

A genealogical investigation of the conditions of possibility for the emergence of Improving Access to Psychological Therapies (IAPT) services.

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ABSTRACT

The purpose of this research was to investigate the conditions of possibility for the emergence of Improving Access to Psychological Therapies (IAPT) services as a dominant service-provision model. The research undertook a text-based genealogical analysis which drew upon the works of Foucault. The data consisted of 116 publicly available documents. A collection of dispositifs were plotted onto a visual map in order to examine the system of relations between key elements, and their strategic functions. Three nexus points from the map were selected as key conditions of possibility for IAPT's emergence; the creation of the 'third way' by New Labour, the role of clinical psychologists in research and government and the convergence of discourses constructing unemployment. This research suggests that scientific constructions of research strengthened medical and economic discourses of mental 'disorder', which legitimised the neoliberal and capitalist ideology through which IAPT emerged. Through this process, mental distress was constructed as an individual problem, and unemployment as individual pathology. This enabled the proposal of therapy as a solution, whilst subjugating discourses of social justice and interventions at a community- or political-level.

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1. INTRODUCTION

1.1 Background to the research and researcher's position

The idea for this research came as a result of the conflict between my experiences working in Improving Access to Psychological Therapy (IAPT) services as a Psychological Wellbeing Practitioner (PWP) and my subsequent training as a clinical psychologist on a course which adopts a critical approach to clinical training and the 'psy' professions (Harper, Patel, Davidson & Byrne, 2007).

Prior to my clinical training, I worked in IAPT for four years as both a PWP and a senior PWP, training and supervising others in IAPT low-intensity interventions. I believed then, and continue to believe, that there are people working in IAPT services delivering useful interventions, that it has increased the availability of therapy and reduced waiting lists and that Cognitive Behaviour Therapy (CBT) can be helpful for some people, some of the time.

However, since starting clinical training, I have learnt about the political context of therapy and services and started to question the effectiveness and ethics of some of the clinical practices I utilised and trained others in through IAPT. My increasing awareness of the problems with IAPT felt discordant with the growth of IAPT in comparison to other mental health services. I was aware, for example, that although IAPT was initially created to treat anxiety and depressive disorders in adult mental health, it has since evolved as a model used in child and young people's services (Department of Health, 2014), services for severe and enduring mental health problems (Hann et al., 2015; Jolley et al., 2015) and services for people with long-term health conditions (Wroe et al., 2015). It is also a service model which is being replicated and adapted for other countries, such as Australia and Japan (Bastiampillai, 2014; Kobori et al., 2014).

This led me to question what factors were underpinning IAPT, not only its growth but its emergence in the first place. Although literature was available which provided a non-critical history of IAPT, there was not a critical account of the emergence of IAPT which evaluated it and acknowledged the social and political apparatus of power in its emergence.

I therefore wondered how it had come to be that IAPT had been apportioned the power it had, despite its critics. This interest led me to draw on the work of Michel Foucault, in particular his methodology of genealogy. Extended examples of genealogy were found in *Discipline and Punish* (Foucault, 1991) and *The History of Sexuality*, volume one (Foucault, 1978). This led to the question underpinning this research; what were the conditions of possibility for the emergence of IAPT?

1.2 Aims of the research

One of the purposes of this research is to evaluate IAPT as the sole service provider for primary care adult mental health services. A secondary purpose is to perturbate taken-for-granted truths about the necessity of the IAPT model, which silences questions and prevents other approaches from emerging. The aim of doing so is to enable a presentation of the pertinent social and political apparatus of power which gave space for the emergence of IAPT, as these powers may be relevant in considering the possible emergence of other, improved, mental health services in the future.

1.3 Overview of the chapter

IAPT has been the subject of research and critical discussion since its inception in 2006. Given the critical stance of the research method, I have chosen to focus on the features of IAPT which make it distinct and problematic. Histories of IAPT which could be considered to be more supportive can be found elsewhere, such as the book *'Thrive'* by Layard and Clark (2014). The problematising of the IAPT model is an important first step of the genealogical approach (Dreyfus & Rabinow, 1982) from which I will trace the cultural and historical practices which led to it. In the introduction, I will therefore isolate and evaluate key features of the IAPT model, drawing upon my experience of IAPT, as well as the critiques presented in the literature.

In section 1.7 of the introduction, I will outline the staffing structure of IAPT and its education and training programme. I will argue that the staffing structure acts to deprofessionalise therapists working in IAPT, that it negatively impacts the wellbeing of staff and makes changing the system difficult as a staff member.

Focusing on the IAPT service model, in section 1.8 I will suggest that the stepped care model favours quantity of clinical contacts over their quality. I will highlight the emphasis placed on employment status as an outcome in IAPT and the related rise in unethical workfare practices. With regard to equity of access to IAPT services, I will argue that IAPT's evidence-based practice does not allow for required adjustments to enable access to IAPT for discriminated against groups.

In section 1.9, I will highlight the conflict between the patient-centred approach and the use of diagnoses in the assessment processes of IAPT. I will also explore the impact of NICE¹ guidelines on the therapy offered in IAPT, in particular the extent to which NICE acts as a barrier against psychologists utilising formulation skills in therapy. I will also discuss the dominance of CBT within IAPT and the problems that arise from this. Finally, in section 1.10 I will explore the impact of sessional outcome measures questionnaires on the experience of therapy and the construction of recovery, in IAPT services.

1.4 Defining the literature

The text-based nature of the research method required a systematic approach to differentiate literature to be included in the introduction from the analysis. As the research sought to analyse the conditions of possibility for the emergence of IAPT, texts which explicitly named 'IAPT', or evaluated its services were not included in the analysis. Further information on the protocol for the collection of documents for analysis is outlined in the methodology.

For the introduction, the search strategy involved systematic searching of academic electronic databases (PsychInfo, PsychArticles, CINAHL), and the internet search engine Google Scholar. Initial search terms included 'Improving Access to Psychological Therapies'; 'Improving Access to Psychological Therapy'; 'IAPT'. Combinations included 'IAPT' and 'policy'; 'turnover'; 'outcomes'; 'CBT'; 'management'; 'evaluation' and 'targets'. After reading abstracts, the most relevant references were obtained, read and their inclusion

¹ NICE is the National Institute for Clinical Excellence, a government funded group which evaluates medical interventions on the basis of submitted research. It is described in greater detail in section 1.9.2.

in the introduction considered.

1.5 Language

Much of the research literature leading up to and resulting from IAPT is written utilising an empirical, medical and individualised construction of mental distress. As such, the word 'patient' is used to describe people using mental health services and diagnostic criteria are referred to when describing the person's experiences. In this introduction I will outline some problems with the use of these terms. However, in presenting the research literature surrounding IAPT, I have, at times, used the same medical language of patients and diagnosis when citing specific research. The use of this medical language is not used without awareness of its inadequacies.

Similarly, when discussing IAPT's equality agenda the term 'black and minority ethnic' (BME) groups has been used in the literature. This term is unhelpful as it masks the heterogeneity of what is essentially anyone who is 'not white'. However, some of the research cited utilises this term. As such, at times the term BME is used in the introduction, despite awareness of its inadequacies.

1.6 What is IAPT?

Layard and Clark (2014) described IAPT as a systematic way of organising the delivery of evidence-based psychological therapy within the NHS. They outlined six main features of the IAPT model:

- IAPT services deliver only evidence-based, NICE recommended therapies.
- Therapists employed by the service are fully trained in how to deliver the relevant treatment.
- Patient outcomes are measured on a session-by-session basis, with at least 90% completeness of data.
- Each patient receives an assessment and is then allocated to low- or high- intensity treatment.
- Each therapist has weekly supervision.
- The service is open to self-referral, without patients having to go through their GP, though this is also an option.

(Summarised from Layard & Clark, 2014, p. 202).

In the following sections I argue that there are issues both in the practical implementation of these features, as well as the epistemological foundations on which they are based. I will evaluate some of these key characteristics, outlining issues which concern me as a researcher and have inspired the focus of the thesis.

1.7 IAPT staffing

IAPT is staffed by a range of therapists who have trained specifically within the IAPT model, such as high-intensity CBT practitioners who make up 42% of the workforce, and Psychological Wellbeing Practitioners (PWP) who make up 28% of the workforce (IAPT workforce census, 2014).

PWPs identify and assess common mental health disorders, such as 'depression' or 'anxiety'. They deliver cognitive behavioural interventions at a lower intensity than high-intensity CBT, often over the telephone, or through web-based programmes, group facilitation and self-help workbooks (IAPT, 2014). Sessions are fewer than in high-intensity CBT and usually last 30 minutes or less. High-intensity workers have usually been trained in a recognised health care professional role (e.g. counsellor, nurse or psychologist). CBT is the most common high-intensity therapy offered in IAPT although other therapeutic approaches are represented such as counselling (4.4% of the workforce), couples therapy (1.4%), brief dynamic interpersonal therapy (1.1%) and interpersonal psychotherapy (2.3%). High intensity interventions are delivered face-to-face, usually for one-hour over a course of 12 to 20 therapeutic sessions (IAPT, 2014).

This is different from previous primary care mental health services, which anecdotally had a wider range of professions, utilising a range of therapeutic techniques.

In the following section I will outline the impact of the change in the IAPT workforce and training on the professional status of therapists in primary care. I will argue that the IAPT system has deprofessionalised therapists working

within IAPT services, resulting in worsening staff wellbeing and increased staff turnover. I suggest that these staffing practices act as a barrier to staff implementing change at a local level, which facilitates the maintenance of problematic practices within the IAPT model.

1.7.1 Workforce education and training

IAPT has utilised a centrally created, nationally implemented training model in which researchers developed competences, created curriculums and disseminated training handbooks to courses across the country. The centralised nature of IAPT training favours a protocol-based approach to therapy, to ensure consistency within the national programme. Clark (2013) explained that training was made a priority for the IAPT programme as the NHS did not have enough therapists to roll-out the IAPT model. However, there were already counsellors in GP surgeries, graduate mental health workers and psychiatric nurses working in primary care mental health services, as well as psychologists and other therapists. The training therefore addressed the numbers of people trained in CBT. Given that there were already trained clinical professionals working in the NHS, the decision to standardise specific competences, create training based on these and re-train already trained therapists could be considered a form of social control, with the effect of deprofessionalising therapists in order to ensure they carry out government authorised psychological interventions only.

Technologies can be understood as an assembly of knowledge, instruments, persons, buildings and spaces which act on human conduct from a distance (Rose, 1998). These are often considered to be technologies of power, but technologies can also apply to how individuals problematise and regulate their own conduct. These are referred to as technologies of the self (Foucault, 1988). The IAPT training programme could be considered as a regulatory technology of the state, used to shape the subjectivity of individual therapists to ensure that the therapeutic ambitions of the professional are matched to the political ambitions of the state. In this research, subjectivity is understood as the process by which the subject creates itself by different forms, at different times, through the use of varied practices (Kelly, 2013). For instance, Barrett (2009) has highlighted the shift in language to describe professionals working in IAPT services; from the title 'therapist' to the description of 'worker'. This re-

positioning of 'therapists' to 'workers' could be considered to be a technology of disciplinary power, which has implications for the subjectivity of the worker and their patients. In *Discipline and Punish*, Foucault (1991) described disciplinary power as a source of social discipline and conformity, created in administrative systems such as prisons and schools. This type of power does not require force or violence, as people behave in self-governing ways in line with societal expectations. The function of this change in language could be to reduce the expectation of independent decision-making, with 'workers' being expected to undertake certain techniques within IAPT services, without the flexibility afforded to therapists trained in other services. In this sense, the loss of agency afforded to 'workers' in IAPT services could be indicative of a loss of professionalism. In fact, Loewenthal (2016) has suggested that the reliance upon protocols and guides in training results in the production of trainees unprepared for the realities of clinical practice.

The deprofessionalisation of the therapeutic profession through the standardisation of IAPT training is a problem; leading to reduced autonomy for clinicians and restricted therapeutic options for people accessing services. The emphasis placed upon skills such as formulation in the training of clinical psychology (Division of Clinical Psychology(DCP), 2011) implies that no one therapeutic approach will be beneficial for all people, hence the importance of a person-centred assessment and formulation. Following on from this, CBT will not be the most useful therapeutic approach for *all* people presenting in mental health services. Therefore, as training in CBT approaches for IAPT continues to be prioritised, there will be an increasing proportion of the public whose needs are not met by mental health services.

1.7.2 Workforce support and welfare

A survey of over 1, 300 psychological professionals within the NHS by the British Psychological Society (BPS) and the New Savoy Partnership (NSP) (2015) demonstrated worsening levels of burnout, stress and depression as well as low morale. Although this survey was conducted across all mental health professionals, some comments explicitly cited IAPT as a contributing factor to worsening wellbeing;

“IAPT is a politically driven monster which does not cater for staff feedback/input in any way. All we are told is TARGETS!!! and work harder.”
(BPS & NSP, 2015, quotation taken from website)

The above quotation highlights the impact of centrally driven targets which do not allow professionals to innovate in services. It also highlights the pressure staff are under to achieve targets, with an emphasis on staff working harder. In IAPT services, PWPs are expected to ‘treat’ 213 people per year (UCL, 2015), this can be made up of six to eight 30 minute contacts per day as well as subsequent administrative duties. In my experience, balancing the requirement to complete questionnaires whilst adhering to the treatment protocol sometimes made it difficult to meaningfully engage with the person attending the session. Perhaps as a result of this, IAPT workers have demonstrated feelings of guilt and anxiety about the systematic lack of opportunity for meaningful emotional involvement with clients which has led to dissatisfaction with their work (Rizq, 2011). Lewis (2012) suggested that the values of staff working in IAPT (which are often to maximise the development, health and welfare of the people who access services) are being undermined by the target-focused culture within IAPT services, impacting staff practices and wellbeing.

The worsening wellbeing, and subsequent high turnover, of staff working in IAPT services is problematic on a number of levels. The wellbeing of staff influences their ability to contain the strong emotions of people accessing services; this is problematic given research proposing that the therapeutic relationship is the main curative component in therapy (Lambert & Barley, 2001). The high rate of staff turnover (Chris E, 2016) is also an economic problem; with investment in IAPT training only benefitting IAPT services for a short period of time. Clinical psychology training is implicated in this, with up to 39% of a clinical training cohort coming from employment as a PWP prior to training (DCP, 2015). In this example, the trainee clinical psychologist will have been paid to complete both the post-graduate certificate when training as PWP, and a doctorate when training as a clinical psychologist. Whilst it is important to acknowledge that many people train as PWPs with the intention of later entering a career in clinical psychology, the pressure of targets and the impact on wellbeing of IAPT staff may reduce the time spent utilising their skills in IAPT

services before moving elsewhere, not to mention the wasted investment in professionals who leave the profession altogether and the knowledge-base that goes with them.

I believe the high rates of staff turnover in IAPT is problematic not just for individual IAPT services, but for mental health services in the NHS as a whole. The high proportion of people working on a short term basis does not provide an environment in which workers can voice concerns about the service and act to influence change. As such, the practices currently ongoing in IAPT services which I will construct as problematic in this introduction, are less likely to be highlighted and changed as a result.

1.8 The IAPT service-delivery model

The IAPT service-delivery model has a collection of features which distinguishes it from other mental health services; the stepped care approach, the inclusion of employment status in the service's outcomes and the availability of self-referral to improve equity of access for 'hard to reach' groups.

In the following three sections I will outline how I believe each of these features is structurally problematic. I will describe how the stepped care approach favours quantity of clinical contacts over quality. I will suggest that the focus on employment individualises and depoliticises social issues. I will finally argue that the availability of self-referral in IAPT, though laudable in its intentions, does not allow for the flexibility required to engage different groups and that IAPT is thus failing to engage 'hard to reach' groups as a result.

1.8.1 Stepped care

IAPT utilises a stepped care model to service delivery. Bower and Gilbody (2005) described the stepped care model as having two key features; that the recommended treatment should be the least restrictive of those available, and that the model is self-correcting. The least restrictive feature can be applied to both the patient and the service. When applied to the patient, this may refer to the least amount of cost or personal inconvenience whereas for the service it may be the amount of specialist therapist time required (this is often referred to as treatment intensity, hence the low- and high- intensity treatments described

in IAPT). The self-correcting feature refers to the possible transition between low- and high- intensity therapies through the systematic monitoring of the outcome of treatment. For example, if the low-intensity treatment offered is not achieving 'significant health gain' (Bower & Gilbody, 2005) then the person is 'stepped up' to a high-intensity treatment.

In practice, the stepped care approach in IAPT means that PWP's often undertake a telephone 'assessment' or 'triage' in which they collect enough information to allocate a person to low- (step two) or high- (step three) intensity waiting lists². A feature of the stepped care model is the higher proportion of people offered low-intensity intervention (46%), 34% attend high-intensity treatment and 20% attend both low- and high-intensity treatment (Layard & Clark, 2004).

One problem with this model is that it takes away patient choice as the expectation is that the majority of people will be treated in step two in the first instance. Despite this, IAPT services may still appear to offer patient choice through the presentation of a variety of low-intensity interventions. These options are predominately CBT-informed, but vary in their delivery (in groups, over the telephone or through a computerised programme). Based on this, a person entering the service is more likely to be offered a low-intensity cognitive behavioural approach through a process of guided self-help, with other options (such as person-centred counselling or psychodynamic approaches) not discussed unless the person is 'stepped up' for high-intensity treatment. Mackinnon and Murphy (2016) highlight that through the promotion of self-help discourses, IAPT is at risk of participating in a cultural pathologising of dependency, contributing towards the deprofessionalisation of therapeutic staff outlined in the previous section of this introduction.

In this thesis, discourse is understood to describe a construct which assigns meaning to, or between, objects, subjects and statements (Foucault, 1969). It is therefore not just a form of communication but also a form of knowledge, materiality and power (Hook, 2001). Drawing upon economic discourses of

² The effects of this assessment procedure are evaluated further in section 1.9.

restricted funding for NHS services, the stepped care approach allows IAPT to 'treat' higher numbers of people than traditional mental health services; as low-intensity interventions are shorter, and cheaper to offer. In this respect, the stepped care model prioritises the number of people treated in IAPT services over patient- or clinician- choice of therapy. This is in conflict with the emphasis placed on formulation skills in clinical psychology training, in which the intervention offered is founded upon a patient-centred understanding of the person's presentation and the meaning of this in their context (DCP, 2011).

Advocates of the IAPT stepped care model would argue that the self-correcting feature allows for access to alternative approaches on completion of low-intensity interventions. However, based on my experience of working in IAPT, people who had attended low-intensity interventions without 'significant health gain' often felt hesitant about engaging in further therapy. This might have been because of uncertainty about the effectiveness of the approach (for example, if the referral was from low-intensity to high-intensity CBT), an unwillingness to attend another assessment and create a relationship with another professional, or a feeling of failure at not having achieved 'recovery'³. I would therefore argue that it is not only the lack of patient choice in the stepped care model which makes it problematic, but also the effect it has on engagement (or more specifically, drop-out rates), leading to people exiting IAPT services without benefitting from therapy as a result.

1.8.2 Employment

IAPT proposes that if a person on incapacity benefits with a mental disorder attends therapy, they will 'recover' from the disorder and return to employment as a result⁴ (Layard, Clark, Knapp & Mayraz, 2007). The relationship between employment and mental health is also constructed as bi-directional, with employment being proposed as a protective factor against worsening mental health (Layard, 2004). Employment is therefore central to the IAPT service model, with employment status recorded at every clinical contact.

³ This term will be deconstructed and evaluated in section 10.2 of this chapter.

