

# The UK NHS Talking Therapies Fantasy

## La Fantasía de las Terapias Conversacionales del NHS en Reino Unido

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### Abstract

In February 2023, the English program "Improving Access to Psychological Therapies" (IAPT) was rebranded as "NHS Talking Therapies", although this change did not translate into substantial improvements indicating an advancement in service quality. The primary purpose of this article is to critically assess the myths perpetuated by the IAPT (now NHS Talking Therapies). Despite the striking marketing campaign of NHS Talking Therapies, it does not appear to have succeeded in reducing the burden of mental health in the United Kingdom. The service has claimed to be merely a conduit for providing protocols endorsed by the National Institute for Health and Care Excellence. IAPT is sustained through a series of myths that are refuted and extensively discussed. Without using criteria to determine whether a psychological treatment is empirically supported, countries are likely to fall prey to well-marketed pharmacological or psychological interventions. Furthermore, without such controls, service providers are licensed to squander money, sidelining the needs of the population.

**Keywords:** Improving Access to Psychological Therapies, outcomes, National Institute of Health and Care Excellence, public health, psychological treatment.

### Resumen

En febrero de 2023, el programa del *National Health System* (NHS) inglés *Improving Access to Psychological Therapies* (IAPT) fue rebautizado como *NHS Talking Therapies*, aunque este cambio no se tradujo en mejoras sustanciales que indiquen un avance en la calidad del servicio. El propósito fundamental de este artículo es realizar una evaluación crítica de los mitos perpetuados por el IAPT (ahora NHS Talking Therapies). A pesar de la sorprendente campaña de marketing de NHS Talking Therapies, no parece haberse logrado reducir la carga de salud mental en el Reino Unido. El programa se ha confirmado como un mero canal en la aplicación de protocolos respaldados por el *National Institute for Health and Care Excellence*, que se sostienen a través de una serie de mitos ampliamente discutidos y refutados en este trabajo. Sin utilizar criterios claros para determinar si un tratamiento psicológico está apoyado empíricamente, es probable que los países caigan presa de intervenciones farmacológicas o psicológicas bien comercializadas. Ante tal ausencia de control, los proveedores de servicios de salud tendrían licencia para malgastar el dinero, dejando las necesidades de la población en segundo plano.

**Palabras clave:** Improving Access to Psychological Therapies, Resultados, National Institute of Health and Care Excellence, Salud Pública, Tratamiento Psicológico.

In February 2023 the English, Improving Access to Psychological Therapies (IAPT) programme was re-branded NHS Talking Therapies. But, without any change in its' 15 year, *modus operandi*, suggesting all may not be well. It was hailed as a "world beater" in the influential journal *Nature* in 2012 (p. 474) and it has become a reference point for countries around the globe, concerned to improve their mental health services. But there has been no publicly funded independent evaluation, despite spending £1.75 billion in the year 2021-2022 on the service for adults, children and adolescents. The Service relates to provision in England alone, Scotland, Northern Ireland and Wales have their own mental health systems.

In this paper I will critically appraise the myths perpetuated by the Service. The marketing of NHS Talking Therapies has been truly astounding. From the outset leading politicians from all parties have been taken on board. The Service has claimed to be simply a conduit for the National Institute for Health and Care Excellence (NICE) protocols, with its' luminaries and fellow travellers moving freely between the NHS, the British Psychological Society (BPS) and the British Association for Behavioural and Cognitive Psychotherapy (BABCP). The Service has been maintained by a series of myths which I will proceed to rebut. I addressed some of them in a paper in the *British Journal of Clinical Psychology* in 2021. There has been no published rebuttal and I welcome this opportunity to update and extend my critique here.

### **Myth 1 It's a World Beater**

One *New York Times* article described it as "the world's most ambitious effort to treat depression, anxiety and other common mental illnesses" (Carey, 2017). An editorial in the journal *Nature* (2012) asserted that IAPT "represents a world-beating standard thanks to the scale of its implementation and the validation of its treatments" (p. 473). According to the UK Adult Psychiatric Morbidity Survey 2014 (McManus et al., 2016), the incidence of common mental disorders has increased since 2007 (a year before the inception of IAPT).

