CHAPTER 2

Proliferating Therapy
The Rise of the Improving Access to Psychological Therapy (IAPT) Initiative

At the turn of the century, an adult in England who felt very down, lacking in hope, and unable to enjoy everyday pleasures, might have made an appointment with their primary care General (Medical) Practitioner (GP). The GP would then, perhaps, have concluded that their patient should receive a diagnosis of depression, with that in turn resulting in a prescription for a pharmaceutical such as a selective serotonin reuptake inhibitor (SSRI). Today, there is a good chance that some kind of psychological therapy would be recommended. In fact, a GP appointment is not always necessary at all: often people can call a local NHS therapy service and refer themselves directly. Such services are likely to have developed from something called the Improving Access to Psychological Therapies (IAPT) initiative – rebadged in 2023 as NHS Talking Therapies (Clark and Whittington, 2023). This much-lauded public health programme has had many millions of pounds invested in it, with the objective of making treatment for mental ill-health more accessible (Department of Health, 2012).

The advent of IAPT is largely associated with the campaigning of (among others) London-based academic and clinical psychologist David Clark alongside health economist and member of the House of Lords, Richard Layard. Through the English IAPT initiative, the number of clinicians delivering therapy has proliferated, and ideas about the salience of the psychological within the NHS across the United Kingdom have been reshaped. During the early days of IAPT, its therapists targeted men and women of working age and focused on depression and anxiety, employing psychological interventions to treat those conditions. IAPT later began to include older adults (Ghosh, 2009), and since 2011 children and adolescents have been the focus of a linked initiative (Fonagy and Clark, 2015). Some services further extended into the terrain of 'severe and enduring mental illness' (Jolley et al., 2015) – although IAPT, and now NHS Talking Therapies, continued to emphasise depression and anxiety. IAPT gained substantial media coverage in the United Kingdom and

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subsequently abroad, with one *New York Times* article describing it as 'the world's most ambitious effort to treat depression, anxiety and other common mental illnesses' (Carey, 2017). An editorial in the journal *Nature* (2012, p. 473) asserted that IAPT 'represents a world-beating standard thanks to the scale of its implementation and the validation of its treatments'. Such comments have acted to stimulate, and have been stimulated by, significant international clinical and policy attention to and mimesis of the initiative.

In this chapter, I examine the instantiation, operations, and ramifications of IAPT – perhaps the most striking and significant materialisation of an ethic of access in the United Kingdom, and a singular example internationally. I draw on interviews with professional and policy actors working in organisations that shape the wider field of psychological care, alongside interviews and conversations with dozens of NHS practitioners (especially clinical psychologists, from whom we will hear much more in the second part of this book). My sources also include an array of English, UK, and international policy papers, journal articles, clinical guidelines, and charity campaign materials (from 2005 onwards). Through these I sought to better understand the development and reception of IAPT, and the repertories of accountability through which it has been both celebrated and critiqued.

I focus on some of the movements in healthcare the IAPT initiative reflected, helped to stabilise, and further propelled. IAPT was a specifically English initiative, given the devolution of healthcare provision to the constituent nations constituting the United Kingdom of Great Britain and Northern Ireland. Yet, its logics and effects are readily apparent beyond England, with IAPT contributing to revivifying psychological framings of pathology and therapy across the United Kingdom. However, it has achieved this in ways that are more familiar within biomedical contexts, for example through recourse to randomised controlled trials (RCTs) studies (cf. Healy, 2004; Horwitz and Wakefield, 2007; Kitanaka, 2012; Lee, 1999; Luhrmann, 2000; Rose, 2007; Rosenberg, 2006).