⁴ The discourses underpinning this construction of employment will be explored in section three of the analysis chapter.

On a practical note, the employment focus of IAPT services has not had the effect that Layard initially proposed. In 2014/2015 only 22.1% of those who were 'unemployed and seeking work' when starting treatment had moved to 'employed and not actively seeking work' by the end of their treatment. Focusing on job retention, the 71.8% of people who were 'employed and not actively seeking work' when they started treatment had reduced by 12% on completion of treatment. There could be multiple reasons why IAPT has not been successful in improving employment rates, however it is the assumption that employment is a useful measure to evaluate the success of mental health services which I will now critique.

The assumption that employment acts as a protective factor for mental health could be incorrect. Rogers and Pilgrim (2003) suggested that insecure unemployment causes greater distress and existential uncertainty than unemployment in itself. Based on this, the aim of IAPT to return people to work could be unethical. Barrett (2009) highlighted the conflict of interest when working with someone whose employment context is worsening their mental health and for whom stopping work might improve their wellbeing. This has implications for the success of IAPT services, as change in employment status is evaluated to determine the service's success (and subsequent funding). Based on my experience in IAPT, this conflict was rarely discussed or acknowledged, allowing assumptions regarding the health-benefits of employment to go unchallenged, possibly increasing the potential for unethical practice as a result.

Secondly, the inclusion of employment support within IAPT services presents unemployment as an individualistic problem. This functions to place responsibility for change on the individual over the state and depoliticises issues of unemployment or poor employment practices. Watts (2016) has suggested that the emergence of this link between psychology and welfare services provided a way for politicians to blame the individual for unemployment as opposed to government policies, without appearing to point blame. Through the therapeutic encounter, IAPT workers therefore communicate the government's blame to the individual by focusing on opportunities for individual behavioural change and goal setting. In this respect, the therapeutic encounter could be

considered as a regulatory power of the state, used to shape the subjectivity of individuals attending therapy through discursive practices which pathologise unemployment.

The link between psychology and welfare services has also led to involvement of psychology in coercive practices which are damaging to people's mental health. A practical example is the recent placement of IAPT therapists in Job Centres with the intention to integrate employment and mental health support for benefit claimants with depression and anxiety and the provision of computerised CBT for 40, 000 people accessing benefits (Therapy today, 2015). This is in the context of mandatory activities organised by the Department for Work and Pensions (DWP) which intend to modify the beliefs, attitudes, dispositions or personalities of benefit claimants (Friedli & Stearn, 2015). Examples include workshops which benefit claimants are required to attend to improve their 'resilience' or 'self-esteem'. If they do not attend, this will count as evidence of the person not engaging with the job-seeking process and their benefits will be ceased as a result. Often people are then required to attend food banks in order to survive, with subsequent feelings of guilt and shame which worsen mental distress (Kendler et al., 2003). The practices are coercive, forcing individuals to attend workshops on personal topics, and withholding resources vital to living if the individual does not comply. This generates fear and anger for those accessing the system, who are already vilified as being 'benefit scroungers' in the mainstream media and public discourse.

The techniques used by the Job Centre in order to control claimants in line with the government's understanding of a citizen's responsibilities could be understood as examples of governmentality, the concept used by Foucault to describe the techniques and strategies by which a society is governed. Governmentality can be understood as the process of freedom through which modern forms of political power operate. Society is exposed to certain ways of thinking or 'truths' which enable certain ways of acting, it is therefore through the 'truths' that are available to people, that the government's power operates (Foucault, 1997).

Friedli and Stearn (2015) have argued that psychology is being used to erase the experience and effects of social and economic inequalities. Furthermore, psychology is being used to construct a psychological ideal that links unemployment to psychological deficit, and to authorise the extension of state surveillance to psychological characteristics. This is clearly unethical. People working in IAPT may believe themselves to be acting ethically in their therapeutic encounters, but they cannot ignore the broader context of the service in which the therapy is being delivered. This is particularly important to consider if IAPT service managers act on current proposals to locate their therapeutic staff in Job Centres, as IAPT workers will be complicit in the individualising and depoliticising of unemployment as an issue, masking possible social solutions through their provision of individual therapy.

1.8.3 Equity of access for 'hard-to-reach' groups

IAPT intended to increase the proportion of older adults and people from BME groups accessing psychological therapies (Health and Social Care Information Centre (HSCIC), 2015). Despite this, white British people are disproportionately represented in IAPT services, and the recovery rate for white British people is approximately 5% higher than 'BME ethnicities' (HSCIC, 2016). Thus, less people from non 'white' backgrounds are accessing IAPT and when they do, they are less likely to recover as a result of treatment.

The training of IAPT workers is important to consider here. Bassegy and Melluish (2012) reported that for most IAPT therapists, the training programme was not considered to adequately address issues of culture and their influence in the practice of CBT. IAPT workers also attributed their acquired 'cultural competence' to personal and professional experience and a personal motivation to learn about the influence of culture in therapy, not the IAPT training. Given the economic investment in the continuous training of IAPT workers, both low- and high- intensity levels, the failure of IAPT training to adequately address 'cultural competence' is problematic. The dominance of CBT within IAPT may restrict the emphasis placed upon social factors, such as culture, this is discussed further in section 1.9.3.

Older adults are also significantly under-represented in the IAPT population, with the proportion of people referred to IAPT aged over 65 years ranging from 12.2 to 13.3% (HSCIC, 2016). People with learning disabilities are also often excluded from IAPT services (Chinn, Abraham, Burke & Davies, 2014). Chinn et al. (2016) posited that the procedures resulting from the evidence-based culture within IAPT, when strictly enforced, presented access barriers to people with learning disabilities. The systematic exclusion of people with learning disabilities is not just in tension with the accessibility agenda which IAPT promotes, but it also breaches the Equalities Act (2010) in which service providers are legally obliged to make reasonable adjustments so that people with disabilities can use services.

Another factor to consider in discussing equity of access, which isn't included as a protected characteristic through the Equalities Act, is poverty. Delgadillo, Asaria, Ali and Gilbody (2015) highlighted that despite IAPT services receiving more referrals in deprived areas, caseloads were not higher, indicating a reduced likelihood in starting therapy for poorer people. Delgadillo et al. (2015) also found evidence of poorer areas having lower recovery rates. Factors involved in these differences may be practical, such as poorer people not being able to financially afford the travel costs to appointments, or it might be a result of the therapies offered, with CBT not placing emphasis on issues of social inequality which may feel pertinent to poorer individuals (see section 1.9.3 for a more detailed discussion of this). Notwithstanding the possible factors influencing the difference, it is important to note the range of groups which research indicates are either not accessing IAPT services, or when they do, their outcomes are below average.

Extending the explanation outlined by Chinn et al. (2014), the emphasis on evidence-based practice in IAPT services and resulting centrally-driven service protocols, do not allow flexibility in IAPT services to make reasonable adjustments for people who are members of minority groups. As such, IAPT services are tailored towards the majority, excluding groups of people who, given the effects of societal discrimination and prejudice, are likely to be in greater need of mental health services and support. This perpetuates the power differences at play in society, in which resources are disproportionately

allocated to the majority, and most powerful group. The dominance of CBT in IAPT could be argued to worsen this effect, with little discussion of power or social inequality within its therapeutic scope. This results in issues such as racism or classism being made invisible within IAPT services, meaning a source of the person's distress is not acknowledged or discussed.

The huge increase in funding for IAPT has reduced available funds for investment in mental health elsewhere in the NHS. As such, IAPT services have a moral, as well as a legal, duty to meet the needs of people who are members of minority groups, which IAPT appears unable to do at present. This results in the groups of people who are most in need of support being systemically excluded from services, which is a problematic feature of the IAPT service design.

1.9 Assessment and treatment

Assessment and treatment within IAPT is constructed as patient-centred whilst also being based on protocols utilising diagnostic categories. I will argue that this is a conflict which acts as a barrier to therapists utilising person-centred techniques, such as formulation. I will explore the reliance upon NICE guidelines in IAPT, and question the assumptions of cost- and clinical-effectiveness. Furthermore, CBT continues to be the most common therapeutic approach offered as part of IAPT which I will argue is problematic.

1.9.1 Patient-centred assessments with provisional diagnoses

The process of 'assessment' has been re-interpreted in IAPT services in comparison to other mental health services, which typically undertake assessments in person, over one or more sessions of 60 minutes. In contrast, IAPT assessments are undertaken in a structured and brief manner, over the telephone, following broad diagnostic categories and matching the provisional diagnosis to the relevant treatment (Binnie, 2015). This adaptation has taken place in order to meet targets set for the number of days a person waits for assessment or treatment. For example, assessments are at times undertaken over two telephone appointments which the computer system records as assessment and treatment, meaning the target wait times have been achieved

without the person realistically commencing treatment (Binnie, 2015). Watts (2016) suggested that the high drop-out rate at the point between assessment and treatment in IAPT services may be indicative that this approach is not useful to the patient.

Given the psychological and therapeutic intentions of IAPT services, the use of psychiatric diagnostic categories in the IAPT assessment process appears out of place. The process of psychiatric diagnosis takes place within a medical framework in which an assessment of biological signs and symptoms leads to a diagnosis of a particular mental disorder. Critics of this approach cite a lack of evidence supporting an organic biological origin of mental distress, poor validity and reliability of psychiatric diagnoses and unethical medicalising of presentations which could be considered to be understandable (or useful) in the context of the person's environment. They also highlight the impact of psychiatric diagnoses, in which social circumstances that have caused or contributed to the persons' suffering go unexamined, or unchallenged (Rapley, Moncrieff & Dillon, 2011).

Diagnoses are used in IAPT services to ensure that the person receives the 'evidence-based' therapy for their specific 'disorder'. IAPT therefore assumes that people accessing IAPT services are presenting either with 'anxiety' or 'depression'. However, Heggul et al. (2016) undertook a survey of people waiting to be seen in a London IAPT service. They presented high rates of psychiatric co-morbidity, with traits of personality disorder. The high rates of co-morbidity could be used as further evidence for the poor validity of psychiatric diagnosis. Alternatively, if diagnoses are assumed to be a correct representation of a person's experience, the people surveyed in the research had complex and severe mental health disorders, making IAPT inappropriate for the majority of people waiting to be seen. Furthermore, the finding that over a third of the sample were not presenting to IAPT services for the first time implies that the IAPT service model is being applied to presentations which it was not designed to treat.

Based on the complexity of the presentations in IAPT outlined above, the use of a brief telephone assessment undertaken by PWPs over the course of 30

minutes cannot adequately assess the needs of the patient. What *is* possible within a short telephone assessment is to follow an assessment protocol in which the person's responses can be aligned to a particular provisional diagnosis. This allows the person to be referred to a particular intervention (based on the recommendations of NICE, discussed in the next section). This means that from the beginning of the person's interactions with the IAPT service, their distress is understood as an internal experience which can be 'treated' through therapy rather than an understandable reaction to the social difficulties that the individual may have faced/is currently experiencing. This has the effect of individualising distress, making the individual responsible for change and depoliticising the person and the IAPT worker in the process. This is problematic for people who, having entered into an IAPT service, do not feel listened to and disengage as a result. It is also problematic for people who receive diagnoses which IAPT is not designed to treat, leading them to be referred onto secondary care mental health services which are comparatively poorly resourced. Furthermore, it is problematic for IAPT workers who attempt to engage a person in an intervention which is not appropriate.

1.9.2 National Institute of Clinical Excellence (NICE)-recommended and evidence-based treatments

NICE is a government-funded organisation which publishes clinical guidelines for interventions or treatments which should be offered in the NHS, based upon an evaluation of the clinical- and cost-effectiveness of the intervention. I will explore the emergence of NICE further in my analysis, as well as its epistemological underpinnings. For the purpose of this introduction, it is important to note that NICE proposes that it utilises scientific methods to evaluate research. The evaluation of the research is constructed into 'evidence-based' recommendations, the purpose of IAPT then being to implement these recommendations nationally. In practice, CBT has collated the greatest sum of 'scientific' research and thus has the strongest 'evidence-base'. CBT has therefore been the dominant approach in the IAPT programme. This will be considered in greater detail in the subsequent section, but first I will evaluate the problems with NICE and its influence on IAPT.

Charlton (2007) challenged the authority of NICE to make recommendations over professionals working in the field, on the basis of the underlying philosophies of scientific endeavour and the clinical expertise of the professionals creating and critiquing research. For instance, NICE has neither special access to research evidence nor a secret method for analysing it, as such there is no reason to assume that NICE would perform any better than any other government or professional body in providing recommendations. Furthermore, by conflating clinical-effectiveness with cost-effectiveness in its mission statements, NICE implies that these distinct variables can be satisfied by a single recommendation. Charlton (2007) therefore proposed that NICE is primarily driven by government and managers attaining statutory power to control the clinical decisions of medical professionals, as opposed to the continuing of scientific endeavour which is how NICE has positioned itself. This could be considered to be an example of regulatory power, in which NICE is enacting governmentality through its control of what therapies mental health services can receive funding to offer.

One option suggested by Loewenthal (2016) is for NICE to adopt a pluralist approach to research methodologies, following the lead of the American Psychological Association. This would acknowledge the benefit of collecting and evaluating research and using this to agree service models and approaches, whilst allowing for a variety of research methods to be considered. Pilgrim (2009) argued that the government's emphasis on putting 'the patient experience' at the top of the health policy agenda means that it is not evidence about effectiveness that is most important, but evidence about acceptability and appropriateness. He argued that a patient entering therapy is less concerned about what aggregate data say about effectiveness and is much more concerned about their fate as an individual.

In summary, the wholesale application of NICE guidelines is central to the aims of IAPT and how it is evaluated. I suggest that this uncritical application of NICE guidelines stifles professional skills and knowledge and provides a sub-standard service to people accessing IAPT services as a result.

1.9.3 Cognitive Behaviour Therapy

CBT is the most common high-intensity therapy offered in IAPT (at 33.8% of appointment types), and guided self-help, a form of low-intensity cognitive behavioural intervention, is the second most common (16.2%) (HSCIC, 2015). So accounting for low- and high- intensity approaches, CBT makes up over 50% of the interventions offered (HISC, 2014). The dominance of CBT in IAPT can be related to the NICE guidelines for depression and anxiety (NICE 2004a, NICE 2004b) which recommended CBT alongside other therapeutic approaches, such as interpersonal therapy for depression. However, Turpin et al. (2008) highlighted that research into variants of CBT which could be characterised as low- or high- intensity also prompted its dominance in IAPT. This allowed theoretically consistent treatments to be delivered in different formats and settings which fit the stepped care model and enabled greater numbers of people to access the service. As a result, CBT was prioritised in the training plan for IAPT, with other therapies added later in the programme's development.

Boyle (2011) suggested that CBT individualises distress and avoids acknowledging the impact of people's environments and life experiences as causes. More recently, Watts (2016) highlighted that whilst information about early childhood experiences can be included in a cognitive behavioural formulation, the focus of the work is not on acknowledging or working through these experiences and is instead focused on changing present-day thinking styles. The result is that individuals are encouraged to believe that the present-day incidents are not enough to lead to serious emotional distress and that the cause of distress is therefore rooted internally (Boyle, 2011). This minimises focus on social issues, such as racism, sexual-abuse or poverty, and distracts from solutions which might entail changes at a structural level. A concern is therefore that CBT assumes that people are able to change themselves and their situation through forces of sheer will, ignoring the social and environmental forces acting against them (Smail, 2004).

It is important to differentiate between CBT generally and CBT which is offered within an IAPT service. In IAPT, people are offered a restricted number of sessions and the expectation is that IAPT workers will work from a specific

treatment protocol based on the provisional diagnosis. This does not allow for patient-centred flexibility, which has problematic consequences for engagement. Perhaps one of the reasons that IAPT workers are expected to deliver CBT in line with a protocol is that they have received comparatively less training than their CBT peers trained outside of IAPT (Binnie, 2015). In this sense, although the IAPT model is increasing access to therapies at a national level, the therapy offered is of a lesser quality due to shortened training restricting the development of therapeutic skills and knowledge.

The CBT practised in IAPT is not only effected by changes in training, but also by the expectations of NHS managers on IAPT workers, with greater emphasis placed on therapists meeting targets. For example, the British Association of Behavioural and Cognitive Psychotherapies (BABCP, 2014) cited examples of the clinical judgement of their members being undermined by services attempting to meet unrealistic demands by offering people a lesser number of sessions than recommended by NICE guidelines. This involved service managers recommending people were offered six to eight sessions of CBT to ensure that the service was able to 'treat' a larger number of people within a defined timeframe, despite NICE guidelines recommending up to 20 sessions for some presentations. In these examples, the targets set by government for IAPT to treat 15% of their local population appeared to be prioritised over the quality of service delivered to people once they had entered into treatment.

1.10 Outcomes data collection

The session-by-session collection of self-report questionnaires (thus referred to as 'outcome measures') and their use in supervision and service commissioning, are distinctive features of the IAPT programme. In the next section I will suggest that they impact both patients' and IAPT workers' construction of the presenting problem in an unhelpful way. I will also outline the impact of sessional outcome measurement on the understanding of 'recovery' in IAPT, and how this functions to further deprofessionalise the IAPT workforce, and reduce the quality of services offered to patients as a result.

1.10.1 Sessional outcome measurement

All IAPT services are expected to collect session-by-session outcome measures, which are input into the service's IT systems and reportedly used to improve service quality and accountability. The central role of outcome measurement to the IAPT programme is highlighted by Layard and Clark (2014);

“Outcome measurement is probably the most important single feature of IAPT. It is really the only ultimate guarantee of quality” (p. 205).

Clark suggested that collection of session-by-session outcomes has had two main benefits; it has allowed for continued political support of the programme as government ministers can see how their investment is utilised, and it has increased transparency in mental health services with outcome data from all services in the country being published on a quarterly basis, allowing benchmarking and quality improvement (Evans, 2013).

However, based on my experience of service user involvement in IAPT, people often reported that the completion of the outcome measures questionnaires did not represent their experiences, that completing them took up precious time which could have otherwise been used talking to the therapist, or negative emotions were elicited by seeing this list of ‘symptoms’ written down. Some commented that consistently high ‘scores’ from the questionnaire indicated that they were doing something wrong as the ‘treatment’ wasn’t working. It was often noted that the questionnaires did not capture the changes which were truly felt to have impacted the person; a change to their benefits, new information from their landlord about their housing, or an outcome at work. The use of the current outcome measures questionnaires therefore appears to negatively impact the experience of therapy for people attending sessions, or does not adequately capture the nature of positive changes.

Another issue with the session-by-session completion of outcome measures is the impact on patients’ construction of distress. The choice of what factors are included in the outcome measures used in IAPT follow a psychiatric construction of depression or anxiety disorders, with the questionnaires

following the diagnostic criteria. The impact of this is to indicate to the person accessing the service that their experiences are biological and individual in nature. Mackinnon and Murphy (2016) demonstrated that people who had received treatment within IAPT tended to construct mental health as individual pathology, and as an entity which could be measured. The completion of outcome measures questionnaires thus becomes a technology of the self by which individuals problematise and regulate their own conduct. This influences the subjectivity of the person completing the questionnaire, and enables certain ways of acting in relation to this. Watts (2016) highlighted the 'invisible standard' set up by the outcome measures utilised in IAPT which ask only about the internal experience of the patient. The focus on the internal experience of the person therefore detracts from any social causes of their distress. In this respect, it may not be the completion of the outcome measures themselves, but the factors which are asked about and recorded through the measures which are problematic.