Whilst the proportion of suicide attempts has remained static over this period. At face value the Service has not it seems reduced the mental health burden in the community.

There are no published international comparisons of the effectiveness of psychological therapy. However, absence of evidence does not mean that there might not be a real-world difference between the effectiveness of NHS Talking Therapies and those delivered in Spain and other countries. Nevertheless, the starting point, has to be, the null hypothesis, that there is no significant difference. The burden of proof is on those who would claim an important difference. If the added value of NHS Talking Therapies was put before the Court of psychologists, it would not clear the evidential bar of being true 'beyond reasonable doubt', and it is doubtful that it would clear the lower threshold of being true 'on the balance of probability'.

The Court is likely to be confused/suspicious of a change of terminology. Originally the UK Service was focussed on the provision of 'psychological therapy' but in its' new incarnation 'talking therapies' are promulgated. Psychological therapies are, arguably, based on a unique knowledge base of 'What Works For Whom?' but what is the supposed knowledge base of 'talking-therapies'?. A fairly tightly defined term, 'psychological therapy' (disorder specific treatment protocols, involving matching treatment targets and interventions) has been replaced by a 'fuzzy', 'talking- therapies'. The Judge might wonder whether his/her conversation with a colleague in the cafeteria the previous day constituted a 'talking therapy'. She/he might muse whether there is a hidden agenda to obfuscate matters.

### **Myth 2 50% Recovery Rate**

In the same month as IAPT's name change, the UK National Audit Office (NAO) repeated the Services mantra of a 50% recovery rate, for those who attend two or more treatment sessions. Whilst acknowledging, without comment, that only 50% complete 'treatment'. The take home message from the NAO report for politicians and the public was that the Service

was value for money. The NAO recommended to other mental health services the Services method of self-audit. In so doing, the NAO was pronouncing outside its' area of competence.

NHS Talking Therapies has selected a self-serving metric of recovery. This involves completion of two psychometric tests, the PHQ-9 (Kroenke et al., 2001), and GAD-7 (Spitzer et al., 2006) at every treatment session, with recovery defined as a drop to below 'caseness' on both measures (below 10 on the PHQ-9 and below 8 on the GAD-7).

There is a chasm between NHS Talking Therapies metric of recovery and what a member of the public would understand as recovery. For the latter it would mean being back to their old selves or almost back to their old selves. Such a metric has been used by Bruce et al., (2005) in charting the natural history of the anxiety disorders. Crucially assessment of recovery involves blind assessment using a standardised diagnostic interview. No such independent assessments have been made of NHS Talking Therapies clients. The nearest approximation was my own study (Scott, 2018), conducted as an Expert Witness to the Court of 90 clients going through IAPT who pursued personal injury litigation. Whether or not they were treated before or after the personal injury only the tip of the iceberg recovered based on the SCID (First et al., 2016).

What then are the tests administered by IAPT clinicians actually measuring? The PHQ-9 was designed to measure the severity of depression in a population known to be depressed according to a 'gold-standard' diagnostic interview such as the SCID (First et al., 2016). Similarly, the GAD-7 was designed to measure the severity of generalised anxiety disorder (GAD) in a population known to be suffering from GAD based on a standardised diagnostic interview. In NHS Talking Therapies these measures have been used without any diagnostic context. In the Services re-brand it purports to focus on 'Anxiety and Depression' but it has taken no steps to ensure that this is indeed the case. There is thus no certainty about what these tests are measuring when used in a vacuum.