Following its success, IAPT was held up as a model for other psychological services and augmented the legitimacy of public bodies that have the capacity to shape healthcare (most notably the National Institute for Health and Care Excellence (NICE)). Lessons from it have been widely deemed valuable to learn, and clinical psychologists sometimes speak – often critically – of the influence of IAPT on their profession and the services they provide (e.g. its focus on patient throughput). Consequently, IAPT has enjoined wider shifts in the landscape of UK – and international – mental healthcare. I suggest that IAPT morphed from being

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one ostensibly novel component of this terrain into an element around which other services are constituted (cf. MacKenzie and Pardo-Guerra, 2014). In effect, it has moved from being content to context (MacKenzie, 2015), with its renaming as NHS Talking Therapies signalling its expansive remit and effects. IAPT has played a significant role within mental healthcare, producing standards against which other ventures have been held to account.

Problematising Access

As noted earlier, IAPT per se can be largely – though clearly not wholly – traced to the actions of two key individuals: David Clark and Richard Layard. Currently a professor at the University of Oxford (previously King's College, London), Clark is also National Clinical and Informatics Advisor for NHS Talking Therapies. He is prominent for his research around anxiety disorders and as a major innovator of CBT. Layard is an emeritus professor at the London School of Economics and Political Science (LSE) and a very influential economist. He has played a number of major policy roles relating to mental health and well-being. In 2000, Layard was made a life peer by Prime Minister Tony Blair and remains a member of the Labour Party in the elite UK House of Lords. Both Clark and Layard were elected Fellows of the British Academy in 2003, and it was at the Academy that they first met (Evans, 2013a, 2013b; Layard and Clark, 2014). Subsequently, they came to work together closely to try and move access to therapy further up the policy agenda. To do so, they actively sought to expand their own influence regarding how issues of access and therapy should be understood and addressed. Their research and campaigning found favour within the Department of Health and at Downing Street, helping to impel reconfigurations of the matrix of clinicians, services, guidelines, treatment sites, and more that comprise mental healthcare. Ultimately, they played vital roles in orchestrating the development and rollout of IAPT.

However, the campaigning of Layard and Clark did not emerge de novo. In the 1990s and during the early 2000s, many patients and clinicians were troubled by ever more testimonies that people experiencing mental ill-health were not receiving the care they needed, including because of shockingly long waiting times. As a result of considerable charitable and clinical advocacy work, policymakers became more sensitised to these issues, with admission to services noted in (for instance) the major NHS policy document, *A National Service Framework for Mental*

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Health (Department of Health, 1999a). This Framework also stated a requirement to expand the numbers of professionals deemed competent to deliver mental health interventions. Wider concerns were furthermore emerging about the economic 'costs of mental illness' (Sainsbury Centre for Mental Health, 2003, p. 1), which likewise attracted attention.

Layard proved adept at steadily entwining these discourses of access and economy, focusing on depression specifically, and ultimately delimiting a straightforward framing of the (economic) problem(s) of access. In the early 2000s, he was an active publisher across a range of discursive spheres, and his widely reviewed trade book, *Happiness: Lessons from a New Science* (Layard, 2005b), argued that depression was a social problem that could be addressed through psychological therapy at scale. Following the publication of *Happiness*, Layard also authored various clinically oriented writings (e.g. Layard, 2006a) and was a regular discussant on related issues with journalists and policymakers. Through such activities, he worked to at once characterise the nature of the problem of access and to articulate its solution (cf. Callon, 1986).

Layard's messaging generated policy traction. For example, in January 2005, he was invited to present a report to the Prime Minister's Strategy Unit, in a seminar at which Clark was also present (Evans, 2013b). Titled 'Mental Health: Britain's Biggest Social Problem?' (Layard, 2005a), this document claimed that mental illness 'imposes heavy costs on the economy'. It asserted – in bold typeface: 'There are now more mentally ill people drawing incapacity benefits than there are unemployed people on Jobseeker's Allowance' (Layard, 2005a, p. 1). An apt response, Layard argued (like the Department of Health before him), was a massive expansion of the mental health workforce.