Sessional collection of outcome measures also influences IAPT workers' constructions of distress. Rizq (2012) suggested that the strict undertaking of protocols, outcome measures, and updating of computer systems in IAPT constructs a virtual reality of the work of the service, which is separate to the reality of the therapist being in the room with a patient. She suggested that in this virtual world, the attention paid to targets, outcomes, protocols and policies is privileged over the patient's psychological needs. Instead IAPT workers are focused on ensuring that the people they are working with have completed the questionnaires, in order for session to be counted as a 'clinical contact' and receive funding from the commissioners. This provides another barrier to the development of the therapeutic relationship, the importance of which has already been discussed in section 1.7.2.

1.10.2 'Recovery'

The session-by-session collection of outcome measures enables services to present a recovery rate. This is calculated using the concept of 'reliable improvement' in which the reduction in symptoms measured by the questionnaires is defined as large enough to warrant 'recovery' (IAPT, 2014). The government target for recovery is that 50% of referrals to IAPT services

should move to recovery by the end of their course of treatment. In 2014/2015 the recovery rate was 44.8% (HSCIC, 2015). Based on these figures, IAPT services are not currently meeting the recovery targets. However, the target of 50% appears to have been arbitrarily set and although no service will meet the needs of all people, all of the time, it appears to allow IAPT workers to uncritically assume that half of the people they work with will not get better, reducing incentives to think creatively about how they could successfully engage people in therapy, or questioning whether an alternative approach might have a different effect.

Furthermore, the use of the questionnaires to determine recovery changes the construct of recovery from both the IAPT worker's and patient's perspective. Anecdotally, there were instances when nearing the completion of therapy, a person's life appeared to have changed dramatically for the better and they had achieved their goals of therapy, yet the questionnaire scores remained the same. Alternatively, there were instances in which patients' scores had significantly reduced without corresponding changes to their life situation, behaviour or presentation. This could be a problem with the self-reporting nature of the questionnaires which can be affected by reporting bias and social desirability (Williams, 2015). For instance, the person whose scores are drastically reduced in the final session as they did not wish to offend the work of the therapist, or be seen as a 'bad patient'.

The use of outcome measurement data to re-construct 'recovery' also impacts the clinical power of people working in IAPT. Charlton (2007) asserted that much of the increased emphasis on explicit information and statistical analysis as tools of NHS policy could be seen as a rhetorical strategy with which to override the claims of clinical professionals. Increasingly, he argued, clinical training, experience and patient contact were being derided as subjective, and marginalized as anecdotal compared with health service data and the objective statistical analysis. This contributes to the deprofessionalisation of IAPT workers outlined earlier in the introduction and impacts the care offered to people accessing IAPT services as a result. Not only does this impact the clinical professionals working in IAPT, this deprofessionalisation impacts all therapists and psychologists working in the NHS through the re-construction of

therapy from a governmental perspective and the expectations of commissioners, and the public, of psychological therapies as a result.

1.11 Summary

The introduction has presented some of the problems with IAPT. There are epistemological critiques regarding the empiricist and naïve realist assumptions of the research underpinning the programme. There are social and political critiques highlighting the depoliticising impact of IAPT through its individualisation and medicalisation of distress. There are also psychodynamic critiques of IAPT's inability to contain people's anxiety, and the emotional impact on IAPT professionals as a result. More practically, there are suggestions that IAPT is not doing what it said it would; that BME groups, older adults and people from poorer backgrounds are either less likely to access the service, and if they do, achieve worse recovery rates than others. Furthermore, IAPT services have been unable to meet their target recovery rate of 50% and demonstrate a high drop-out rate between referral, assessment and treatment.

Despite these critiques, IAPT continues to grow into other areas of mental health service provision and is being replicated across the globe. I would argue that as a result of government involvement in the creation of IAPT, it is being presented as a framework for mental health services beyond its intended scope. The central role of government in the creation of IAPT and its subsequent growth invites a power-based exploration of the conditions of IAPT's emergence. In particular, the convergence of unemployment and mental health disorders within the same government programme. I am interested in how the government was able to bring these two social issues together, and propose increased access to psychological therapy as a solution.

An analysis of power appears to be central to understanding how it was that IAPT was enabled to grow, in particular using the work of Michel Foucault and his ideas of governmentality and subjectivity. Although there are histories of IAPT available, such as the description of IAPT in *Thrive* (Layard & Clark, 2014) or the discussion of the involvement of clinical psychology in the development of IAPT in *Clinical psychology in Britain, historical perspectives* (Marks, 2015), there is not an account in which IAPT is evaluated and clearly problematised.

As such I will now utilise a genealogical approach to explore the conditions of possibility for the emergence of IAPT. The methodology will provide further information regarding the epistemological and practical considerations of the approach.

2. METHODOLOGY

2.1 Introduction to Methodology

In this chapter I will outline the key features of Foucauldian genealogical investigation and explain why I have chosen this approach for the research question. I will briefly outline the epistemological position of the research and present the important role of reflexivity in this approach. I will explore ethical considerations of the research, and outline the methodological protocol. Lastly, I will determine the corpus of statements analysed in the research and analytic foci used as tools to structure the analysis. The corpus of statements are samples of data which express a relationship between 'rules' and 'statements' in the research (Arribas – Ayllon & Walkerdine, 2008). With respect to this research, the corpus of statements is bound together by their contribution to the conditions of possibility for the emergence of IAPT.

2.2 Key Features of a Genealogy

In 'Nietzsche, genealogy, history' Foucault (1977) stated that the *"traditional devices for constructing a comprehensive view of history and for retracing the past as a patient and continuous development must be systemically dismantled."* (p. 380). This highlighted the importance in this approach of dismantling the assumed chronology of historical events, and instead pointing out the range of possible outcomes by bringing attention to the influential forces which enabled a particular event to take place.

O'Farrell (2005) suggested that a genealogy is an approach which Foucault used to dismantle the continuous presentation of the past, and present subjugated historical knowledge which he often presented in terms of power. It is supposed that Foucault drew upon Nietzschean ideas of genealogy, particularly the construction of the history of systems of thought as moments of emergence and descent (Elden, 2002). Foucault proposed that knowledge was

not constructed from an underlying reality but was instead fabricated by fragments of truth which co-exist in various forms of correlation, opposition or juxtaposition (Tamboukou, 1999). 'Emergence' and 'descent' are the processes by which ideas taken to be 'truths' appear or discontinue through the process of production. For example, noticing ideas which gained power and status and those which simultaneously lost power and status; as well as being interested in the factors which may have been involved in this shifting distribution of power. This interest in specific moments is demonstrated by Hook (2007) who explained the nature of genealogy as "*a poised moment of converging contingencies and intersecting lines of force rather than a self-sustained, autonomous entity*" (p. 145).

Foucault's approach contrasted with the dominant portrayal of the development of knowledge as continuous. For example, the proposal that one theory is rejected and replaced by another when there is an accumulation of evidence highlighting the deficiency of the current paradigm (which is the body of knowledge) leading to a scientific revolution (Kuhn, 1970). The earlier quotation from Foucault instead demonstrates the interaction of a variety of different factors which influenced a specific system of thought gaining power at a particular point in time. As such, rather than history consisting of a single thread of continuously developing ideas, Foucault presented a complex inter-dependent network of systems of thought, which gained or lost power at different points in time in response to the cultural context.

Researchers have suggested that genealogies are concerned with the processes through which truth and knowledge are produced. In tracing and exploring the interweaving of cultural and historical practices, a genealogical approach presents possible ways in which 'reality' has been constructed (Tamboukou, 2003). As such, in undertaking a genealogy, the task of the researcher is to analyse the emergence and descent, and capture discontinuity and resistance within the process of the production of 'things' taken to be truths (Tamboukou, 1999).

It has been said that a Foucauldian genealogical investigation is, first and foremost, a mode of critique whose overall function is to oppose the centralising power effects of institutional knowledge and scientific discourse (Hook, 2005). The genealogical analysis therefore commences with the isolation of a

'problem'. The researcher then traces the current practices that could relate to the problem, formulating a network of relations between the practices and the problem (Dreyfus & Rabinow, 1982). In this analysis, the construction of IAPT as a dominant model of mental health service provision is problematised in order to trace the cultural and historical practices which gave space to IAPT's emergence and the subsequent descent of alternative practices in mental health.

2.3 Why Genealogy?

In the introduction I have proposed that the IAPT model is being presented as a framework for mental health services beyond its intended scope. Despite the limitations of IAPT as a framework for service delivery, it continues to gain momentum in its application to other areas of mental health. In continuing to structure services in this way, alternative options for service delivery are being closed down or ignored. This could be considered to be the 'problem' with which I chose to begin a genealogical analysis.

The procedures of genealogy aim to produce counter-intuitive ways of seeing in order to enforce an awareness that things have not always been there (Hook, 2005). In exploring the conditions of possibility for the emergence of IAPT, I hoped to trace the contemporaneous practices which have led to its emergence and in doing so explore what practices are simultaneously being excluded.

Arribas – Ayllon and Walkerdine (2008) highlighted the potential for a genealogical approach to undertake a historical investigation of technical and governmental intervention. This allows for consideration of the specific effects by which IAPT has been constituted. Foucault (1991) posited that power operates at a local level through a multiplicity of dispersed sites within society. As such he suggested that it was important to include analysis at both the macro- and micro-level to reveal particular techniques of power. A genealogy therefore allows for analysis of the mundane practices, both discursive and non-discursive, to explore wider themes related to the emergence and maintenance of IAPT.

In analysing historical material, I attempted to consider the conditions of possibility necessary for the emergence of IAPT. A condition of possibility is a philosophical concept used to establish the necessary framework for the

possible appearance of given entities. In this way, the thesis is a genealogy of the emergence of IAPT which aims to identify a particular historical development (Foucault, 1977). It also considered “descent”, which is to say the ideas or practices which have been excluded in order for IAPT to emerge.

2.4 Challenges of this approach

Foucault did not provide clear guidance on how to undertake a genealogical analysis. Despite this, he explained that he wished his work to be used as a *“kind of tool box which others can rummage through to find a tool which they can use however they wish in their own area. I would like [my work] to be useful to an educator, a warden, a magistrate, a conscientious objector. I don’t write for an audience, I write for users, not readers”* (Foucault, 1994, p. 523-524). His history of punishment and imprisonment, ‘Discipline and Punish’ (1975) is considered to be a sustained use of his genealogical approach, as is ‘The History of Sexuality. Vol. 1. An Introduction’ (Foucault & Gordon, 1980). As such, reading examples of Foucault’s use of a genealogical approach has allowed for some common factors to be extracted, these include;

- Statements with an emphasis on power;
- Power explored through a history of the present;
- Statements on ongoing processes; and
- A strategic use of historic material to answer problems about the present (Kendall & Wickham, 1998).

Foucault also presented genealogy as *“grey, meticulous, and patiently documentary. It operates on a field of entangled and confused parchments, that have been scratched over and recopied many times... Genealogy, consequently, requires patience and a knowledge of details, and it depends on a vast accumulation of source material.”* (Foucault, 1994, p.136). The accumulation of a vast quantity of materials, as well as the implied length of time proposed for its analysis, presented a challenge in incorporating the time-demands of this approach alongside the simultaneous demands of undertaking a practice-based clinical psychology doctorate. As such, this research should be considered as the application of a genealogical approach, not a genealogy in its

purest theoretical form, which attempted to apply Foucault's principles despite not drawing from the same 'vast accumulation' of source material as undertaken by Foucault.

2.5 Epistemology

Epistemology is the philosophy of knowledge, also defined by Burr (2003) as "*the study of the nature of knowledge and the methods of obtaining it*" (p. 202). The epistemological position of this research is social constructionist critical realist (Harper, 2012). It is social constructionist in its interest in how knowledge is generated and how some claims about reality are seen as having more validity than others (Gergen & Davis, 1985). It is simultaneously critical realist as it makes ontological assumptions about reality and pre-existing material practices whilst acknowledging that analysis was set within a broader historical, cultural and social context. Willig (2012) suggested that critical realist social constructionist researchers are concerned with the ways in which available discourses can constrain and limit what can be said or done within particular contexts. This might be compared to a realist position which posits that there is a 'real world' which exists independent of the person observing it (Bhaskar, 1975). The decision to maintain this position is in response to criticisms of the language of social constructionism which has been said to replace one form of essentialism, naturalism, with another, social determinism (Blackman, 2008). In taking this epistemological position I acknowledge the possible tension of holding two inconsistent positions; ontological realist and epistemological relativist. A reflexive stance was therefore vital in undertaking the analysis in order to maintain epistemological consistency throughout the research.

2.6 Reflexivity

Accordingly to Mills (2012), a genealogy reveals disparity and dispersion behind the constructed identity of the origin. It therefore rejects the uninterrupted continuities and stable forms of traditional history and aims to reveal the complexity and contingency surrounding historical events. Holding this position whilst undertaking the analysis was challenging and I guarded against being drawn towards a linear and more straightforward construction of the 'history of

IAPT'. It was therefore important to maintain a reflexive stance throughout the process to ensure that the multiplicity of factors surrounding the emergence of IAPT was attended to.

Reflexivity has been defined as the ability to engage critically in understanding the contribution the researcher's experiences have had in shaping the research and its "findings" (Harper & Thompson, 2012). In qualitative research the intersubjective relationship between the researcher and the researched data is acknowledged, making it important that the epistemological judgements and analysis applied to other forms of knowledge are also applied to the research and its associated claims. This could involve owning and stating one's own values and positions which inform the research whilst observing how these are deployed throughout the research process (Burr, 2003).

Having worked in IAPT services I have attempted to be mindful of the possibility for role conflict which could arise from having been an 'insider' (Kagan, Burton, & Siddiquee, 2008) and the possible influence of this on the research. Furthermore, my previous experience of research has been within closed methodological frameworks, such as experimental design. As such I have challenged my need for certainty and have instead sought to build a 'tool-box' of Foucauldian theoretical-analytical questions to interrogate the corpus of statements.

In order to nurture a reflexive stance, a research journal was completed throughout the research process. Although the primary function of the journal was to maintain a reflexive stance, it acquired secondary roles depending on the stage of research. For instance, whilst collecting data I recorded the decisions regarding choice of documents collected and analysed, what informed this iterative choice process and acknowledged what options may have been excluded in doing so. I also recorded my reactions to the data collected, particularly when I was surprised or confused. These reflections were referred to when undertaking the analysis to highlight moments which required further comment, perhaps as an example of resistance, or an example of something which did not 'fit' with one line of development, indicating that another practice

was coming to my attention (see appendix A for an example page from the journal).

2.7 Ethics

The critical stance of the research means that it has the potential to disrupt notions of service delivery and treatment for professionals and institutions implicated in the analysis. I am also aware that on completion of the study, I am not in control of how findings might be used by other people and institutions (Willig, 2008). As such, there is a possibility that taking a critical stance towards any psychological therapies service in the current political context of austerity is a risk. Given current restrictive funding allocated to mental health, one might question the utility of criticising investment of any kind in psychological therapy services. Despite acknowledging this ethical concern, I believe it is important that clinical psychologists are able to deconstruct what factors are giving some service-delivery models greater power than others; particularly if we are to understand what is likely to influence future change.

This dataset consisted of documents already in the public domain. Issues of recruitment, consent, and well-being of participants was therefore not considered and NHS and UEL ethical clearance was not required.

2.8 Method

Genealogical investigation cannot be undertaken linearly and the process of collecting, analysing and interpreting data was intertwined. However, the analysis was guided by the following principles:

- Selecting and narrowing down possible sources of data;
- Becoming familiar with the data;
- Identifying themes, categories and 'objects' of the discourse;
- Looking for inter-relationships between discourses;
- Ascertaining the discursive strategies and techniques employed;
- Identifying absences and silences; looking for resistances and counter-discourses; and
- Contextualising the material within the social, political and cultural and economic context (Carabine, 2001).

In accordance with a genealogical approach, I did not seek to produce an account of coherent narratives and underlying reality. Instead, I focused on interrogating the workings of discursive practices in which knowledge about IAPT has been constituted (Tamboukou, 1999).

2.9 Selecting a corpus of statements

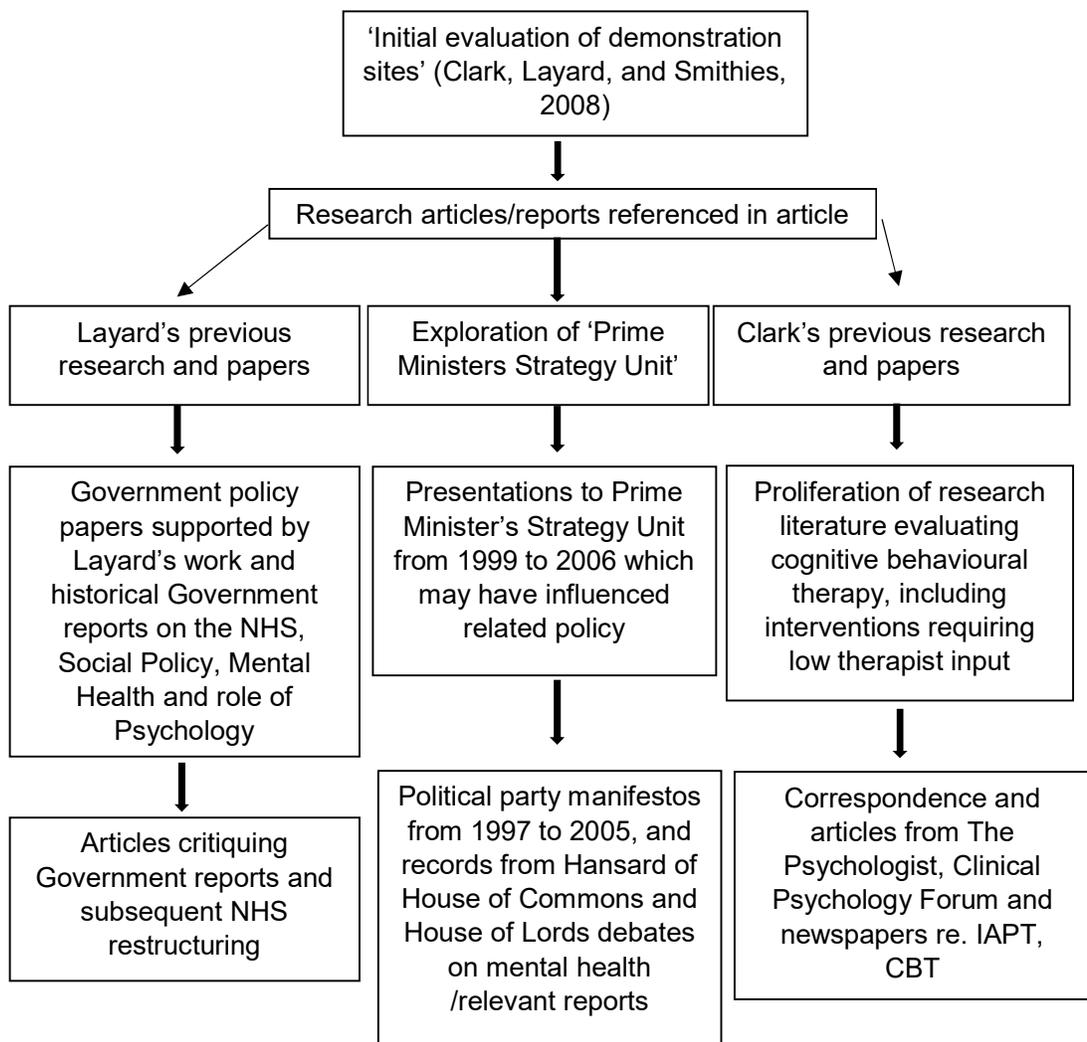
In undertaking this research, IAPT was analysed within the matrix of discursive and non- discursive practices that have given rise to its existence. Tamboukou (1999) wrote that Foucault drew upon a *“polymorphous and diverse map of documents and sources”* (p. 8). It was therefore important to explore a variety of texts, as well as considering practises established from the texts. Foucault (1977) posited that genealogy *“requires patience and a knowledge of details and it depends on a vast accumulation of source materials”* (p. 140). Other genealogical researchers have spent years immersing themselves in the primary, secondary and related data sources (Carabine, 2001). However, the current research was undertaken as part of a professional doctoral thesis. As such I had a defined time-frame in which to complete the genealogy. The sources drawn upon were primarily drawn from two areas of research, psychological and political. This was informed by the psychological context in which the research took place and the political nature of the questions posed.