### **Myth 3 Real World Lasting Changes**

NHS Talking Therapies for Anxiety and Depression provides snapshots of clients at each therapy session, using two psychometric tests. But these 'pictures' provide no indication as to whether the client would regard themselves as having returned to normal (or best ever) functioning for a meaningful period. Despite this NHS Talking therapies claims a 50% recovery rate! The time-frame used in the tests is the past two weeks, but remission in epidemiological studies (Bruce et al., 2005) and DSM-5-TR (American Psychiatric Association [APA], 2023) is defined as having no significant signs or symptoms for 2 months. NHS Talking Therapies has never used the 2-month real-world window, as the minimum period necessary for declaring recovery from an episode of anxiety or depression. Even this period would be insufficient for declaring lasting recovery. The changes depicted by the trajectory of the two psychometric tests, are a dubious basis for inferring a treatment effect as a result of the Services ministrations.

The Service defends itself by claiming fidelity to the NICE guidelines, but this is no more plausible than a Government justifying its' actions on the basis of allegiance to 'the will of God'. To know what the Service truly believes it is necessary to look at their actions and not to be persuaded by the powerful rhetoric of charismatic characters. Closer inspection of NHS Talking Therapies functioning reveals chaos.

For example, a UK Government document states: "People with hypochondriacal disorders (76.9%) and generalised anxiety (71.4%) were most likely to experience improvement in their condition after finishing a course of IAPT" (House of Commons Library, 2023, p.24). But these extraordinary claims are based on NHS Talking Therapies cavalier use of time frames. A diagnosis of illness anxiety disorder requires symptoms to have been present for at least 6 months. This means that the time frame for assessing recovery must also be 6 months. But NHS Talking Therapies and its' predecessor IAPT have never assessed clients over this time span. What the service has done is to take a snapshot of such clients at their last contact, reflecting

functioning over the previous two weeks. This says nothing about the trajectory of the illness anxiety disorder (hypochondriacal disorders). The DSM diagnostic criteria for GAD, refers to worrying uncontrollably about a wide range of matters, more days than not, for a period of at least 6 months. By contrast the GAD-7, used by the Service simply refers to functioning in the past 2 weeks, it is a misleading 'photograph' rather than the '6 month video' dictated by the DSM. The Services claimed, highest recovery rates are with disorders that it has most blatantly failed to reliably assess. The DSM-5-TR criteria for social anxiety disorder also stipulates that "The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more" for defining the presence or absence of the disorder (APA, 2023, p. 236). The Service has not charted the fluctuations of social anxiety symptoms over a real-world interval again making claims of recovery meaningless.

NHS Talking Therapies routine measures assess, at best, levels of depression and generalised anxiety disorder. But theirs is a very restricted range of application, they do not measure most common mental disorders including specific phobia, agoraphobia, panic disorder, social anxiety disorder, adjustment disorder and PTSD. Making talk of recovery from these disorders nonsense. It becomes even more absurd, if disorders such as illness anxiety disorder and body dysmorphic disorder are thrown into the mix.

There are more plausible explanations of the changes in psychometric test results over time, than a treatment effect. It is well known that people present for help at their worst, with attention, matters improve and a regression to the mean is likely. But the observed change on a psychometric test does not necessarily mean that an active ingredient for change has been in operation. To determine the presence of an active ingredient would necessitate comparison of results with an attention control condition. NHS Talking Therapies have never engaged in meaningful comparisons. The unreliability of the Services psychometric test data is compounded by the completion of the tests with the knowledge of the treating clinician. This

introduces demand characteristics into the equation, - a desire not to appear ungrateful to the clinician. Further there is the client's self-preserving bias of not wanting to think that they have wasted their time in therapy and benchmarking their current scoring against remembered earlier scoring. In summary, NHS Talking Therapies engages in sham monitoring.

#### **Myth 4 Appropriate for All-Comers**

In the re-branding of IAPT, NHS Talking Therapies have become more explicit about their focus, appending the descriptor 'for Anxiety and Depression'. At face value, this appears to represent a limiting of the reach of the service, but it is more accurately NHS Talking Therapies 'Sans Frontiere'. It has extended its' remit to those with long term physical conditions, such as fibromyalgia. For example, its' most junior staff, Psychological Wellbeing Practitioners (PWP), linking up with physiotherapists in the running of psychoeducational groups for such conditions.

