agency work, carried out and managed digitally. But the issue is the scale and speed at which platforms can become providers of services. The reasons why online platforms are so effective at recruiting workers and clients are the size of their databases and the click-natured simplicity of accessing services. No waiting lists, no more 'inconvenience' of actual face-to-face contact.

The advent of platform companies represents a key component of work in the gig economy, where workers are hired by a platform, on self-employed contracts, to carry out hourly paid or pay-per-product tasks. In general practice, consultations are routinely offered online through such platforms and it is now happening in therapy.

The uberisation of therapy is a version of digital Taylorism – a standardised and manualised model that reduces complex work to small, simple tasks. There are some striking similarities between Briken and Taylors' study of Amazon workers[8] and the mental health profession: work intensification, standardised tasks with no deviation, algorithmic control of work and the collection of personal data of both workers and clients. If you can downgrade the task, you can downgrade the job and with it the mental health budget.

The uberisation of therapy, in my view, is not about care, it's about money. I believe we have spent too long in mental health acting as if we're living in a 17th century French court, worrying about the minutiae of independent practice and wheeling out the return on investment of decent therapy. None of this, in my opinion, was of any interest to the major and future providers of care and has subsequently failed to gain any political traction.

Mental health workers are left walking a thin line of professional and personal ethics. In my experience, most will only talk about their concerns if offered a confidential space, for fear of victimisation and job loss. Although many IAPT workers will attempt to deliver the best care they can, they do this despite working with an IAPT model, not because of it. But increasingly, as public opinion starts to move against IAPT, we have to work towards change – both to challenge the current model and to build alliances across the sector to form alternative models of care. As the 2019 Mental Health Crisis Summit revealed, there is a growing call for an inquiry into IAPT carried out by service users and their families.[9] It is on the basis of this new political fault line that mental health workers now need to take a position.

Despite a number of recent mental health inquiries and workforce reviews, there has yet to be any genuine engagement with the emerging crisis in the sector. Given the almost universal criticism of the direction of mental health services on the part of clinicians and service users, the question has to be asked: who benefits from the uncritical continuation and expansion of the IAPT model?

***Elizabeth Cotton** is a reader at the University of Hertfordshire, specialising in employment relations and mental health at work. Elizabeth has worked as an honorary psychotherapist in the NHS and is the founder of www.survivingwork.org and survivingworkinhealth.org*

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