The collection of documents followed an iterative process in which documents were read for possible references and relevant references pursued. Exploration was guided by my previous knowledge of IAPT. Data collection therefore started with the ‘Initial evaluation of two UK demonstration sites’ (Clark, Layard, & Smithies, 2008) as this is a document commonly cited when referring to the beginning of the IAPT programme. From this paper, references were collected for papers or documents relating to the research questions. The decision to continue down lines of enquiry or to stop in order to search elsewhere was recorded in my research journal and was guided by whether additional collection of documents within a particular ‘stream’ would add different data for analysis in line with the genealogical aims of the research. Despite the process of data collection being iterative, I was guided by the principles outlined by Carabine (2001). For example, in collecting documents I was interested in the

role they played in the shifting of power, influencing of discourses, creation of positions and resistance in the process of the emergence of IAPT. I ceased to collect further data when the reading of data was no longer adding new factors into my analysis.

When the collection of the corpus of statements was complete, I retrospectively recorded the pathways I had taken in searching for documents. This is summarised in the flowchart below.

Figure 1: A flowchart of the pathways of exploration in data collection



The arrows do not indicate a specific chronology of data collection but represent a simplistic presentation of data types collected in order to improve transparency as part of the research process.

As I was interested in conditions of possibility for the *emergence* of IAPT, I restricted the search to the time period leading up to the creation of IAPT and only included documents published up to and including 2009. 2009 was the chosen cut off point based on the publication of the initial evaluation of IAPT in late 2008 and the subsequent funding of IAPT services from this point. The data set comprised of 116 documents published from 1977 to 2009. The distribution of this is presented in figure 2.

Figure 2: A table presenting the distribution of the documents included for analysis by time period

	No. of documents	% of data set
1975 - 1979	1	<1
1980 - 1984	1	<1
1985 - 1989	1	<1
1990 - 1994	1	<1
1995 - 1999	13	11
2000 - 2004	52	45
2005 - 2009	47	41
Total	116	100

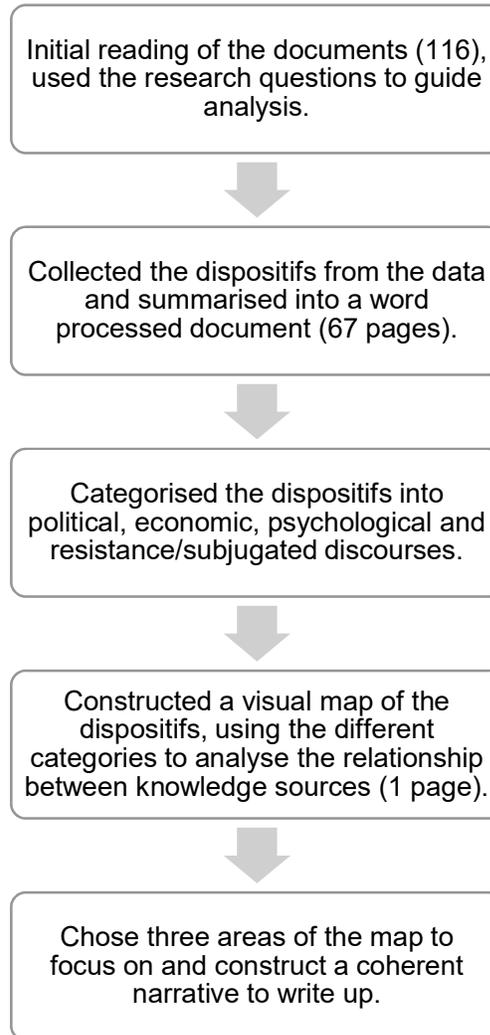
The types of publication ranged from academic articles (27%), government reports (34%), chapters of books (5%), presentations (8%), publicly published letters (6%), lectures (2%) and agendas, archived websites, debates, and special issues of clinical psychology forum (all less than 1%).

2.10 Tools and process of analysis

The process of analysis required me to read 116 documents. To move reading into a power-informed genealogical analysis, a range of tools were utilised. This included the use of genealogically informed research questions used to interrogate the data, Foucault's idea of the *dispositif* (this term is described further in 2.10.2) and awareness of the role of different sources of knowledge

and their interaction in the data. This process is summarised in figure three, and outlined in further detail below.

Figure 3: A flowchart to graphically represent the process undertaken in analysing the data-set



2.10.1 Initial reading of the documents

Based on Kendall and Wickham's (1999) summary of Foucault's archaeological and genealogical methods, my research utilised the following questions to guide the analysis:

- What are the rules for the repeatability of statements, which allow statements to reoccur?
(e.g. What are the dominant discourses in the emergence of IAPT and

their implications? What are the subjugated discourses and how might these help us consider alternative conditions that might improve people's wellbeing outside of popular models of mental health services?)

- What are the positions which are established between subjects in relation to these statements?
(e.g. Where does this position service users, clinical psychologists, commissioners, GPs and politicians?)
- How was the conceptual shift in service delivery 'made' possible?
(e.g. What material and discursive practices gave space for IAPT to grow? What practices continue to hold it in place?)

These questions guided my questioning of the data. An incorporation of power is central to understanding these questions and, whilst not explicitly stated in the questions, consideration of power was central to the process of analysis. A different coloured pen was used for each of the three questions. Each document was read a minimum of three times, each time with a different question in mind and notes recorded in the margins in the relevant colour. An example of this process is found in appendix B.

2.10.2 Collecting the dispositifs

A dispositif is a term used by Foucault to describe “*a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific énoncés, philosophical, moral and philanthropic propositions*” (interview quoted in Elden (2002)). The notes collected in the margins of the data were understood to represent the collection of dispositifs, constructed in response to the questions outlined above.

On reading the document three times (for each of the research questions), my notes were summarised in a word processed document. This information was organised and re-organised into constructed collections of dispositifs as the analysis developed. An outline of the headings and subheadings used to organise this summary is found in appendix C. This was an iterative process with headings changing as the data collection proceeded. The headings and

subheadings in appendix C are the headings and subheadings used to organise the summary of dispositifs at the reading of the final piece of data. The word processed document contained 67 pages of notes generated in answer to the research questions.

2.10.3 Mapping the dispositifs

As the research process developed, three sources of knowledge were repeatedly noted by the researcher; political, economic and psychological. In order to manage the increasing size of the data summary, the information was categorised into these three sub-headings. A fourth category was also used to note the examples of resistance or subjugated ideas.

In outlining the role of dispositifs in a genealogical approach, Foucault suggested that *“what needs to be examined is the system of relations between these elements, the nature of their connections and their strategic functions”* (Foucault, 1994). As such, the research considered the relationship between the dispositifs and how these relationships went on to create the conditions of possibility for the emergence of IAPT.

The information from the summary helped construct a visual map of the dispositifs. By separating out the knowledge sources into three different colours it allowed a graphic representation of when the three sources of knowledge were joining together to strengthen a particular practice or technology, or construct a particular object or discourse. Areas of space on the map were also noted and considered, as were examples of resistance which were mapped onto the constructed diagram using a fourth colour. Please see appendix D and E for two examples of the map; one with lines to portray the relationships between dispositifs (appendix D) and one without lines in which the dispositifs can be seen more clearly (appendix E). Economic sources of knowledge are coloured green, psychological sources of knowledge are coloured pink, political sources of knowledge are coloured orange and examples of resistance to the dominant narratives or practices are coloured purple.

2.10.4 Constructing a linear narrative for the write up

The construction of the map allowed an analysis of the relationships between the dispositifs, from which key points of convergence could be seen by multiple

lines joining together. The map was complex with a vast number of intersecting relationships between dispositifs. To focus the write up of the analysis, I chose to focus on three 'conditions' which seemed most connected to multiple dispositifs on the map and without which IAPT in its current form may not have emerged. Acknowledgement of resistance was incorporated into the analysis of these three conditions. It is important to note that although I have chosen to focus on three 'key conditions', the map demonstrates the complexity and interactivity between the dispositifs, and another researcher may have chosen to focus on three different conditions, which would have led to a different focus of the analysis.

Key texts from Foucault, or those influenced by his work, such as Rose (1990) were referred to throughout this process.

3. ANALYSIS

The conditions of possibility for the emergence of IAPT did not originate from one homogeneous source but a variety of scattered discursive and material practices which converged at different times. However, due to the time and word constraints of this doctoral thesis, I have focused on three key conditions from my data. A fuller and more complex interaction can be seen in my mapping of the dispositifs undertaken as part of the analysis (see appendix E).

I will first focus on the way New Labour constructed its relationship with the NHS and the public. I will consider the impact of this on the subject positions available to members of the public as a result. A subject position identifies a location for a person within a structure of power which governs what discourses are available to the person, what truth claims can be made and their moral location within social interaction (Arribas-Ayllon and Walkerdine, 2008). I will also consider the increasing importance of uniformity of services and measurement of success within the NHS, the deprofessionalising impact of this on clinicians and how these contributed to the culture of medically-oriented measurement and evaluation of interventions in IAPT.

Secondly I will explore the role of clinical psychologists as both researchers and government workers. I will particularly focus on the 'scientist-practitioner'

construction of clinical psychologists in the creation and evaluation of research, and how this enabled the IAPT model to be depoliticised. I will also suggest that the involvement of psychologists in central government legitimised economic discourses of cost-effectiveness in mental health service provision, enabling the stepped care model and low-intensity interventions which are characteristic of IAPT.

Lastly, I will outline the combination of discourses used by the government to construct and problematise unemployment. I will consider the moral expectations of employment intrinsic in New Labour's neoliberal subject positioning of citizens, the use of capitalist discourses to construct the 'cost' of unemployment to the individual and society, and medical discourses which positioned employment as curative whilst simultaneously problematising welfare dependence. I will argue that these discourses enabled the political partnership between government welfare and mental health services, in particular the inclusion of employment status as a measure of IAPT services' success.

3.1 Creation of the 'Third Way' by New Labour

In *'The New NHS. Modern. Dependable.'* (NHS Executive, 1997) the newly elected Labour government presented a move away from the competitive market-place introduced into the NHS by the previous Conservative government. They presented a 'third way' which they positioned between the centralised controlling government of the 1970s and the diversified internal market system of the 1990s. The 'third way' could also describe the continuation of the 'New Public Management' (NPM) system introduced by Thatcher's government in 1983 which promoted managers, markets and measurement in the management of the NHS (Lees, 2016a).

The 'third way' can be understood as a body of knowledge, constructed by modernisation and economic discourses which highlighted a shift in ideology within the Labour Party, away from its socialist foundations towards a neoliberal stance. Bell and Green (2016) highlighted the varied use of the term 'neoliberal' in critical health research. It can broadly be thought of deregulation of markets with the intention of achieving economic growth and public welfare (Maskovsky & Fisher, 2001). A Foucauldian understanding of the term can also be utilised in which the state is understood to govern from a distance via shifts in the

subjectivity of its citizens (Ward and England, 2007). In the context of this research, the Foucauldian understanding of neoliberalism will primarily be drawn upon, with some references to it as an approach to policy-making.

The modernisation discourse used to construct the neoliberal stance can be traced back to the ideals of the 'age of enlightenment' in which reason was the primary source of authority. The 'third way' particularly drew upon ideas of scientific progress in the modernisation discourse, which positioned resistance to its policies as 'anti-progress', and backwards or old-fashioned as a result. The modernisation discourse utilised scientific technologies to gain status. For example, the utilisation of data collection, in particular the introduction of individualised costings of treatment and therapy;

"...the Government will develop a national schedule of 'reference costs' which will itemise what individual treatments across the NHS cost." (NHS Executive, 1997, p. 23).

The itemisation of treatments was legitimised not only through the discourse of modernisation, but also through economic discourses of efficiency;

"All NHS Trusts will in future publish the costs of the treatments they offer, so that inefficient performance can be identified and tackled" (NHS Executive, 1997, p. 57).

The itemisation of treatment costs and subsequent detailed data available for government analysis was driven by the importance placed upon competition between services, in order to drive up quality. The influence of this on IAPT's specific service design is outlined in 3.1.1.3.

The 'third way' enabled the government to maintain control over services whilst reducing government responsibility for the outcome, as responsibility was devolved to the citizen to maintain their health. The proposed partnership between the government and its citizens appeared to increase the responsibility of the individual whilst benefiting society as a whole;

"It is our social contract: we help you, you help yourself; you benefit and the country benefits." (Labour Party, 2005, p. 9).

This neoliberal subject position influenced subjectivity through an expectation that individuals would be able to meet their own needs. This positioned the government as less involved and thus less responsible for communities. The proposed partnership between the government and its citizens did not acknowledge structural inequalities which disadvantaged people. It thus made invisible the barriers to taking up the responsible neoliberal subject position, such as poverty, racism and classism. By making the barriers invisible, the subject position was not there to be taken up. As positions need to be taken up to be resisted, opportunities for resistance were reduced. Furthermore, by focusing on a partnership, with individual's taking responsibility for their health, solutions were constructed on an individual basis. The implications of this on IAPT service-design and therapies offered is explored in section 3.1.2.1 and 3.1.2.2.

I believe that Labour's introduction of the 'third way' influenced a change in the relationships between the government and the professionals in its health services, and its citizens. In the next two sections I will evaluate these changing relationships, and the impact they had on the emergence of IAPT.

3.1.1 The changing relationship between the Government and the NHS

The Government proposed that in;

"...the new NHS, all NHS trusts will be required to open up their board meetings to the public" (NHS Executive, 1997, p. 18).

The government drew upon discourses of openness and transparency to propose a shift towards collaboration between local services which required greater sharing of information, both between services and with government-funded bodies who ensured a consistent national approach. The presentation of collaboration to justify increased transparency subjugated alternative intentions, such as the use of information sharing by the government as a means of control of health professionals and a reduction in professional independent clinical decision making. Discourses of openness and transparency positioned those resisting these practices as 'having something to hide'. Discourses of consistency were also used as a reason for data collection by government-

funded bodies, however, this ignored social, economic and health differences between different populations across the UK. The involvement of Government-funded bodies in ensuring a uniform approach to service delivery was central to the new relationship between the state and the NHS, as was the importance of measuring the success of services based on centrally derived criteria. To consider the role of the changing relationship between the government and the NHS on the emergence of IAPT, I have explored two aspects of the relationship which appear to be pertinent;

- The emergence of uniformity of care; and
- the increasing importance of measuring the success of services.

3.1.1.2 Performance driven uniformity of care

Uniformity of services appeared to be motivated by equality of access across the country;

“Some of these developments are already available to some patients, but not everywhere. The government wants to see them available to all as part and parcel of the new NHS” (NHS Executive, 1997, p. 6).

By focusing on equality of access to health services, the government was able to draw upon discourses of equality without addressing the specific issues of inequality which caused the differences in service provision to emerge in the first place (such as higher levels of poverty leading to worsening health and higher pressure on the NHS in certain parts of the country.) This positioned the government as taking a stance against inequality (in access to services) without committing to structural interventions to target societal inequalities (as this would not have fitted with market-based principles of neoliberalism popular at the time.) However, the focus on equality of access to services was not straight forward, and presented a tension between two aspects of New Labour’s approach; giving local services power whilst also ensuring that they provided a nationally-standardised service.

Despite emphasising the importance of local services having power for independent decision-making, the practices implemented by the government

clearly demonstrated a commitment to the standardisation of service delivery. An example of this is demonstrated in the following quotation which outlines the transference of financial responsibility to clinicians, alongside clear guidance regarding expectations of how investment should be spent;

“For the first time in the history of the NHS the Government will align clinical and financial responsibility to give all the professionals who make prescribing and referring decisions the opportunity to make financial decisions in the best interests of their patients. That will better attune local services to meet local needs. But the Government will set a framework of national standards and will monitor performance to ensure consistency and fairness.” (NHS Executive, 1997, p. 9).

In this example, referring decisions were made the responsibility of clinical professionals on the understanding that they would be made in the best interest of the patient. However, the government continued to control the referrals of clinicians by monitoring their performance, thus influencing the subjectivity of professionals in the process and ensuring their practice was in line with the ideology of the government. This enactment of governmentality was justified through discourses of consistency and fairness, which distracted from practices of government control and subsequent reduction in professionals’ power for independent decision making.

Furthermore, the government proposed that the choice to align clinical and financial responsibility would attune local services to local needs. However, the expectation of services to share information with government-funded bodies did not support this. The emphasis placed on national information sharing contrasted with the lack of guidance regarding the incorporation of local knowledge and how this could fit into the commissioning of services. Had this aspect of service delivery been prioritised, services may have been better able to respond flexibly to local needs. This is a feature not currently present in IAPT services with resulting low rates of engagement and recovery for minority groups outlined in the introduction to this research.

Local implementation of national guidance was supported by the development of a range of government-funded, quasi-independent bodies. The following quotation introduced the creation of the National Service Framework (NSF) and the National Institute of Clinical Excellence (NICE):

“Nationally there will be: new evidence-based National Service Frameworks to help ensure consistent access to services and quality of care right across the country; a new National Institute for Clinical Excellence to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service.” (NHS Executive, 1997, p. 22).

The NSF produced reports for health professionals and the public which outlined expectations of service delivery. The NSF reports utilised recommendations made by NICE which suggested treatments for specific disorders (the specific role of NICE in relation to psychology and the emergence of IAPT is considered in section 3.2.2.2 of this chapter). The combination of these two government-funded bodies reduced incentives for innovative local responses to clinical need, and subjugated knowledges deemed not to have a strong enough evidence-base to be included in NICE guidance. This was important in the emergence of IAPT, as the creation of NSF and NICE thus homogenised clinical provision and ignored diversity of local need as a result. NSF and NICE also provided a mechanism to provide highly detailed service specifications for IAPT services, based on the research collated and evaluated by members of NICE panels. The creation of NICE and NSF were thus examples of governmentality, as they enabled the government to extend control over services (allowing certain ways of thinking to govern individuals' options for acting) without being *seen* to be involved in their delivery. The creation of these bodies was important for New Labour to maintain control whilst appearing ideologically 'progressive' by devolving power to clinical professionals to make decisions.

NICE and NSF were later joined by the National Institute for Mental Health in England (NIMHE), which was created to enforce the national implementation of the targets outlined by NSF. To understand the proliferation of health monitoring bodies at this time, it is perhaps useful to consider the changing status of

medics, and the impact this had on how power was subsequently shared within the health service. The Labour Party Manifesto in 2005 stated;

“In light of the findings of the Shipman Inquiry⁵, we will strengthen clinical governance in the NHS to ensure that professional activity is fully accountable to patients, their families and the wider public.” (Labour Party, 2005, p. 61).