NHS Talking Therapy clinicians are invited to apply a diagnostic code to clients, but the Service also claims that they do not make a formal diagnosis. Unsurprisingly, the service utilises a motley collection of diagnostic labels with noticeable absences, such as adjustment disorders. In practise the Service takes in all-comers in distress, with a pretence it has the competence to offer NICE approved treatments for the spectrum of disorders presenting. No allowances are made for individuals natural destabilisation after a major negative life event. 'Watchful waiting' is not in the Services vocabulary, talking therapy is apparently always the answer, no matter what question the client's debility raises. Consequently, a person living in squalor, that would make anyone depressed, particularly if they a single parent caring for young children, could be a candidate for the Service. The Service has delusions of grandeur and reflects a psychological imperialism, committed to expansion.

But the Tolin et al., (2015) criteria for an empirically supported treatment (EST), adopted by the American Psychological Association, provides quality control on psychological and pharmacological wares. Tolin et al., (2015) use

the mnemonic PICOTS, to filter out 'fake goods'. The 'P' stands for population and requires a precise specification of those receiving the intervention (the 'I'). There is an implicit acknowledgement that an empirically supported treatment cannot be for 'all-comers', any EST is only pertinent to a particular population. NHS Talking Therapies imprecision about who it is treating means that claims about the Services potency lack credibility.

### **Myth 5 It Delivers Evidence-based Psychological Therapy**

NHS Talking Therapies claims to be NICE compliant. But there have been no fidelity checks on the Services interventions, the service simply alleges that its' clientele has received an EST. Applying the PICOTS framework this means that the "I" (intervention) is vague, with no evidence that a particular therapist has used a specific protocol to deliver therapy to a client. General Practitioners (GPs) typically receive from the service entry and exit scores of their patients on the PHQ-9 and GAD-7 with commentary on whether the said scores indicate recovery. Treatment is a 'black-box'. There is no reliable indication of what treatment has been given to whom? In short compliance is alleged rather than demonstrated.

In randomised controlled trials (RCT) there are fidelity checks to ensure that the scheduled treatment has actually taken place. Recordings of treatment sessions are taken and integrity checks made to ensure that appropriate targets and matching treatment strategies have been the focus. Not only is the content of the sessions evaluated but a judgement is also made of the therapists's skill in delivering treatment. No such fidelity checks have been made in NHS Talking Therapies. The claim of the Service to be NICE compliant is baseless.

It is not sufficient for therapists to assert that they believe that they are doing a good job. Whilst this believe makes continuance of their role viable, history is replete with ordinary people who, it seems, genuinely believed they were doing good and what was asked of them by their superiors. The Nuremburg trials challenged the validity of a purely subjective notion of doing

good. What is notably absent with regards to NHS Talking Therapies (and its' predecessor IAPT) is the absence of public debate. For example, inspection of BPS's Clinical Psychology Forum, the Psychologist and BABCPs CBT Today, are bereft of debate on the credibility of NHS Talking Therapies. This suggests powerful forces at work, with vested interests to constrain discussion.

But just as in totalitarian regimes, there is leakage of information out, about what is actually going on. Drew et al., (2021) noted that IAPT has been accused of being "'scripted', 'tick box', 'robotic', and as having characteristics of a 'call centre', 'production line', 'process-driven', 'one-size-fits-all' service, delivered to a formula" (p. 2). These authors investigated the interactions of PWP's and clients during telephone treatment. Step 2 care is delivered by psychological well-being practitioners (PWPs) trained over one year to a standardised curriculum accredited by the BPS. Drew et al.'s (2021) principal findings were that only rarely were patients asked open questions, early in the interaction, about why they had approached a mental health service for support. PWPs prioritised the routine outcomes measures questionnaires and other proforma question banks. There was evidence of a routinised approach and lack of flexibility in treatment delivery. In similar vein Faija et al., (2022) noted that the psychometric tests we're always administered at the start of a treatment session, and were seen by the PWPs as an encumbrance and the results did not influence the sessions at all. These authors called for a more conversational style but also noted that this would put extra time pressure on the PWP.

### **Myth 6 Low Intensity Interventions Are Effective**

None of the studies of low intensity interventions involve a comparison with an attention control condition, as such claims that they are ESTs lack credibility. They fail to clear the 'C' requirement of PICOTS.

PWPs deliver the smallest dose of psychological interventions (low intensity CBT), less than 6 hours of contact per client (Shafran

2021). Making it cheaper than high intensity CBT. But there is little evidence that the PWP ministrations make a difference the client would recognise. There are no randomised controlled trials of high or moderate quality that attest to low intensity CBTs efficacy. Researchers on the efficacy of low intensity interventions have ignored all the methodological recommendations for trials of psychological interventions put forward by Guidi et al., (2018) 5 years ago. In particular, that “Assessment should be performed blind before and after treatment and at long-term follow-up” and that “a combination of observer- and self-rated measures is recommended” (pp. 1-2). These authors further note “A clinical response after treatment is not synonymous with an effect that can be attributed to psychotherapy. The latter can only be accurately estimated with reference to an appropriate control group. The randomized controlled trials (RCT) play the most important role in this” (p. 2). IAPT based studies, fail to properly address the ‘O’ (outcome) of PICOTS by relying entirely on self-report measures. Nevertheless papers continue to be published and proselytised in prestigious journals, without a hint of methodological rigour, e.g. Owen et al., (2023).

The PWPs are not psychological therapists, as such, most NHS Talking Therapies clients do not receive psychological therapy. With the re-branding of IAPT we are invited to consider that the Service’s clients receive talking therapy, but it is unclear in what way that is different to the conversations that might occur between staff and clients at a Citizen’s Advice Bureau. There is no evidence that the low intensity talking therapies confers any advantage.

Low intensity CBT is intended to be the first step for those suffering from depression and the anxiety disorders, with PTSD and obsessive-compulsive disorder clients going straight to high intensity interventions. Most clients first encounter low intensity CBT, should they not respond they are placed on a waiting list for high intensity CBT. In practice comparatively few, about 10%, are stepped up, but with wide regional variations.

## **Myth 7 Monitoring Is at the Heart of NHS Talking Therapies**

IAPT (National Collaborating Centre for Mental Health [NCCMH], 2021) boasts 98% completeness of continuous monitoring of clients functioning. The IAPT manual highlights how the use of session-by-session outcome measures aims to benefit services, practitioners and patients (NCCMH, 2021). But the study of Fajia et al., (2022) suggests that administration of the psychometric tests, is in practice, a ritual conducted at the start of the therapy session, with no bearing on the content of the session. These authors cite Rushton et al., (2019) “the completion of outcome measures session by session eroded valuable clinical time and presented a potential social desirability risk, influencing patients to report improvements due to the on-the-spot nature of being questioned about their symptoms by telephone” (p. 822). This calls into question the whole edifice of NHS Talking Therapies use of psychometric tests, in isolation, to demonstrate recovery.

The tests results are also used for performance monitoring, a therapist routinely unable to demonstrate a 50% recovery rate is subjected to sanctions, a powerful incentive consciously or non-consciously to manipulate test results in conversation with the client. The last psychometric test conducted, is like a signpost blowing in the wind, pointing to nowhere, much less a vector for the need for a high intensity intervention.

NHS Talking Therapies proclaims a 50% recovery rate, (NCCMH, 2023) across a heterogeneous set of disorders. Depression and GAD are but two of the multitude of disorders that present to the Service. An assessment of clientele by Hepgul et al., (2016) using a diagnostic interview, covering 16 disorders, found that just over a third, 37%, fell into the depression or GAD category. Thus, the Service has pontificated on outcome for the two thirds of its population that it has not used a disorder specific measure for. Matters are even worse in that specific phobia, body dysmorphic disorder and illness anxiety disorder were not assessed by Hepgul et al., (2016). Making the spectrum of disorders even broader. NHS Talking Therapies is

telling more than it can possibly know, this is blatant marketing.