In this example, the government utilised discourses of accountability to discursively present their higher status than medical professionals. However, this power dynamic was not made explicit, with the government instead positioning medical professionals as accountable to patients and the public. This strengthened the neoliberal subject position in which members of the public were expected to take responsibility for their health and play an active role in holding the medical professional to account. The effect of this was a shift in the type of power available to health professionals; from pastoral power with which health professionals ‘looked after’ the public to a regulated power with which professionals acted on the recommendations of the government. This process positioned clinicians as technicians, and patients as neoliberal subjects who were expected to self-regulate their health and hold medical professionals to account.

NICE and NSF also provided an important link between the research community and the government, which enabled the development of research outside of the clinical practice of medical professionals; for instance, the convergence of clinical and cost-effectiveness of interventions which was motivated by the government’s increasing interest in health service efficiency. As the government strengthened its links with the research community, power was therefore shifted away from clinical professionals in the health sector, making it difficult for individual professionals to resist the implementation of IAPT when it was later introduced at a national level. In addition to this, clinicians were being afforded greater responsibility for the financial, as well as clinical, decisions within the health service and were aware that services’ efficiency would have to be demonstrated in order for them to receive funding.

⁵ The Shipman Inquiry investigated the activities of Harold Shipman, a General Practitioner and convicted serial murderer. The inquiry found flaws in the processes of death registration, prescription of drugs and monitoring of doctors.

As such, the evaluation of the clinical- and cost-effectiveness of treatments by NICE aligned with the changing role of health professionals within the health service at this time.

The combination of the increased role of government monitoring bodies, a shift in the type of power afforded to medical professionals and the convergence of clinical and cost efficiency in political and NHS management settings, provided an environment in which IAPT, a service-delivery model which allegedly demonstrated good clinical outcomes and cost-effectiveness, was supported politically and financially, enabling its rapid implementation.

3.1.1.3 Measuring the success of services

Another feature of the changing relationship between the government and the NHS was the increasing prevalence of outcome measurement to determine the success of services. In order to measure the extent to which services had implemented the Government's recommendations, the recording and sharing of outcome measures increased in importance. However, the government continued to present ideas of clinical autonomy, whilst simultaneously ensuring that services provided government endorsed treatments. The collection of outcome measures was therefore utilised as a technique of both surveillance, and a method to encourage clinicians to become self-governing. This was achieved through a re-construction of 'success' of services.

Measuring the success of a mental health service initially drew upon a variety of constructions;

- *“Equity. Is it available equally to all those who need it irrespective of irrelevant factors e.g. social class, ethnicity, age?”*
- *Accessibility. Is it easily accessed by those in need, e.g. geographically accessible, available without unacceptably long waiting times, etc.*
- *Acceptability. Is it acceptable to the users and does it meet their requirements, e.g. as measured by user satisfaction, rates of treatment completion, service take up, a choice of therapies? Does it satisfy referrers’*

and purchasers' requirements, e.g. in terms of good communication about care.

- *Efficiency. Is it cost-effective, maximising volume and quality of activity within a given resource?*
- *Effectiveness. Does it yield the clinical results in terms of reducing levels of mental ill health and improving people's functioning?"*
(Parry & Richardson, 1996, p. 61).

However, in contrast to this multi-factorial construction of success, the NSF for Mental Health presented outcome as the most important factor, thus prioritising efficiency and effectiveness over other factors;

"In the past, measurement has focused on input and process rather than on outcome. Better outcome measures are required" (Department of Health, 1999a, p. 96).

In order to measure outcomes, services needed to be clear about the phenomena or change which was being measured and reported on. The increased importance of outcome measurement therefore shaped how a person's problems were constructed and required all problems to fit into a particular framework. In order for services to be comparable, and thus competitive, a particular construction of the problem was required, such as the use of psychiatric diagnostic categories to construct 'depression'. These biological constructions were then reified and treated as unquestionable truths, enabling specific treatment-protocols and service designs, such as IAPT for 'anxiety' and 'depression'. Success of services was thus constructed using these specific terms and demonstrated by a reduction in medical 'symptoms' as a result of 'treatment'. However, the practice of implementing this was problematic. This was acknowledged when comparing services' ability to implement national service designs for coronary heart disease with mental health;

"Firstly, what constitutes appropriate outcomes in the mental health arena are highly contested compared to general medicine (e.g. there is a debate over whether 'observable' outcomes based on standardised interviews and 'objective' measurement are more appropriate outcomes than those based on subjective patient experience" (Rogers et al., 2002, p. 211).

Despite the contested nature of 'objective measurement' in mental health, the British Psychological Society was involved in the creation of another body, the Centre for Outcomes Research and Effectiveness (CORE) which utilised research to propose 'objective' measures of clinical impact;

"It is through CORE that more objective measures of clinical impact, such as the Health of the Nation Outcome scales have been promoted." (Burbidge, Chamberlain, & Gallsworthy, 2004).

Through scientific discourses of objectivity and medical constructions of 'disorder' and 'treatment', CORE constructed a 'reliable' way to measure change in mental distress, and the impact of mental health services as a result. As such, the expectation was for mental health services to demonstrate 'clinically significant' change as a result of their intervention. This prioritised simplistic constructions of medical treatment whilst subjugating complex social, political and intrapersonal constructions of distress which would have made service evaluations more difficult. Measurement of 'clinically significant' change was thus used to demonstrate the potential effectiveness of IAPT services. Outcome measurement was also used to outline targets for IAPT services in terms of the number of patients who were expected to 'recover'. In line with neoliberal use of competition to incentivise service effectiveness and efficiency, the 'recovery rates' were then used by the government to compare services nationally, and to award new contracts for IAPT services who successfully achieved these targets.

The collection of outcome measurement data by the government calls to mind Foucault's presentation of the 'Panopticon' as a model for the operation of power and surveillance (Foucault, 1991). The Panopticon was a design for a prison produced by Jeremy Bentham in the late eighteenth century which grouped cells around a central viewing tower. The Panopticon's design used surveillance to enable a change in behaviour of prisoners, as the potential for being seen caused the prisoner to become self-governing, behaving as though they were observed due to the constant possibility of this being the case. Foucault explained that the effect of the Panopticon was;

“to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power” (Foucault, 1991, p. 201).

In this respect, the Government’s expectation of services to share information at a national level allowed the government to monitor the implementation of their strategies and encouraged self-governing behaviour of professionals working within the services to align with the expectations of the government. An example of this in IAPT was the importance placed on the completion of a selection of questionnaires for every contact between the patient and the service. This was regulated by the government through payment, as without the completion of the questionnaire, contact between the patient and the professional would not be deemed a ‘clinical contact’ and as a result would not be included in the service’s statistics on which the service was paid. Not only did the collection of outcome measures act as a method of surveillance of services, it also acted as a subjugating technology of the self by giving an explanation of peoples’ distress which was individualised, shifting the focus away from social factors and possible social solutions.

3.1.2 Partnership between the state and its citizens

In the ‘third way’ New Labour constructed patient experience as another marker of service success. Through this, the government demonstrated an expectation on individuals to make ‘healthy choices’ using the consumer subject position. The government also drew upon the ethical subject position, which expected members of the public to engage in a process of self-monitoring and improvement. I will now consider how the increased prominence of these subject positions, and their subsequent impact on individual subjectivity, provided conditions of possibility for the emergence for IAPT.

3.1.2.1 Consumer subject position

The New Labour government placed greater emphasis than previous governments on patient experience in the evaluation of health services;

“And it must be the quality of the patient’s experience as well as the clinical result – quality measured in terms of prompt access, good relationships and efficient administration” (NHS Executive, 1997, p. 21).

The term 'patient experience' drew upon market discourses to construct the consumer subject position within a health service context. Speed (2011) posited that the construction of the consumer subject position could be considered a command and control mechanism deployed by government to reduce the power of professional providers. However, despite the use of market discourses, choices offered were all tightly delimited and tied back to government stipulated tariffs. I believe this was demonstrated in IAPT's portrayal of patient choice within a stepped care model which predominantly offered low-intensity CBT as the first option. If the consumer subject position was taken up by the individual, one of the effects was to distract attention away from the possibility of wider societal change, as patients were encouraged to hold the NHS to account in providing prompt access and efficient administration. One example of this was the emphasis placed on waiting times targets in this time period. Service success was constructed in terms of target waiting times, and this was enforced by patients who had taken up the consumer subject position. In contrast, an activist subject position may have called for societal changes such as improvements to social housing or reductions in income inequality in order to reduce mental distress.

The construction of the consumer subject position was enabled by the increased availability of information for the public, such as the publication of the 'evidence-base' by bodies such as NICE. As a result of the increased availability of the 'evidence-base', the public were positioned as more responsible for their own health;

"There needs to be a more equal relationship between the NHS and patients. Patients must be better informed and more in control of their care" (Department of Health, 2001, p. 11).

The proposed equality in this relationship acted as a subjugating technology of the self in which imbalances of power between the government and individual members of the public were not acknowledged. Based on this, the subjectivity of the individual was influenced through the expectation that they would 'take responsibility' for themselves by being 'informed' of 'evidence-based' practice. This subjugated local knowledges and positioned choices which were not recommended or 'evidence-based' as irresponsible. This maintained

government control over public health behaviour whilst simultaneously releasing the government from accountability. Through this process, the expectation that IAPT services offered only NICE recommended therapies was enforced by the individuals taking up the consumer subject position. In this sense, the consumer subject position not only enabled the target-focused culture of IAPT to grow, but also maintained the structures of the IAPT model once they were implemented.

3.1.2.2 Ethical subject position

Despite encouraging the public to make informed decisions regarding their care, the government did acknowledge some responsibility for providing the conditions in which informed decisions could be made;

“Government will play its part by creating the right conditions for individuals to make healthy decisions.” (Department of Health, 1999b, paragraph 1.37).

The description of ‘healthy decisions’ placed responsibility on the consumer to take control of and manage their health. This echoed Foucault’s construction of the ethical subject, in which individuals were expected to be engaged in a constant process of self-improvement. Smith (2015) described the construction of the ethical subject as a process whereby the subject reflexively relates to itself in order to enact care of the self. The importance of self-care is demonstrated in IAPT services through the expectation of monitoring, testing and improving the self. In the therapeutic domain this is demonstrated through the expectation that individuals record activities or thoughts in diaries for homework, measure their symptoms in sessional questionnaires and improve themselves through attending therapy. In this sense, a person is not considered to be an ‘ethical’ member of society unless they are doing what they can to keep themselves healthy. In this context, healthy is constructed in a particular way, implicitly individualistic and aligned with government ideology. Yet this ideology is not acknowledged and ‘healthy’ behaviour is constructed within the value-free constructions of the ‘evidence-base’, making critique or resistance difficult and subjugating ideas that it could be the person’s context which was causing them distress or ill-health.

3.1.3 Summary of section one: Creation of the 'Third Way' by New Labour

To summarise, the increasing importance of uniformity of care and outcome measures in the NHS indicated a shift in the relationship between the government and clinical professionals. This provided conditions of possibility for the emergence of IAPT through the introduction of government bodies and related systems which evaluated research and made recommendations for service delivery based on medical models of mental health. Through these practices of governmentality, clinical professionals were encouraged to develop self-governing behaviour with their clinical practice increasingly aligned to the government's ideology as a result. The subjectivity of clinicians was also influenced by the shift from pastoral power to regulated power. This simultaneously constructed the public in a neoliberal subject position, encouraging them to hold medical professionals to account.

The neoliberal stance of New Labour also enabled the construction of two subject positions for the public, the consumer and ethical subject positions. Through the consumer subject position, the relationship between the government and the public was presented as equal, with individual members of the public expected to be informed and in control of their health. In addition to this, New Labour called upon the ethical subject position, in which citizens were morally obligated to engage in self-care through a process of monitoring, testing and improving the self. The convergence of these positions increased individual responsibility for health which enabled the growth of individualistic therapies, such as CBT, whilst subjugating alternative subject positions such as the activist which would have focused on responsibility for health at a social or structural level.

3.2 The role of clinical psychologists in research and government

The emergence of IAPT relied upon the status of clinical psychologists who had undertaken, evaluated or utilised research in the construction of government guidelines. More specifically, the scientific construction of psychological research enabled the introduction of IAPT to appear apolitical. This was achieved through the positioning of clinical psychologists as 'neutral', which enabled the social issue of unemployment to be reconstructed as the result of a mental health disorder. The presence of psychologists in government also

legitimised the emphasis placed upon cost-effectiveness in the evaluation of therapies, in which the choice to favour cost-effectiveness over meaningful utility was not made explicit. Furthermore, the application of scientific methods of evaluating psychological research evidence was legitimised, utilising the same grading system for both psychological and pharmacological research.

In the following two sections I will argue that the combination of ‘scientific’ psychological research and national therapeutic guidelines enabled the CBT ‘evidence-base’ to grow at a faster rate than other approaches. The ‘scientific’ presentation of CBT research aligned with the emphasis placed upon ‘evidence-based’ policy-making in New Labour. By making the ideology underpinning the research process invisible, resistance was made difficult and alternative ‘truths’ were subjugated. This enabled and maintained power for the IAPT programme which drew upon this ‘evidence-base’, resulting in IAPT’s national roll-out as a service delivery model.

3.2.1 Clinical psychologists as researchers

The proposals for the IAPT programme drew heavily from scientifically-framed psychological research literature. As early as 1977 clinical psychologists had been constructed as scientists; *“developing systematic methods of scientific enquiry”* (Department of Health and Social Security, 1977, p. 6) and researchers; *“adding to and developing the sum of knowledge and the range of methods”* (Department of Health and Social Security, 1977, p. 6). I will argue that the scientific positioning of psychological research, alongside the presentation of subsequent research as ‘neutral’, enabled the emergence of IAPT by making its political ideology invisible.

3.2.1.1 The scientific construction of psychological research

Alongside the psychodynamic stance commonly used by therapists practising in Britain, the early development of clinical psychology took place in hospitals under the guidance of psychiatrists;

“95% of the patients seen by clinical psychologists were referred to them by psychiatrists” (Department of Health and Social Security, 1977, p. 2).

As such, psychologists had to actively differentiate themselves from psychiatrists, whilst continuing to work within a medically and biologically oriented system. The biological basis of medical research was founded upon a positivist epistemology, from which presentations of human distress could be observed, measured and categorised from an objective and value-free position. In taking a realist position to research, clinical psychologists worked from the basis that there was a 'real' world that existed independently from the person observing it.

Psychological research was therefore undertaken within this framework, informing the 'evidence base' on which subsequent therapeutic practice was based. The scientific construction of mental health was individualistic, drawing upon biological to cognitive explanations of distress. This subjugated explanations of distress which located the variables in the person's context; such as family relationships, housing situations or wider cultural variables such as racism, classism, or poverty. As such, psychological interventions were aimed at an individual level, with responsibility for change located in the individual as opposed to the need for wider societal change. Some therapies, such as CBT, were epistemologically aligned to these research practices. Thus, when Layard called upon the Government to provide 'evidence-based' therapies, CBT was in a strong position.

In response to the dominance of CBT within the psychological research literature, psychologists working for the Government requested research from other approaches;

"There is an urgent need for controlled research on the clinical effectiveness of psychoanalytic therapies and eclectic psychotherapy. This should include attention to developing valid and reliable technologies to measure psychodynamic aspects of clinical change..." (Parry & Richardson, 1996, p.10).

Here we see government psychologists acknowledge the need for alternative therapeutic approaches, specifically psychodynamic and eclectic psychotherapy. However, the epistemological positions from which these approaches were practised were not aligned to the framework used to evaluate them. The realist and positivist position of the government evaluators was

demonstrated in the language in the above quotation which called for controlled research using valid and reliable technologies to measure change. Furthermore, the epistemological assumptions underpinning this request were not acknowledged. This problematised the different therapeutic approaches for not producing adequate research, and implicitly blamed researchers in these fields for not contributing to the evidence base. Through this process, the evaluation of evidence was presented as a neutral process and the systematic discrimination against research which did not work from a realist positivist position was not acknowledged. This acted as a barrier to other therapeutic approaches contributing to the 'evidence-base', with subsequent implications for the variety of therapies offered nationally through IAPT. The dominance of CBT in the 'evidence-base' was thus constructed as a result of CBT being a more 'clinically effective' therapy, as opposed to a therapy which was best suited to government-preferred evaluation methods. This justified the dominance of an approach which individualised distress, the problems with which have been outlined in 1.9.3 of the introduction. Despite this, alternative therapeutic approaches did not disappear, with institutions such as the Tavistock and Portman NHS Trust providing a site of resistance through continuing to receive funding to practise psychodynamically.

3.2.1.2 The proposed neutrality of psychologists undertaking the research

The positioning of psychologists as 'scientist-practitioners' afforded them status within a medically aligned system. Their engagement in research also allowed for the production of psychological knowledge. The development of research skills continues to be important to the identity of clinical psychology today, with the completion of doctoral research in clinical training differentiating psychologists from other therapists. Although clinical psychologists are trained in a diverse range of research methods, historically a neutral scientific research approach has been idealised;

"The clinical psychologist was a channel through which developments in general psychology could be transmitted and used to help patients, either by psychologists themselves or by passing them on to clinical colleagues."

(Department of Health and Social Security, 1977, p. 6).

Psychologists in the above quotation were constructed as not bringing their own values or interpretations to the research, and were framed as neutral ‘channels’ through which the information could be shared. Furthermore, in considering the role of psychologists in the application of scientific investigation to applied settings, psychologists were positioned as;

“adding to and developing the sum of knowledge and the range of methods”
(Department of Health and Social Security, 1977, p. 6).

In terms of the production of knowledge, this positioned clinical psychologists in a powerful position in which they were able to produce, evaluate and disseminate their knowledge from a politically neutral position. The construction of neutrality was a technology of power, against which resistance was difficult, as the political assumptions underpinning research and guidelines were hidden by the use of scientific discourse.

The scientific, neutral stance of psychological research enabled the emergence of IAPT in its depoliticising of unemployment and re-construction of unemployment as the result of an individual mental health disorder. For example, by focusing on individual pathology (such as mental disorder) as the cause of unemployment, attention was diverted away from broader social and political causes such as the introduction of the free market and changes in jobs available in the UK. This led to individual solutions to unemployment (such as therapy) being proposed, not on ideological grounds, but on the basis of ‘scientific evidence’. Politicians were thus able to utilise ‘scientific’ and ‘neutral’ research to support ideological changes to health and welfare systems, without political resistance. More specifically, Layard used psychological research to assert that happiness could be constructed in objective measurable terms, and to propose that any job was better than no job for individual happiness;

“That is why low unemployment should be a key goal for any government. It also means that almost any job is better than no job” (Layard, 2003, p. 5)

The use of scientific and neutral discourses when citing psychological research obstructed from view the ideological assumptions underlying the government’s intervention, namely capitalist constructions of happiness relating to material gain and the importance of productivity in citizenship (this will be explored further in section 3.3.2). The use of scientific discourses when drawing upon

psychological research therefore masked the political motivations of the government in combining the issue of unemployment with mental health. In particular, the use of these discourses enabled a construction of unemployment as an individualised problem, without acknowledgement of the wider societal and cultural context. This subjugated resistance to IAPT, as arguments opposed to investment in mental health services based on 'scientific research' and the 'evidence-base' were positioned as ideological and without substance.