Monitoring is crucial in all professional walks of life, flying an aeroplane or working in an operating theatre. Those charged with doing the monitoring have to be free to challenge those with more power e.g the Surgeon or flight pilot, when somethings look amiss. There is an 'authority gradient' in all institutions. But in NHS Talking Therapies there is no means of climbing the authority gradient, supervisors act at the behest of their employer. Faija et al., (2022) conclude: "findings indicate a lack of consistency in the administration of the outcome measures within and across practitioners, posing a question about the validity, reliability and meaningfulness of the data collected during telephone-treatment sessions" (pp. 832-833). In reality the Service operates sham monitoring.

### **Myth 8 Formulation Is Sufficient, No Need for Diagnosis**

A formulation is a personalised working model of how the person came to be distressed now. In some instances, the formulation is very simple, for example, distress at the sudden and unexpected death of a loved one. But even at its simplest level the formulation does not speak for itself. Clinically, distress at a recent unexpected bereavement of a loved one is likely to be viewed very differently to a similar level of distress, years afterwards. Long term impairment in social and occupational functioning may be judged an appropriate therapeutic target in contrast to a temporary destabilisation in functioning. Nevertheless, the conclusion that there is long-term impairment, rests on the judgement that some agreed threshold for impairment has been cleared. Staying with this example, upset simply on significant days such as anniversaries, birthdays and Christmas would be unlikely to be seen as clinically significant, falling below the threshold. Impairment in psychosocial functioning is an integral part of DSM-5-TR diagnostic criteria, to help prevent pathologising normal functioning. The DSM-5-TR also has operational criteria to distinguish one disorder from another. Formulation out of the context of public thresholds and disorders makes

communication between professionals almost impossible. There is a need to sing from the 'same hymn sheet', albeit that at times the 'hymn sheet' itself needs modifying, this is reflected for good and evil in the changing criteria in the DSM over the years. Formulation by itself is insufficient, what is needed is 'case formulation'. There has been no demonstrated predictive value of 'formulation', but 'case formulations' have been intrinsic to the RCTs for depression and the anxiety disorders and form the foundation for NICE recommendations.

In NHS Talking Therapies 'formulation' rules and not 'case formulation'. Although the Service's clinicians assign a diagnostic code, the IAPT Manual asserts that they do not make a diagnosis. You may well be bewildered at this, evoking a 'what's going on here?' response. You might further query whether this is an attempt to avoid accountability, muddying any discussion of 'recovery'. The 'get out of gaol' card for NHS Talking Therapies is that all clients are individuals and treatment has to be tailored to their needs, leaving therapists with no boundaries about what they should or should not do. Whilst the therapist might greatly value and guard this autonomy, it is nevertheless an exercise in unbridled clinical judgement. We live in an era of increasingly personalised medicine but unbridled clinical judgments are not acceptable in Courts of Law or in case discussions amongst professional medics. The burden of proof is with those who extol the use of. formulation alone.

### **Myth 9 It Works Having the Least Qualified Practitioners as Gatekeepers**

Here is an example of a letter from the Service to a GP following a referral of a patient with work-related stress:

"Thank you for referring X, presented with low mood/anxiety as evidenced by scores of 15 and 16 respectively on the PHQ-9 and GAD-7 scales...happy to commence working on their mood using guided self-help to address their difficulties, and I shall be supporting them with this for up to 8 sessions...will keep you updated on progress" Trainee Psychological Wellbeing Practitioner.