3.2.2 Clinical psychologists in governmental positions

IAPT not only relied upon the status of scientific discourses in its promotion of psychological research. It also relied upon the research skills of psychologists working in civil servant roles who constructed the specific IAPT programme model through the combination of the 'evidence base' and government ideology. By the emergence of IAPT, the role of psychologists in government was well established, as the Trethowan Report had proposed a role for psychologists at a national level since 1977;

"We think that the Department should in addition appoint centrally a full-time psychologist with responsibilities for the development of the service nationally" (Department of Health and Social Security, 1977, p. 19).

Clinical psychologists had subsequently held influential positions within the Department of Health, having written and disseminated national guidelines such as '*NHS Psychotherapy services in England. A Review of Strategic Policy*' (Parry & Richardson, 1996) and '*Treatment choice in psychological therapies and counselling*' (Parry, 2001). Discourses of scientific objectivity appeared to empower greater status to psychologists writing national guidelines, resulting in knowledge communicated through these guidelines being positioned as of higher status than that of professionals working in a clinical capacity. In this respect, the psychology-researchers in government acted as a technology of power, deployed by the government to reduce the power of clinicians to engage in independent decision-making.

In the following section I will argue that the privileging of research-based psychological guidelines over local clinician knowledge enabled the emergence of IAPT in two ways;

- status afforded to cost-effectiveness enabled clinical decision-making to be re-constructed within the stepped care model; and
- the process through which psychological research ‘evidence’ was graded prioritised randomised controlled trials, increasing the dominance of CBT and subjugating alternative constructions of distress, particularly from those with lived experience of distress and mental health services.

3.2.2.1 The authority of cost-effectiveness in government-provided literature

In 1996 there was a clear economic objective to the national review of psychotherapies on offer in the NHS, and cost-effectiveness of therapies was presented as important;

“To be cost-effective, psychotherapeutic intervention should be at the least complex, costly and intrusive level consistent with effective treatment” (Parry and Richardson, 1996, p. 7).

This was related to increased discourses of efficiency within New Labour’s investment in public services outlined in 3.1. In order for a definition of ‘cost-effective’ to work, a clear understanding of ‘effective treatment’ was required. This drew upon medical constructions of ‘mental disorder’, which contrasted with other constructions of effectiveness, such as psychodynamic approaches which emphasised increased understanding of one’s emotional reactions or relationships. The power of researcher-psychologists in government to create guidelines used to evaluate services influenced the ‘truths’ available and enabled certain ways of acting. Through this process of governmentality, economic discourses of cost-effectiveness and medical discourses of symptom reduction converged. Due to its epistemological alignment with these ‘truths’ CBT was therefore presented as a cost-effective ‘treatment’ of ‘mental disorders’, requiring less therapist input than traditional psychodynamic approaches.

Cost-effectiveness was therefore included as a factor to consider by both NSF and NICE when making recommendations on which therapies should be offered by the NHS. This led to the creation of clinical interventions which could be undertaken in ways to reduce costs, such as;

“Offering less sessions of CBT than in RCTs; Self-study assisted CBT; Group CBT; Problem-solving and supervised exercise programmes; Computerised CBT, CBT oriented guided self-help” (Clark et al., 2007, p. 18 - 22.)

The above quotation is taken from Clark’s presentation on CBT to the government, as part of the IAPT proposal process. Given the emphasis placed upon scientific discourses of psychological ‘evidence-based’ research, it is surprising to note that offering less sessions than in research studies is proposed as an option for government consideration regarding cost-effectiveness. This highlights the power of economic discourses at the time, not only to politicians, but to the researchers presenting the ‘evidence-base’. The importance placed upon cost-effectiveness led to the creation of ‘low-intensity’ interventions’ such as those undertaken by PWP’s, the problems with which have been outlined in the introduction. The prioritisation of economic discourses of cost-effectiveness within health policy resulted in targets, such as a reduction in waiting times, being prioritised over meaningful engagement with services and alternative constructions of ‘recovery’ or ‘improvement’. This has been demonstrated in IAPT by a reduction in the provision of long-term therapies, with increased emphasis on people being seen quickly, albeit for such short-term therapy, with inconsistent emphasis placed on quality and subsequent effects on engagement and ‘recovery’ as a result.

3.2.2.2 The strategy chosen to grade psychological research ‘evidence’

The NICE recommendations on which IAPT was based prioritised research from randomised controlled trials, the evidence from which was graded as ‘type one’. This grading process took place within a positivist epistemological framework and led to a hierarchy of evidence in which positivist methodological approaches were given higher status and power to influence clinical recommendations and guidelines. For example, the NSF, explained different types of evidence;

“Type 1 evidence – at least one good systematic review, including at least one randomised controlled trial. Type 2 evidence – at least one good randomised controlled trial. Type 3 evidence – at least one well designed intervention study without randomisation. Type 4 evidence – at least one well designed observational study. Type 5 evidence – expert opinion, including the opinion of service users and carers” (Department of Health, 1999a, p. 6).

The allocation of higher status to randomised controlled trials in the evaluation of evidence influenced the subsequent dominance of cognitive behavioural approaches. Following from the arguments outlined in 3.2.1.1., this allocation of higher status to ‘scientific’ research methodology and evidence subjugated alternative constructions of distress and possible solutions. In relation to IAPT, it subjugated social, relational and political constructions of distress, and perpetuated research which proposed individualistic solutions, such as psychotherapy or pharmacology. It also subjugated expert opinion and the opinion of service users and carers, placing this in the lowest position in the hierarchy of evidence types. The exclusion of lived experience knowledge from ‘type one’ evidence demonstrated powerful processes of governmentality and subjectification, in which people with lived experience were excluded from the processes by which political and service-level decisions were being made. This constructed mental health services as something being done to the individuals, forcing ‘patients’ to inhabit subject positions of ‘service user’ for services which they had little control or power to influence.

The NSF quotation above outlines the evaluation of the ‘evidence-base’ for mental health ‘treatments’. The framework used to evaluate this research is biological in origin and was referenced from a paper evaluating the evidence for;

“four important groups of drugs – angiotensin converting enzyme inhibitors in patients with heart failure, choice of antidepressants, non-steroidal anti-inflammatory drugs in patients with osteoarthritis, and aspirin as an antithrombotic agent” (Eccles, Freemantle & Mason, 1998, p. 1232).

The original use of the framework in the evaluation of drugs has problematic implications for the types of evidence evaluated. Firstly, the biological principles

used to evaluate research evidence subjugated knowledge from experts by experience. This influenced subjectivity of both professionals and the public, by asserting that scientific and biological constructions of distress deserved greater status and profile than alternative accounts. Secondly, the biological research from which this framework originated is not explicitly acknowledged by the NSF. This makes its underpinning biological assumptions invisible, making it difficult to critique its position. Finally, the biological assumptions underpinning the framework were epistemologically aligned with CBT, which, although psychological in approach, draws upon similar assumptions of scientific objectivity in its research methodology. This strengthened the ‘evidence-base’ for this type of approach over others and subjugated research demonstrating the effectiveness of alternative therapies which did not exclusively utilise RCTs.

An inadvertent consequence of this approach to the grading of evidence, was that some areas of clinical practice have subsequently developed within a bubble of ‘practice-based evidence’ due to the specific focus of their work. For example, in many specific health and social settings, the small number of those receiving psychological intervention in a specific context make recruiting for large-scale RCTs problematic. As such, these areas of practice do not tend to have large ‘evidence-bases’ on which to base recommendations. Psychologists in these fields therefore practice with an awareness of the research relevant to their field, whilst escaping from the regulatory practices of NICE and related bodies.

3.2.3 Summary of section two: The role of clinical psychologists in research and government

The scientific construction of psychological research afforded status to individual constructions of mental disorder and unemployment. The neutral positioning of psychologists and their research enabled the portrayal of the IAPT model as an apolitical, ‘evidence-based’ approach to policy making. This process subjugated other possible interventions for unemployment or mental health, at a social or political level. The incorporation of cost-effectiveness into the evaluation of clinical research encouraged a focus on low-cost therapeutic interventions, such as low-intensity CBT which went on to be a key characteristic of IAPT. Psychologists in government positions also perpetuated

a medical construction of mental health through the application of an evidence-grading system initially used in pharmacology for psychological therapies. This process did not value knowledge from service users or clinical professionals, reducing their power to influence the 'truths' made available to people through research, subsequently impacting subjectivity of individuals as a result.

3.3 The convergence of discourses constructing unemployment

Layard proposed that the IAPT programme would be cost-neutral; that the savings made by the reduction in numbers of people claiming incapacity benefit alongside an increase in taxation of those becoming economically active, would balance the investment in IAPT services without increasing taxes or the government's deficit. In order to make these claims, Layard drew upon multiple discourses surrounding unemployment including;

- the moral expectations of citizens to work;
- the economic impact of the unproductive subject; and
- the health benefits of employment.

In the next section I will explore how these discourses, the subject positions they created and the implications these had on subjectivity, enabled the emergence of IAPT.

3.3.1 Moral expectations of citizens to work

One of the aims of New Labour was to improve national employment levels, which they targeted through the 'Welfare-to-work' programme. This required claimants of Job Seeker's Allowance to comply with direction from employment advisors in order to receive benefits;

"Under the Job Seeker's Allowance introduced in 1996, job-seekers can be given explicit directions by their adviser. Failure to comply with the rules can lead to loss of benefit for up to six months." (Layard, 2000, p.279).

The above quotation highlights the expectation that welfare claimants would perform certain activities in order to remain eligible for support. Arribas-Ayllon (2005) suggested that these sorts of activities, in the context of welfare reform, accessed the self-regulating capacities of individuals which elicited forms of

responsibility, moral and psychological adjustment, to cultivate forms of motivation and self-esteem to ensure the moral reformation of the self.

This moral model of employment was constructed using neoliberal discourses of rights and responsibilities in which individuals were obliged to engage in a choice of activities (such as paid work, training or voluntary placements) in order to receive job seekers allowance;

“This is a system of ‘stick’ and ‘carrot’, based on mutual rights and responsibilities. Everyone has the right to offers but in return they have the responsibility to use them – or at least to stop drawing benefits. Rights and responsibilities is a central philosophy of New Labour and of the New Deal” (Layard, 2000, p. 280).

The use of the carrot metaphor for the distribution of finances to incentivise the behaviour of people claiming job seekers allowance echoes Foucault’s ideas of disciplinary power in which, through the allocation of resource (in this case welfare benefits) the government;

“defined how one may have a hold over others’ bodies, not only so that they may do what one wishes, but so that they may operate as one wishes” (Foucault, 1991, p. 138).

In this example, the government was able to control the actions of the individual and incentivise certain behaviours which were authorised by the government (paid work, training or voluntary placements). More specifically, the person was expected to comply with the explicit directions of an adviser, or lose access to benefits for up to six months. This quotation also draws upon ideas outlined in section one of the analysis, regarding the portrayed equal relationship between the government and citizens through the use of discourses of ‘mutual rights and responsibilities’. In this sense, the explicit power difference between the government and the citizen (in which they will be punished if they do not comply) is masked by the rhetoric of equal partnership.

The construction of employment as a moral obligation also constructed individuals in the ethical subject position, defined in section 3.1.2.2. Using this ethical subject position, citizens were expected to uphold their responsibility to

improve themselves and the focus of change was directed at an individual, rather than a social or political level. This subjugated resistance to the reconstruction of unemployment which was taking place through IAPT, whereby unemployment was being re-constructed as an individual mental health disorder, not a national political problem. IAPT drew upon discourses of rights and responsibilities, not just in its approach to employment, but also in the expectation that people would engage in therapy. In IAPT, the right of the citizen to receive evidence-based therapy was followed by their responsibility to engage with the therapy, and make changes to their lives in order to 'get better'. The implications for the individual's subjectivity was the taking up of a self-governing subject position, in which the individual was made responsible for change, both on a psychic level (through therapy) and a practical level (through gaining employment). This distracted from the rights of citizens to meaningful employment, perhaps indicative of the lessening power of trade unionism which had taken place throughout the Thatcher era which preceded the New Labour government.

3.3.2 The cost of the unproductive subject

Despite the apparent reduction in unemployment, in 2003 the levels of economic inactivity remained the same (Prime Ministers Strategy Unit, 2003). This could be considered in the context of decreased production in the UK economy following systematic reductions in manufacturing and increased outsourcing of jobs overseas. It could also be considered within the context of weakened labour rights and trade union power since 1979 (Nolan, 1989). However, Layard did not construct stagnating economic activity at this political or social level, instead he focused on individual constructions of unemployment, specifically the construction of unemployment as a state caused by mental health disorders, leading people to claim incapacity benefit;

"There are now more mentally ill people drawing incapacity benefits than there are unemployed people on Jobseeker's allowance. Now that we have so successfully reduced unemployment, mental illness becomes the next priority target for action." (Layard, 2005, p.2).

Layard drew upon medical discourses of mental illness to explain the number of people claiming incapacity benefit. In contrast to discourses of rights and

responsibilities outlined in the previous section, the use of medical discourses did not blame the individual for their economic inactivity as they were positioned in the 'sick' role. The construction of the 'sick' benefit claimant converged with capitalist discourses, with Layard outlining the societal cost of unemployment;

“All this means a loss of output and income. The loss of output is a loss to society. The individual sufferer bears only a part of this loss, because in most cases he receives incapacity benefits which partly offset the loss of earnings. Thus the loss is shared between the individual and the taxpayer” (Layard, 2006, p.2).

The use of economic language constructed the individual within capitalist discourses of loss of output and income. This problematised the non-worker, and highlighted the financial consequences to society. This construction of the unproductive subject presented a narrow idea of productivity, in which labour resulted in goods or services of monetary value. However, this subjugated other categories of production, such as reproductive labour, which was associated with labour in the private sphere and was subsequently unwaged, for example, cleaning, cooking and having children (Vogel, 2013). This problematising of the non-worker also subjugated alternative constructions of the non-worker outside of capitalist discourses, such as citizens caring for family members or contributing to society through voluntary work.

Aside from economic cost, Layard also utilised the ethical subject position in constructing the moral costs of unemployment to society;

“It is first to eliminate the economic waste incurred when thousands of people are producing nothing at considerable expense to the taxpayer. This is a pure efficiency issue. Second, it is to reduce the considerable side-effects which follow from high unemployment – crime, family break-up, drug dependence and the scarring effects of unemployment upon people’s subsequent productivity and employment.” (Layard, 2001, p. 284).

Here, the economically inactive person was constructed as a resource which had been wasted. Furthermore, not only was the economically inactive subject a waste of resource, they were also a cost to the taxpayer, both directly through their dependence on benefits, but also indirectly through the costs of crime,

family-break up and drug dependency which Layard linked to unemployment. The use of 'crime' as a discursive practice to legitimise national intervention on unemployment demonstrated the role of employment as a technology of power and a means of social control. Employment encouraged the individual to take up the 'productive citizen' subject position, which (following Layard's logic) simultaneously took away opportunities to take up other positions such as criminal, or drug user. Layard's construction of employment distracted attention away from other sources of crime, in particular 'white collar' crime, such as the behaviours engaged in by individuals in the financial sector leading up to the collapse of the UK economy and subsequent need for the government to 'bail out the banks'. This more complex construction of employment, which inhabits both productive and criminal positions is not made available, instead presenting the employed subject as the moral position. Through this construction of moral employment, social problems which occurred at a community level, such as crime, were constructed as the result of an individual not engaging in employment. The convergence of the economic and moral discourses in constructing unemployment and the unproductive subject, legitimised government involvement in the reconstruction of unemployment as an individual mental health problem. This resulted in individualistic solutions, such as the provision of individual therapy within the IAPT programme.

Layard's profession as an economist could account for his economic construction of unemployed people with mental health disorders. However, this construction was found elsewhere in government materials, pre-dating Layard's IAPT proposals. The example below is taken from the National Service Framework for mental health, a department of health report (explored both in section one of the analysis as an example of the proliferation of government-funded bodies, and section two with regard to the role of psychologists in government). Here, the cost of mental illness was constructed not only in benefit payments, but also in terms of lost income through employment;

"Besides the immense costs in personal and family suffering, mental illness costs in the region of £32 billion in England each year. This includes almost £12 billion in lost employment and approaching £8 billion in benefits payments" (Department of Health, 1999a, p.14).

The economic construction of mental illness and related unemployment was thus already well established in the department of health, prior to IAPT proposals. This construction of people claiming incapacity benefit in an unproductive subject position closely aligned within the rights and responsibility discourses of New Labour, as well as the related consumer and ethical subject positions. Therefore, once Layard was able to provide 'evidence' for the effectiveness of therapeutic interventions for mental illness, as well as the cost neutrality of the IAPT model, investment was justified as it fit within the wider ideology of the government of the time.

3.3.3 Employment as curative

Another consequence of the convergence of medical and capitalist discourses, was the construction of employment as curative in itself. This was demonstrated in the department of health report '*Saving lives: our healthier nation*', in which the government proposed that they would be;

"making it easier for people to escape from the benefits trap into work"
(Department of Health, 1999b, p. 4.11).

The construction of the 'benefits trap' was a powerful rhetorical device which positioned people claiming benefit as powerless and stuck, it also constructed employment as the ideal (to which the person escaped). In problematising the 'benefits trap', the government also transformed work into a matter of personal fulfilment. This constructed the financial exchange of work as less significant than the reward employment offered through the identity it gave the person working;

"When a person becomes unemployed his welfare falls for two reasons – first the loss of income, and second the loss of self-respect and sense of significance" (Layard, 2004, p. 1).

Employment was thus constructed as a means to maintain wellbeing, and dependency pathologised at a cultural level as a result. This influenced the 'truths' available to people to enact unemployment, increasing shame in the subjectivity of individuals claiming benefits, and worsening mental health as a result. Considering the employment market of the time, in particular the transference of labour overseas as a result of the introduction of the free

market, the construction of employment as a means to good health could have had alternative solutions, such as the introduction of a wider variety of jobs within the UK market. However, because of the individualist construction of 'mental illness' causing and maintaining unemployment, the solution was instead therapy.

Furthermore, research was presented which suggested that CBT was not only effective in the treatment of mental illness, but could also be used to effect change in employment in itself;

"...CBT has even been found to double the rate at which unemployed people find work." (Layard, 2005, p. 8).

The introduction of CBT for unemployment demonstrated a form of regulation which compelled individuals to realise their obligations to economic participation through therapy. Arribas-Ayllon (2005) has highlighted the operation of power in welfare reforms through which control was designed into new circuits of obligation and activity. The offer of CBT in Job Centres through the possible expansion of IAPT services would be an example of this. Arribas-Ayllon (2005) has also highlighted the role of contemporary forms of power in these circuits of obligation and activity, which increasingly function through information technology and electronic network surveillance. Examples of this in IAPT could include the monitoring of the employment status of the individual, and the completion of questionnaires which construct levels of mental 'disorder', all of which are saved on computer systems and shared nationally.

The construction of employment as curative therefore provided a condition of possibility for the emergence of IAPT in its convergence of medical, ethical capitalist discourses. The link between employment and health enabled Layard to propose circuits of obligation and activity, present in welfare reforms, in a medicalised context in which government and professional involvement was constructed as beneficial to wellbeing. This resulted in employment being central to the IAPT model, with movement from unemployment to employment one of the key outcome measures collected by central government from IAPT services.