The latter betrays little or no understanding of the strengths and limitations of psychometric tests used in isolation. Neither were designed to measure “low mood” or anxiety (the GAD-7 is a measure of the severity of GAD). There is no indication of which if any patient population this person may be an exemplar of. Evidence-based psychological treatments are generally diagnosis based, without it there can be no signposting to appropriate treatment. Guided self-help is apparently plucked from the air on the basis of organisational convenience in that: a) it is within the expertise of the Practitioner b) it is less costly than face to face and c) there is a pre-determined limit on the number of sessions. Organisational need clearly trumps the needs of the patient. Progress is charted by administration of the same tests at each session, but repetition does not make them more valid. In fact, this person was distressed that they had been passed over for promotion, the said tests are of doubtful relevance to patient concerns. The Practitioner did not have the training to consider that adjustment difficulties or adjustment disorder might be germane and ‘watchful waiting’, perhaps the best starting point. From the outset the Practitioner has pathologized the client’s response, paradoxically likely providing unnecessary treatment. The GP would be much less tolerant of the absence of diagnosis and prognosis for a patient referred for cancer.

Almost 3 out of 4 (72%) clients presenting to NHS Talking Therapies, are suffering from two or more disorders (Hepgul et al., 2016). The gatekeepers are not trained to reliably identify these disorders, nor are they trained on how to treat comorbidity. The Service operates as if it believes focussing on the perceived clients Chief Complaint is all that is necessary. But there is no empirical evidence supporting this heuristic (rule of thumb). The inadequacy of the first line treatment becomes even more apparent when it is considered that in the Hepgul et al., (2016) study, 16% were identified as having a borderline personality disorder and 69% were judged as having a high risk of personality disorder. But no NHS Talking Therapies staff are trained in the treatment of personality disorders. In summary the Service is not fit for purpose.

## **Myth 10 Talking Therapy Is the Same as Psychological Therapy**

In the re-branding of IAPT ‘talking therapies’ and has replaced ‘psychological therapy’ as the focus. The latter term has historically been applied to psychological treatments that have been examined in RCTs. But there are no RCTs of ‘talking therapies’, they are not evidence-based. The term can be taken to mean whatever the user wants it to mean. Is a person’s conversation with their hairdresser/barber a ‘talking therapy’, was my meeting, an hour ago, with an old school friend in a coffee bar ‘talking therapy’? NHS Talking Therapies, is it seems dedicated to obscuring what it does, thereby ducking accountability.

The popular wisdom is that it is good to talk. It is suggested that this will help prevent the alarming rate of suicide in young men and aid recovery post trauma. NHS Talking Therapies has sought to capitalise on this zeitgeist. But the mechanism by which ‘talking’ makes a real-world difference is likely to be much more complicated than it is assumed. For example, if in talking with a suicidal young man his sense of hopelessness was reduced this may indeed reduce the likelihood of his acting on suicidal ideas, but if the other person simply reflects back how awful they find their plight no diminution in risk is likely. Similarly repeated recounting of the details of a trauma may evoke despair. The communications between the Service and GPs provide no evidence of compliance that would stand up in Court. The Service is literally ‘All Talk’.

## **Myth 11 It’s Fine that NHS Talking Therapies Has Only Ever Marked Its’ Homework**

We have long outlived the adage ‘trust me, I’m a Doctor’, to be replaced with ‘trust me, I’m an NHS Talking Therapies Practitioner’. Responsibility and accountability have to go together. It is not sufficient for practitioners, or the Service itself to assert that they are doing a good job. All too easily they can shift the focus to operational matters number of people seen, waiting times etc. Whilst these indices are important, the key performance indicator, is



whether or not a person recovers and the duration of that recovery. The 'T' of PICOTS refers to the duration of recovery, for change to be credible it has to be lasting. Further this can only be determined by independent assessment. NHS Talking Therapies show no interest in the permanence of recovery. The final letter of PICOTS, the 'S' refers to setting, it appears that NHS Talking Therapies is not at all interested in the setting to which a client is discharged and their ongoing functioning there, rather it is preoccupied with its' own setting in which therapists are required to jump through hoops for propaganda purposes. NHS Talking Therapy staff have a vested interest in proclaiming recovery. They have got away with it by becoming a 'priestly caste' in the eyes of the public and politicians. But there is a gravitational pull to professionals engaging in lip-service, rather than service, for this reason there has to be built in safeguards regarding their functioning, they should not be expected to police themselves.

For some the mere mention of diagnosis is anathema, an unnecessary medicalization of psychological problems. But it is impossible to see how there could be any accountability in a Court of Law without recourse to diagnosis. It is not necessary to believe that psychological disorders are determined biologically, to espouse the utility of diagnosis. Doubtless all psychological disorders have biological correlates, but that doesn't mean that biology is playing a pivotal role in the genesis of disorder. Diagnosis might be the least-worst way of highlighting treatment options.

### **Myth 12 It's Better Than What Existed Before and Better Than Support - It's Value for Money**

For many, including BABCP and BPS the inception of IAPT is regarded as 'year zero'. But there is a need for quiet reflection on such revolutionary zeal. Just as in recent years historians have challenged the narrative that our cave dwelling ancestors were 'primitive', there is a need for a re-examination of the psychological services pre-2008, the birth of NHS Talking Therapies.

Since the millennium the assessment of the effectiveness of routine psychological services, whether in the UK or Australia, has only been via psychometric tests completed by clients not shielded from clinician influences. This state of affairs, is no different to that which obtained pre-millennium. The methodological quality of studies has not improved. The post millennium psychometric test results are no more credible than those beforehand. Whilst different psychometric tests may have been employed such as the CORE rather than the PHQ-9 and GAD-7 there is no evidence of any clinically significant difference in within subject effect size.

Prior to IAPT it had been demonstrated that counselling in primary care was superior to treatment as usual in the short term but not the long-term (Bower and Roland, 2006). Levels of satisfaction with counselling were high. Thus, unlike in IAPT, there had been a concern to have a comparison group. There is no clear added value to current provision over that which existed before.

Within IAPT there has been found to be no differences between the effectiveness of high intensity CBT and high intensity counselling (Barkham and Saxon, 2018). Further it made no clinical difference whether either treatment was preceded by low intensity CBT or not. There is nothing to suggest that the Counselling is any more potent than that delivered in the pre-IAPT era. Given the equivalence of CBT and Counselling in the study it is unlikely that current services are outperforming pre-IAPT services. The Barkham and Saxon (2018) study also creates doubts that low intensity CBT makes high intensity treatment, of whatever form, more viable. It casts doubts on the validity of the stepped care model and whether NHS Talking therapies is value for money.

### **Avoiding Charlatans**

NHS Talking Therapies (NCCMH, 2023) claim that their Services are guided by the NICE guidelines. But the evidence for this is conspicuous by its absence. Embarking on the search for Guideline compliance, is like searching

for the Holy Grail. The services interventions are therefore misguided.

The hallmark of compliance is Tolin et al., (2015):

- 1) treatment of an identified disorder
- 2) a matching of disorder specific targets and treatment strategies
- 3) the utilisation of the protocol that is evidence based, in that it was evaluated in a randomised controlled trial against an attention control condition
- 4) the protocol was evaluated by independent blind-raters

None of the services low intensity interventions meet the above criteria. It is possible that on occasion an evidence-based treatment might be delivered in high intensity NHS Talking Therapies, there, at least in principle, there is space to deliver a therapeutic dose of treatment. But the quest is akin to searching for the presence of water on other planets. Just as one has to be wary of claims of extra-terrestrial life, so to with the suggestion that NHS Talking Therapies is the best model for other countries to adopt for the delivery of the psychological therapy services.

The American Psychological Association has adopted the Tolin et al., (2015) criteria for determining an empirically supported treatment. Without utilising such-like criteria, Countries are likely to fall prey to well marketed pharmacological or psychological interventions. Without such checks, Service Providers have a license to print money and the needs of the individual are given short shrift. Shortly after the inception of IAPT I suggested a simpler way forward in Scott (2009).

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