3.3.4 Summary of section three: The convergence of discourses constructing unemployment

IAPT was predicted to reduce the numbers of people claiming incapacity benefit and increase numbers of people in employment. These claims were enabled by the convergence of multiple discourses surrounding unemployment within the New Labour political context. The neoliberal subject position was constructed with discourses of rights and responsibilities which outlined the moral obligation of citizens to engage in employment. Through this construction, the unemployed person was positioned as 'a waste' and cost to themselves, the government and society as a whole. This financial construction of the unemployed person extended to government health guidelines, in which the argument for treating mental health disorders was presented in financial terms as opposed to moral or social intentions to end distress or suffering. Finally, employment was constructed as curative in itself, enabling the government's encouragement of individuals into employment as treatment for mental illness. The convergence of economic, medical and moral discourses to construct unemployment provided an important condition of possibility on which Layard based the proposed cost-neutrality of the IAPT programme. I believe the proposed cost-neutrality of the IAPT programme was central to it receiving and maintaining investment from the government, on both financial and political grounds.

3.4 Summary of the chapter

In this analysis, I have outlined three key conditions of possibility for the emergence of IAPT;

- the creation of the third way in New Labour,
- the role of clinical psychologists in research and government; and
- the convergence of discourses constructing unemployment.

In exploring the role of the 'third way' I proposed that the changing relationship between the government; the NHS and the public, provided a condition of possibility for the emergence of IAPT. Firstly, I argued that the neoliberal stance of New Labour drew upon discourses of modernisation to justify increased involvement in the delivery of health services. Through discourses of openness and transparency, the standardisation of services was prioritised, leading to a reduction in status of clinical and local knowledge. Alongside this, the creation

of government-funded monitoring bodies increased government involvement in target-setting and outcome monitoring which provided a framework in which IAPT was quickly established once proposed. This neoliberal stance also constructed two important subject positions for members of the public; the consumer and ethical subject position. These had implications for individuals' subjectivity as they emphasised the moral obligation of the public to take responsibility for their own health, which aligned with the individualist focus of IAPT interventions.

In the second section, I argued that clinical psychologists have played a key role in the emergence of IAPT, both in their involvement in the creation and evaluation of research and its dissemination in government policy. I suggested that the positioning of psychologists as neutral and their research as scientific enabled the depoliticisation of the IAPT programme and subjugated resistance as a result. It also legitimised the introduction of 'cost-effectiveness' into the evaluation of psychological therapies, which was central to the emergence of the stepped care model and low-intensity interventions offered within the IAPT model.

Finally, I focused on the convergence of three discourses regarding unemployment and how they were drawn upon in constructing the IAPT proposal. I argued that the government's neoliberal portrayal of the rights and responsibilities of the citizen suggested a moral expectation of all citizens to contribute economically through capitalist constructions of productivity. I argued that the convergence of economic and medical discourses to construct unemployment gained political status throughout New Labour's government, culminating with individual and therapeutic solutions to the social and political problem of unemployment through the proposed IAPT model.

4. DISCUSSION

In this section, I will revisit and discuss the aims of this research and consider the potential implications for clinical practice, policy and future research. I will outline criteria for evaluating this thesis and reflect on the process of

undertaking a genealogical approach to consider the conditions of possibility for the emergence of IAPT.

4.1. Summary of research and aims

4.1.1 Reinstating the purpose

The purpose of this research was to problematise IAPT as the sole service provider for primary care adult mental health services. The aim was to destabilise taken-for-granted truths about the necessity of this approach, which silences questions or other perspectives, and prevents other approaches or conceptualisations from emerging.

4.1.2 How I undertook these aims

The introduction outlined key features of the IAPT model and evaluated them by drawing upon a range of critiques. This process demonstrated problems with IAPT's staffing, education and training programme and the impact of these on the deprofessionalisation of clinicians working in mental health services and worsening wellbeing in staff members as a result. The introduction also highlighted the problematic nature of the stepped care model and the employment agenda within IAPT, and the extent to which these have acted as barriers to equity of access. The use of diagnoses and NICE guidelines were also problematised, as well as the dominance of CBT within IAPT. Finally, the use of sessional outcome measures was discussed, in particular the negative impact this has had on concepts of recovery within IAPT.

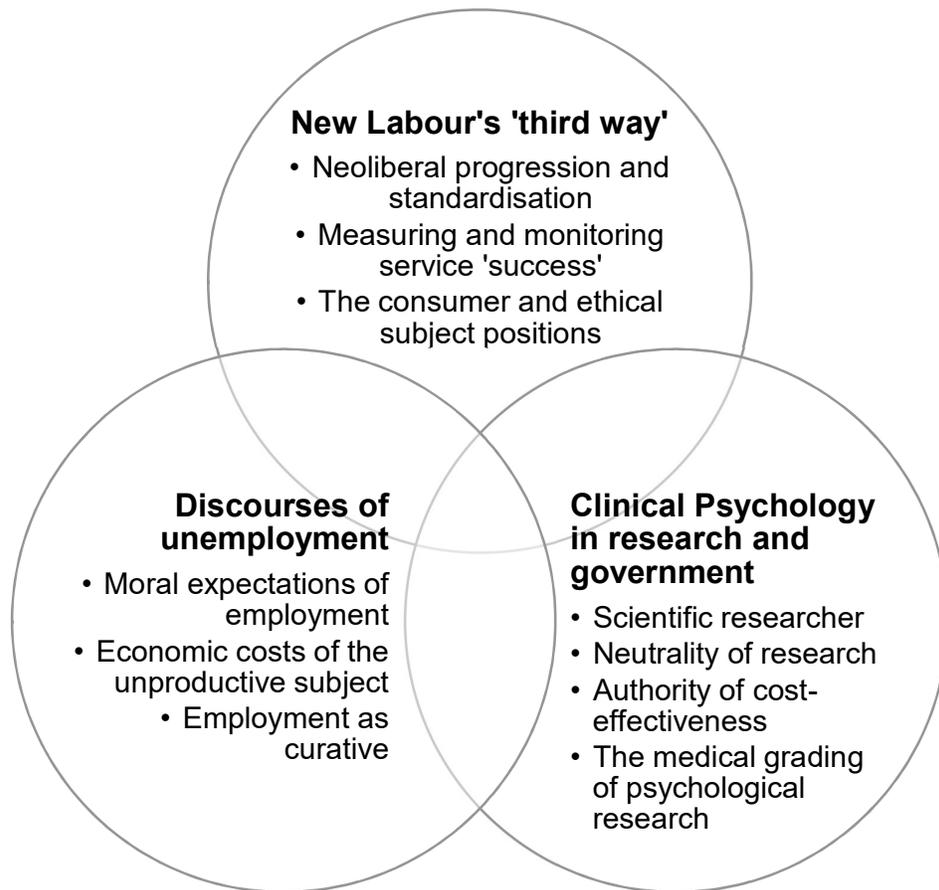
The method consisted of searching for political and psychological literature in the period leading up to the emergence of IAPT. This amounted to 116 documents which were analysed. Utilising Elden's (2002) construction of the Foucauldian 'dispositif', the analysis constructed a visual map of factors which appeared relevant to the researcher for the emergence of IAPT. This highlighted dominant and subjugated discourses, as well as the subject positions and subjectivity related to these. In the context of this information, material and discursive practices which enabled and maintained IAPT were considered. To assist the analytic process, key works from Foucault and

researchers influenced by his work, such as Rose (1990), were drawn upon throughout.

4.1.3 Summary of findings

The analysis focused on three key nexus points in which actions and ideas converged to provide important conditions of possibility for the emergence of IAPT. A summary of the three conditions of possibility can be found in figure 4, the overlapping circles indicate the inter-relatedness of these conditions which have influenced one another. I am aware that by making the argument that these three nexus points are key, there is a risk of fabricating a continuity which is at odds with the aims of genealogy to dislodge the illusion of uniformity of events or truths (Arribas-Ayllon, 2005). The figure below therefore presents three positions of conditionality whilst simultaneously maintaining ideas of discontinuity.

Figure 4: Summary of the analytic nexus points for the conditions of possibility for emergence of IAPT



I will now return to the questions used to guide the analysis, based on Kendall and Wickham's (1996) summary of Foucault's genealogical method to draw together the findings from the research.

4.1.3.1 What are the rules for the repeatability of statements, which allow statements to reoccur?

Scientific knowledge acquisition and evaluation was a central 'rule' for the repeatability of statements dominant throughout the analysis. In order for research to adhere to scientific rules (and thus be repeated), it followed a particular set of codified relations between a precisely constructed knower, and precisely constructed object. This enabled a simplification of ideas about distress and welcomed discourses arranged around these ideas, whilst disqualifying complex constructions which did not fit the scientific rule.

Economic and medical discourses were therefore important in the construction of IAPT. The implication of these dominant discourses was the pathologising of welfare dependence, with no discourse of dignified dependence available to people accessing benefits as a result of unemployment. The dominance of economic discourses of neoliberalism within IAPT presented the economy as the strongest measure of a good and healthy society. This subjugated other features of a healthy society, such as freedom, legal and political spheres of rights, and economic activity in which people work together in harmony and co-operation, not in competition.

The scientific rule also acted as a mask of neutrality, subjugating wider societal discussion regarding government priorities, and their underpinning ideology. This was in contrast to previous historical contexts, such as in the Cold War when members of the public in the UK may have been aware of the 'battle' of conflicting ideologies between communism and capitalism. The political context for the emergence of IAPT was, on its initial presentation, without political ideology, based only on the objective, factual 'evidence-base' allowed within the scientific rule.

As a result of the scientific rule, discourses of social justice, employment rights and non-capitalist accounts of productivity were subjugated. This disqualified complex constructions of psychological distress which incorporated multiple levels of influencing factors, such as Bronfenbrenner's (1992) inclusion of micro to macro factors of distress. Discourses of employment rights could have highlighted the working conditions which posed stress on the workforce and created anxieties, in particular the increasing trend of insecure jobs which made it difficult for a person to develop a narrative of identity, and coherent life history (Lees, 2016b). Consideration of alternative, subjugated discourses could have encouraged discussions about mentally healthy societies, in which mental distress was understood to be a reaction to the imbalances in power across society and the consequences of this. It may have thus encouraged investment in policies which reduced social and financial inequalities, attempting to reduce the need for mental health services as opposed to accepting that mental

disorders were inevitable and required treatment within a medicalised framework.

4.1.3.2 What are the positions which are established between subjects in relation to these statements?

As a result of medical statements dominant in IAPT, individuals in distress were constructed as a collection of individual symptoms. This fragmented the person in line with the medical context in which they were assessed or treated, making it difficult to incorporate social and environmental factors in understanding the cause and maintenance of the person's distress. This placed the person in a less powerful position in comparison to the professionals 'treating' them and led to expectations that the person would adhere to the recommended treatment in order to reduce the medically constructed 'symptoms'. In contrast to this, people were simultaneously constructed with neoliberal discourses of rights and responsibilities, in which individuals were held accountable for their actions and expected to keep themselves 'healthy'. This positioned people as autonomous individuals, making invisible the power dynamics which were influencing their distress or happiness in their community or at a wider societal level. Based on this positioning, individuals in distress were 'empowered' to make change, but only at an individual-level, on the recommendations of medical professionals.

In relation to this, clinical psychologists were positioned as technicians, employed to manipulate psychological variables in order to treat 'symptoms'. Psychologists were thus positioned as powerful in comparison to the people they treated in therapy, but powerless in comparison to civil servants and government officials who designed service models and frameworks on which to evaluate service delivery. This positioning of clinical psychologists enabled practise to be taken-on and incorporated into the therapeutic space uncritically, an example of this being the systematic use of outcome measures throughout NHS psychological therapy services. Through these practices, the government's ideology infiltrated the therapeutic relationship between people, with implications for the subjectivity of both the 'patient' and 'therapist'. The technician position also reduced opportunities for clinical psychologists to take a stance against the government, (for example, supporting benefit claimants who

had their benefits cut as a result of increasing sanctions in job centres) as the link between government policies and 'patients' symptoms was not made clear.

The dominance of the scientific rule, and subsequent economic and medical discourses, also positioned politicians as unable to prevent the symptoms occurring. The only position for politicians to take up was that of the funder; to provide finances to services required to treat the collection of symptoms present in individuals. This positioned politicians as unaccountable for social and environmental determinants of distress and enabled them to continue practices within their ideology without this being debated or critiqued.

4.1.3.3. How was the conceptual shift in service delivery 'made' possible?

As outlined in appendix D and E, there were a wide variety of material and discursive shifts which provided space for IAPT to grow and continues to hold its practices in place.

One of the central practices was the decision to de-regulate the market and increase the power and control of businesses. The intention of this was to increase wealth in the country by incentivising efficiency and growth. The consequences included an increase in poorly paid and unstable jobs for the working class, leading to increased feelings of insecurity and stress. Alongside this, individualised and medical frameworks for understanding mental distress increased in dominance, with research and therapies using medicalised constructions of psychiatric diagnosis to understand and 'treat' people's distress.

Increased distress was interpreted by the government as an increase in mental disorders at a population level with related high numbers of people claiming incapacity benefits. The dominance of individualised approaches to 'treating' this distress legitimised a solution which focused on increasing access to therapies, without consideration of the political and social phenomena related to the change in the job market.

New Public Management and Neoliberal approaches to service design emphasised the importance of management, measurement and markets to the running of health services. Practices related to these priorities, such as centrally-constructed targets for services, national monitoring of outcomes and benchmarking of services based on this information both enabled the emergence of IAPT and have continued to hold it in place.

4.2. Implications of the research

It is important to note that Foucault's genealogical work was not primarily intended to have 'implications' for change; its primary focus (i.e. to destabilise the status quo of understanding or 'taken for granted truths') might be to achieve change in the thinking of the reader. Despite this, because of the demands of the doctoral context in which this research was undertaken, I will now go on to consider the implications of this research to clinical, research and policy-based practices.

4.2.1 Clinical training

Based on the role of government ideology in the clinical practices of psychology within IAPT, clinical training should encourage trainees to think about the social, political and historical context for the services in which they practice. In particular, it would be beneficial for trainees to consider how services in which they are placed are funded and what the implications of this are on how they are positioned within the service, and the practices this enables or subjugates. Trainees should therefore be supported in developing skills in historical analysis in addition to their more traditional research skills base. This would help trainees be able to question the taken for granted assumptions about the discipline of psychology and to gain a broader perspective on the contexts in which they work. Clinical training should also contain specific guidance on how to influence change at a social and political level. Mallinckrodt, Miles and Levy (2014) have proposed a scientist-practitioner-advocate model of training in counselling psychology which includes the development of skills in community consciousness-raising through public speaking, political lobbying, community organization, and persuasion through print media. A similar framework would enable clinical psychologists to utilise their skills to intervene at levels beyond

the individual. This would have consequences for how people in distress were positioned in society, and their subjectivity as a result.

4.2.2 Research implications

At the level of applied research, transformative research should be used by psychologists to enable change at a social and political, rather than individualistic level. Maxey (1999) suggested that by actively and critically reflecting on the world and our position within it, we are better able to act in creative and constructive ways which challenge oppressive power relations rather than reinforcing them.

Based on this research, clinical psychologists, with their advanced skills in research methods, are required to lobby NICE regarding their evaluation of research in psychological therapies. The current practice of evaluating psychological therapies in line with medical interventions is inaccurate and has had a huge effect on the types of therapies offered, and the structure of services as a result. The status afforded to psychologists through their doctorate training places them in a position to lobby NICE to change these practices. In contrast to the current hierarchy of evidence considered by NICE, clinical psychologists should highlight the importance of naturalistic qualitative approaches to research, based on lived experience, and ensure that this is incorporated into discussions about both service design, and policies which influence mental distress or wellbeing more generally.

4.2.3 Policy-level interventions

The East Midlands Critical and Community Psychology Group (2014) highlighted the privileged status of applied psychologists which leads to greater access to spaces, from team meetings and service commissioning meetings to social and mass media. Clinical psychologists are therefore in an important position to utilise their knowledge of the impact of social context, inequality and oppression to all these spaces and document these legitimately in ways that are accessible to policy-makers. Dashjian (2014) suggested a role for psychology doctoral students to lobby agencies about community issues, collaborate with

leaders by offering information and potential solutions for social concerns, and taking direct action in the community in order to see policies through.

Clinical psychologists are therefore required to speak out about the current problematic practises taking place in IAPT services and services which utilise a similar service-delivery model. Research can be used to develop an alternative 'evidence-base' to demonstrate service-delivery models which would better support the wellbeing of its workforce and enable independent clinical decision making of the professionals working there. This might include services with a greater emphasis on formulation, as opposed to diagnosis, and patient-centred approaches instead of reliance upon NICE guidelines. Furthermore, psychology has a role in proposing creative ways in which services can be evaluated, which encourage meaningful constructions of recovery within services whilst enabling assurance to commissioners and politicians that investment is being spent thoughtfully and responsibly in mental health settings. However, it is the responsibility of psychologists to take these debates outside of the domains of service-evaluation and to focus the attention of people in power on the social and environmental factors in distress. This calls for a public health approach to mental health, in which psychologists' wide array of skills can be applied to the prevention of distress, as well as its 'cure'.

4.3. Evaluation and critical review

4.3.1 Assessing quality

The conditions of possibility for the emergence of IAPT presented in this study are not an exhaustive historical reconstruction, and have not been constructed within a framework of historical realism. One of the intentions has been to disrupt knowledge that has been taken for granted. As such, evaluative concepts from positivist science such as reliability, validity, and generalizability are not appropriate to evaluate the quality of this research. I have therefore drawn upon guiding principles presented by Spencer and Ritchie (2012) to consider the contribution, credibility and rigour of the research.

4.3.2 Contribution

As discussed in the analysis, more celebratory histories of IAPT are available in the form of books, such as *Thrive* by Layard & Clark (2014). There is also a vast data set, published online on a quarterly basis which outlines the recovery rates and numbers of people seen in IAPT services nationally. However, this research enhances understanding of the IAPT model in a different way by highlighting how some forms of knowledge (such as the neoliberal discourses around individual responsibility and recovery) have become so entrenched into the NHS and mental health service delivery, that alternatives do not appear available. This research, in deconstructing some of these taken-for-granted truths, highlights alternative discourses and frameworks. In particular, it highlights the role of social justice approaches to considering issues of employment and unemployment. With respect to psychology it highlights the role of clinical psychology in contributing towards a mentally healthy society, influencing policy at a local community and national level through research skills, including participatory research which prioritises voices of lived experience. The hope is that by doing so, an environment can be developed for professionals to problem solve in a different way, and from which new ideas might emerge.

4.3.3 Credibility

Harper (2013) argued that the researcher in qualitative methods needed to become immersed in the theoretical and empirical literature in order to approach the research in a theoretically consistent way. From the beginning of the research process I have attempted to become familiar with the works of Foucault (1991), Rose (1990), Tamboukou (2003), and Elden (2002). This has at times been challenging, and I feel as though my relationship with these texts is still in its infancy with potential for development as my career progresses. However, the intention was to develop a Foucauldian lens with which to interrogate the corpus of statements in my analysis. This was further enabled through the practical suggestions outlined in the work of Hook (2007), Arribas – Ayllon and Walkerdine (2008), Kendall and Wickham (1998) and Carabine (2001) to construct the research questions used to undertake the genealogical analysis. In addition to reading the above texts, I have discussed my ideas in supervision prior to including them in the research. I have also participated in a

peer group of trainee clinical psychologists using Foucauldian methodology, in which I have shared and tested out the concepts outlined in the study.

4.3.4 Rigour

Researchers who have utilised the genealogical approach have explicitly avoided providing a closed methodology. I considered the challenge of this in my methodology chapter. The research has therefore required an acceptance of uncertainty and the utilisation of a reflexive stance (which I have discussed further in the following section). Despite the absence of an 'off the shelf' methodology, it is hoped that the use of the key texts outlined above would enable researchers familiar with the genealogical method, when reading this research, to identify similar concepts in the analysis.

4.3.5 Reflexivity

Hook (2007) suggested that a genealogical analysis of a practice within one's own discipline can create tension, as the critical history of an object or event requires a critical history of the discipline in which it is located. This was especially true of my experience of undertaking this research, having previously worked in IAPT settings and continuing to train as a clinical psychologist. I have attempted to engage critically in understanding the contribution of my experiences in shaping the research, and have explicitly stated when I have drawn upon my own experience.

Having worked in IAPT services previously, the research could be considered to have been undertaken from an insider-researcher position (Breen, 2007). This triggered some difficult emotions for me whilst undertaking the research, in particular feelings of betrayal of former colleagues and supervisors in the problematising of the IAPT model. Additionally, I experienced feelings of guilt related to my role in the training of PWP's in the past, and worries of hypocrisy in relation to the completion of this research. Supervision and the thesis journal were important resources to manage these emotions and to consider how they may have been influencing my analysis.

A final challenge was the tension between Foucault's explicit decision not to offer an alternative after undermining the practices explored through the genealogy, and the expectations of the doctoral research that I will consider clinical and research implications. As outlined in the methodology, the research should be considered to have utilised a genealogical approach and not undertaken a pure genealogy. As such, implications have been considered and included as part of the doctoral requirements.

4.3.6 Limitations

As outlined in the methodology, Foucault presented genealogy as "*grey, meticulous, and patiently documentary*" and reported that "*it depends on a vast accumulation of source material.*" (Foucault, 1994, p.136). This allows genealogy to view things from a distance which allows the researchers to seek out surfaces of events, their arrangement, their shifts and subtle contours (Arribas-Ayllon, 2005). However, the completion of this genealogical research as part of the doctoral research requirements did not allow me the time to accumulate the vast quantity of materials or analyse them in the meticulous detail outlined by Foucault. The research presented here is therefore a focused piece of genealogical research. Had I completed the genealogy in full, I would have included texts from alternative sources, including the survivor movement, and included a closer focus on practises outside of psychology to construct a wider picture of the influencing factors in IAPT's emergence. This would have included a longer term historical analysis, exploring the foundations on which the neoliberal policies explored in this research were based upon. This would have better allowed for the development of the perspectival gaze (Arribas-Ayllon, 2005) necessary for the understanding of particularity and complexity presented in genealogical research.

Hook (2005) proposed that a Foucauldian genealogical investigation is, first and foremost, a mode of critique whose overall function is to oppose the centralising power effects of institutional knowledge and scientific discourse (Hook, 2005). In focusing on the IAPT service model and its practices, I have problematised it. However, this process of analysis may have reified the

'problem' of 'IAPT', and it is important to note my role in the construction of this problem.

4.4. Conclusion

IAPT has been constructed as an ideologically-neutral service-provision model for mental health services. In positioning itself this way, IAPT has hidden the medical and individualistic assumptions underpinning its approach to mental health. It has also made invisible the economic and capitalist ideology underpinning the constructed relationship between IAPT and policies regarding unemployment and the claiming of welfare support. This has primarily been achieved through the utilisation of scientific rules of knowledge in the emergence and maintenance of IAPT, in which 'neutral' research has been drawn upon to construct the 'evidence-base' on which 'treatment' guidelines were made. By attempting to make these ideological foundations invisible, alternative constructions of mental health and wellbeing have been subjugated, in particular those drawing upon social justice and freedoms, employment rights and non-capitalist models of productivity. As a result of this, knowledge produced and evaluated through this scientific framework has been reified and presented as 'the truth'. This method of maintaining power has enabled the continuation of problematic practices in IAPT services, worsening staff wellbeing and poor outcomes for people accessing IAPT services. The same framework has provided legitimacy to coercive practices utilised to encourage individuals into employment. These employment practices have increased instability and stress at a public health level, whilst constructing distress at an individual medical level, thus pathologising people's normal reactions to abnormal situations.

Psychologists have the skills to intervene at multiple levels to reduce distress and prevent these problematic practices from re-occurring at a service- and policy-level. This includes the utilisation of participatory and transformative research to influence policies which work towards a mentally healthy society.

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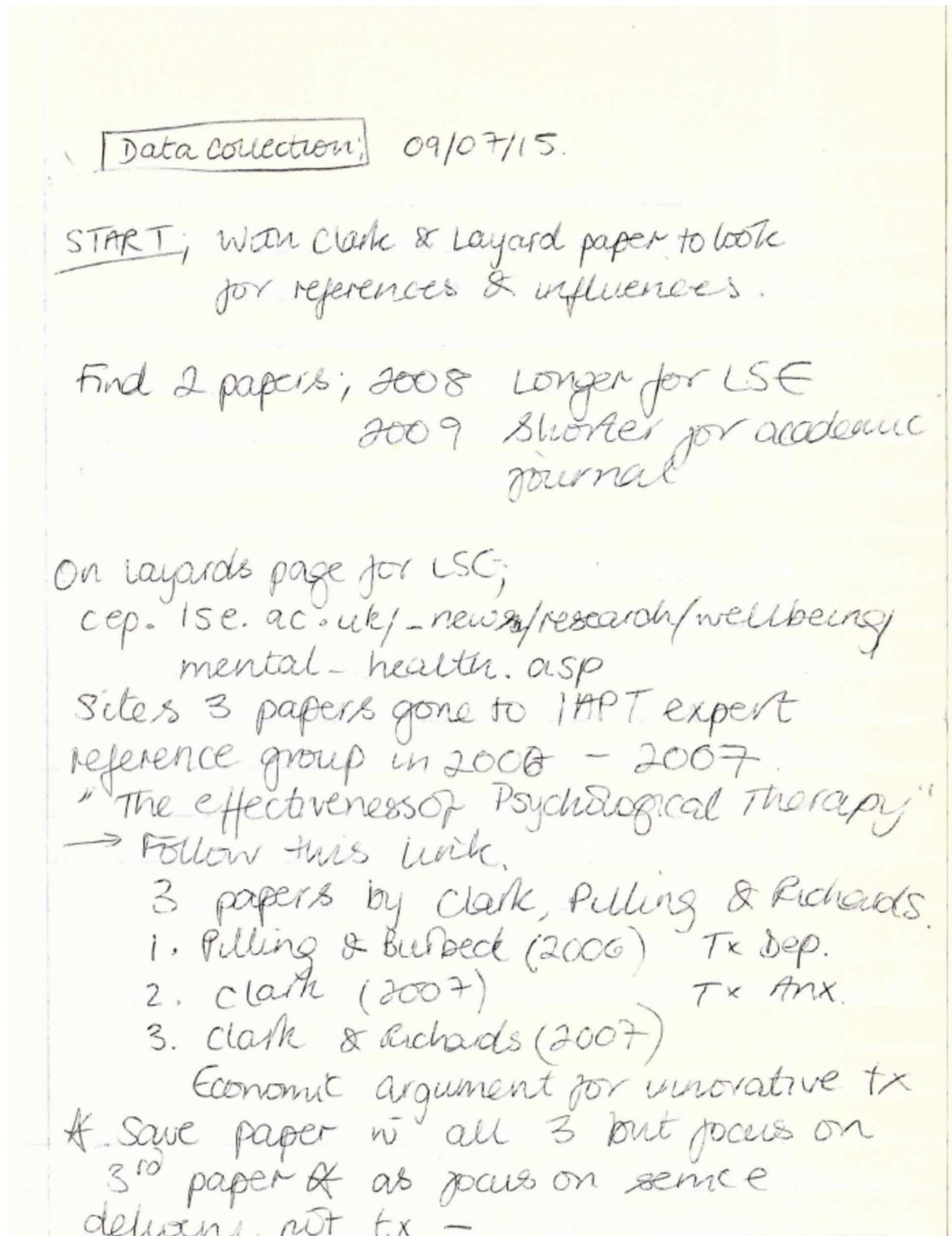
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6. APPENDICES

Appendix A: Example pages from research journal whilst undertaking data collection



This effectiveness paper doesn't have
Layard in it; Clark; CBT Research Unit
Billing; CBT " "
Richards; CBT Nurse(?)

? Where is Layard? Is he in the
committee that this was presented to?
"IAPT expert reference group 2006-07"

I google "IAPT Expert Reference Group"
click on;

(*) "Improving Access to Psychological
Therapies + Specification for the
(2007) commissioner-led Pathfinder programme"
DoH. To see if makes reference
to ERG - it doesn't but does
give reference to supporting evidence/
documentation...

Author is; CSIP Choice & Access
Programme - who is
this?

Also 2007 - evidence still being proposed
to ERP yet pathfinder doc. already
set up - how so quick?

Appendix B: Example page from data analysis, using the research questions to guide questioning of data from a government report.

- In blue are notes relating to the question: What are the rules for the repeatability of statements, which allow statements to reoccur? (e.g. What are the dominant discourses in the emergence of IAPT and their implications? What are the subjugated discourses and how might these help us consider alternative conditions that might improve people's wellbeing outside of popular models of mental health services?)
- In green are notes relating to the question: What are the positions which are established between subjects in relation to these statements? (e.g. Where does this position service users, clinical psychologists, commissioners, GPs and politicians?)
- In red are notes relating to the question: How was the conceptual shift in service delivery 'made' possible? (e.g. What material and discursive practices gave space for IAPT to grow? What practices continue to hold it in place?)

a marked ... use over the past few years; as recently as 1962 the total was only 198.

2.3 The profession has developed in close association with that of psychiatry and the great majority of the work of clinical psychologists still takes place in the fields of mental illness and mental handicap. The British Psychological Society, in the survey of part of its membership which it published in 1968, reported that, as a modal figure, 95% of the patients seen by clinical psychologists were referred to them by psychiatrists. There has, however, been a striking change in the nature of the contribution made by psychologists to the treatment of patients. In former times their role consisted largely of undertaking routine psychological measurements, such as intelligence testing, at the request of psychiatrists and other doctors, and represented in effect an ancillary service to the medical profession. Recent years have seen a substantial expansion in the body of psychological knowledge accompanied by the development of new techniques which have major implications for treatment. One of the effects of these developments has been to make psychological assessment, in contrast to the routine testing activities mentioned above, a much more sophisticated process with a wider range of implications both in determining various aspects of individual need and in evaluating the progress of patients and their response to different forms of therapy. At the same time psychologists have developed a number of new forms of treatment, some of which have been widely applied and represent an important addition to the range of therapeutic resources. The methods which have been most extensively applied are those within the broad category of behaviour therapy which encompasses a wide range of procedures. In some circumstances these techniques may be used to assist quite large groups of patients, for example by applying a token economy scheme to a whole hospital ward.

2.4 In the subsequent sections of our report we return in more detail to some of these matters. But this brief account will already, we think, have suggested some of the issues which we have found ourselves examining. The problems in the field of clinical psychology are those which arise when a new professional discipline develops within an existing organisation which has its own established structure. They involve, in particular, the relationship between clinical psychologists and the members of other health service professions, and, more generally, the ways in which it may be desirable for the organisation to adapt itself so that the fullest use is made of new techniques and skills.

2.5 Psychology is only one of a number of fields in which scientific advance has radically changed the range of options available in the treatment of patients. Many of the professions which this has involved were included in the remit of the Zuckerman Committee on Hospital Scientific and Technical Services which reported in 1968. This Committee recommended the establishment of a new Hospital Scientific Service to include among others, physicists and biochemists. The work of clinical psychologists presents, however, certain special features which distinguish them from most of the other classes which were covered by the Zuckerman Committee's review. The most notable of these is the presence, in certain circumstances, of a face-to-face therapeutic relationship between the psychologist and the individual patient, and indeed we have found this factor to be at the root of many of the issues to which our attention as a committee has been directed. The Zuckerman Committee did in fact consider whether clinical

Government consideration of role of therapy/therapists.

3. THE ISSUES CONSIDERED BY THE SUB-COMMITTEE

3.1 Having considered the general background described in the previous section we were able to reach an initial view on the questions which our review should cover. These may be briefly stated as follows:—

1. The contribution which psychologists should be expected to make in the provision of health services for different age groups, and their relative importance in the treatment of different conditions.
2. The division of psychologists' activities between assessment and diagnosis, treatment and rehabilitation, research and teaching, and any other activities.
3. The kind of organisation of psychology services needed in Regions, Areas and Districts, including in particular the desirability of setting up Independent Departments of Psychology.
4. The possible scope for providing services directly to general practitioners, and to social workers, health visitors and any other staff working in the community.
5. Whether psychology services should be provided from a hospital base.
6. The arrangements for referring patients to psychologists from hospital doctors and general practitioners, and whether there should ever be referrals from non-medical sources.
7. The allocation of clinical responsibility for patients referred to psychologists.
8. Desirable levels of staffing.
9. The scope for employing technicians.
10. The contribution of educational psychologists to health services.
11. The staffing and career structure for psychologists within the National Health Service.
12. The desirable scope and content of training for psychologists.
13. The contribution of psychologists to the teaching and training of other professions.
14. The role of psychologists in research.

1.2 Having determined the subjects we wished to consider we prepared a questionnaire which we sent in February 1973 to a selected number of professional and other organisations. A general invitation to submit evidence was also published in the professional press and copies of the questionnaire were also sent to those organisations and individuals who responded. A copy of the questionnaire appears at Appendix A, and a list of all those who gave evidence at Appendix B. (The list of subjects in the preceding paragraph is a somewhat compressed statement of the ground covered by the questionnaire.)

Psychologists' development of FRP, C & R, and other areas

Psychologists' assessment of mental patients as compared with other professions

Psychologists' assessment of mental patients as compared with other professions

Psychologists' assessment of mental patients as compared with other professions

Psychologists' assessment of mental patients as compared with other professions

The movement away from psychiatric nursing professional responsibility gave space to development of self referral.

Appendix C: Outline of the headings and subheadings used to structure the recording of dispositifs through the data analysis process

Clinical Psychology as a Profession in development

Clinical Psychology seeking autonomy from Psychiatry and greater political influence

Increased funding in Clinical Psychologists / professionalization

Clinical Psychologists as multi-skilled but predominantly therapists

Psychology outsourcing tasks / the development of new professions

Clinical Psychology in Primary Care

Psychologists evaluating cost effectiveness

Psychologists, psychotherapy and the evidence-base debate

The shift from CMHTs

Research and Therapy

The Rise of CBT

The changing face of CBT

LI/HI

Resistance to CBT

A focus on anxiety and depression

CBT for unemployment (and a disorder)

Prevention to early intervention

An economic construction of happiness

Mental Health as a problem not a symptom of a problem

Government before professionals before patients before people

From Quasi Market to Integrated Care

The quasi-market

Patients in the quasi market

The importance of evidence-base

Cost effectiveness

The merging of cost-effectives and evidence-based practice

Standardization versus decentralization “a system of earned autonomy”

Fragmentation

Deprofessionalisation through standardisation

Medicalisation through standardisation

Commissioning

Integrated Care

Health as individual civic duty versus governmental responsibility for public health

Measuring Outcomes

Unemployment

Unemployment and what it tells us about the welfare state

Individualist construction of unemployment

Unemployed as wasted citizens

Unemployment and mental health

Economic justification of health and social investment

Unemployment, poor health and the New Deal – The neoliberal discourse of opportunity

What about work related stress?

Beginnings of workfare

The wider context

International population changes

Increased IT/technology

Global fear

A more demanding electorate

Satisfaction

Rise in individualism

Increased choice and social freedom

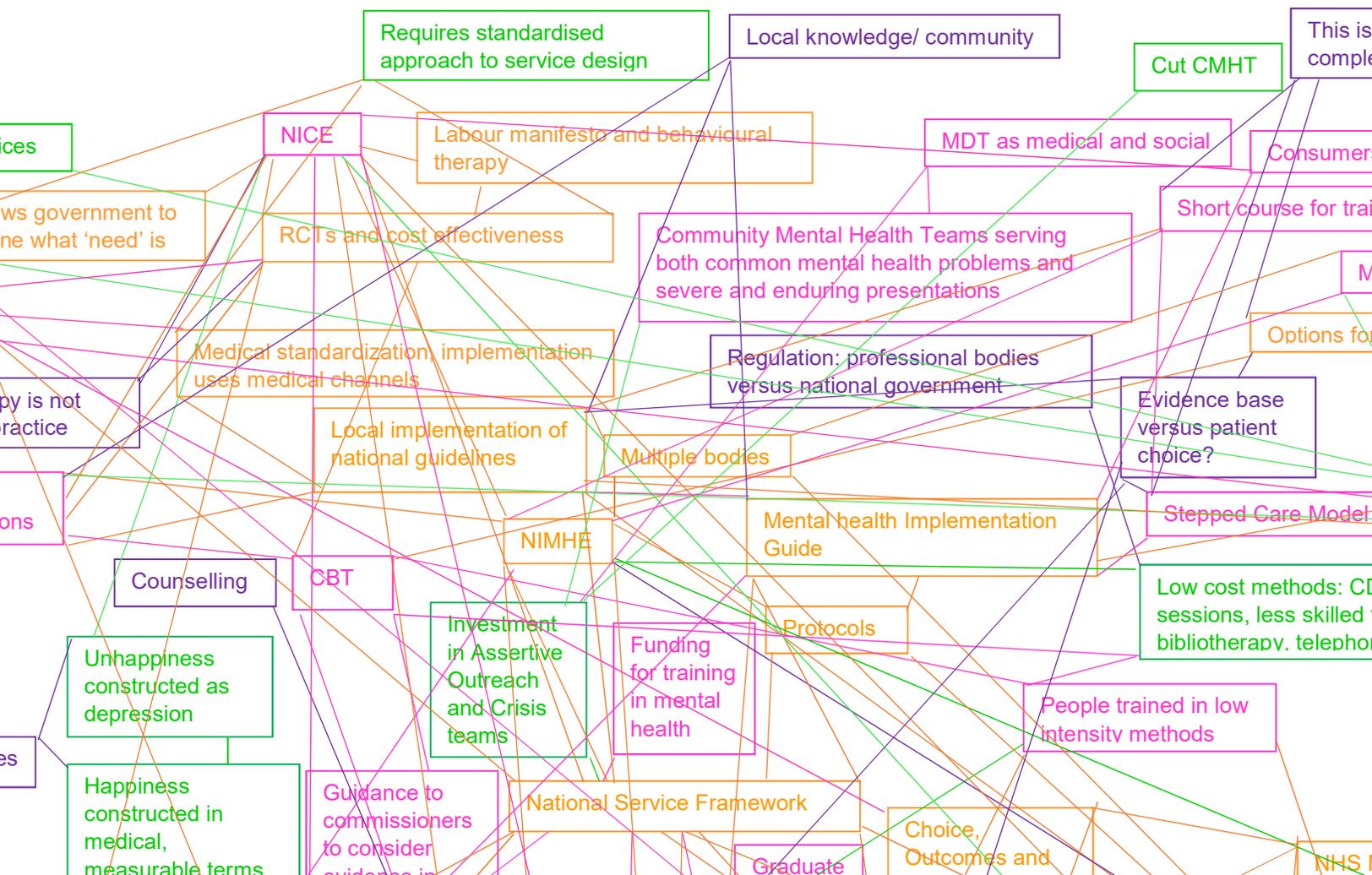
of the dispositifs (with lines to represent relationships between the dispositifs)

knowledge are coloured green

of knowledge are coloured pink

knowledge are coloured orange

to the dominant narratives or practices are coloured purple.



the dispositifs (without lines to represent relationships between the dispositifs)

Knowledge are coloured green

of knowledge are coloured pink

Knowledge are coloured orange

to the dominant narratives or practices are coloured purple.