Senior Labour figures seemed to have been receptive to Layard's arguments: following his presentation, *The 2005 Labour Party Manifesto* committed to improving mental health through 'behavioural as well as drug therapies' (p. 65). The phrasing of the manifesto promise presented psychological services as a kind of addition to the (pharmaco)therapeutic status quo. It thus underscored neurobiology as a key aspect of the UK mental health landscape (see Pilgrim and Rogers, 2005; Rose, 2007). Yet, the commitment also reflected increasingly outspoken voices (such as Layard's) in support of proliferating specifically psychological therapy. As we will see, the Labour Party pledge ultimately materialised as the IAPT initiative.

Layard's 2005 paper was subsequently expanded into *The Depression Report* (Centre for Economic Performance, 2006). Released on 19 June 2006, this was also widely termed the 'Layard Report', indicating

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the importance ascribed to Layard in developing IAPT. Though principally associated with him, the report advertised its authority through a list of impressive signatories from mental health research and practice, including David Clark. It further demonstrated epistemic accountability through its digestible number of endnotes linking the claims it made to relevant academic literature. Immediately prior to publication, Layard promoted *The Depression Report* in the UK left-leaning broadsheet *The Guardian* (Layard, 2006b), with the online edition linking to the LSE website where the report could be downloaded. It was also heralded on its release date in *The Observer* (the Sunday counterpart of *The Guardian*), which later, in September 2006, circulated a hardcopy (with support to do so from the mental health charity, the Charlie Waller Memorial Trust). Such widespread dissemination enabled *The Depression Report* to act as a rhetorical and collectivising device for articulating a particular problematisation of access to therapy, and expanding discussion on depression more generally (cf. Callon, 1986).

The overall message of *The Depression Report* was straightforward: depression negatively impacts the economy, it should be treated, and treatment was affordable. Economics was a key apparatus through which the normative and clinical claims contained with the Report were assembled. Readers were, for instance, told that 'the total loss of output due to depression and chronic anxiety is some £12 billion a year – one per cent of our total national income' (Centre for Economic Performance, 2006, p. 5; in bold type for emphasis in the original). The word 'cost' appeared 24 times in the main text of the 14-page report, including in a section subtitle that added the prefix 'cost-effective' to the word 'therapies'. Pound signs were scattered throughout, and – like in Layard's 2005 paper – the number of people diagnosed with mental illness receiving state benefits appeared on the first page. Even the subtitle of the report – 'A New Deal for Depression and Anxiety Disorders' – gestured towards the economy, reminding some readers of the culturally resonant 1930s US New Deal economic development programme. Altogether, it constructed a vision of a society full of despondent individuals whose despair impacted not only themselves but also (the wallets of) the wider citizenry.

More than any other text of the time, *The Depression Report* braided mental health and the economy within public discourse, relating expertise associated with the latter as an essential feature of (evaluating) attempts to understand and manage the former. Such an economistic framing attracted criticism from many mental health professionals, not least clinical psychologists (articulated across a wide range of blogs, newsletters, and journals).

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Nevertheless, it also garnered support for the therapeutic options it outlined, specifically psychological therapy. As noted, drug treatments for and a neurobiological understanding of depression were prominent within broader popular discourse at the time (Rose, 2007), even if these were never hegemonic (Pickersgill, 2014). *The Depression Report* instead urged the NHS to adopt psychological therapies for redressing the economic, social, and personal costs of depression. It stated that 'hundreds of clinical trials' had helped to show that 'therapy is as effective as drugs in the short-run', and that psychological treatment 'has more long-lasting effects than drugs' (Centre for Economic Performance, 2006, p. 6). This promotion was seemingly a consequence of economic calculation rather than overt ontological partisanship over what depression 'really' was and hence how it should be treated. Overall, psychological therapy was presented as the most (cost-)effective solution to a pressing social problem.

Clinical psychologists and other health professionals I have spoken with often mention Layard as significant in helping to shift the mental health-care landscape, with IAPT itself referred to as, for instance, the 'Layard initiative'. Nevertheless, important as he was, Layard by no means acted alone. As illustrated earlier, his arguments took considerable cues from policy reports and charitable briefings. Aside from David Clark, Layard also worked with colleagues at the LSE (e.g. Layard et al., 2007), and the underscoring of psychological therapy within his campaign put him in dialogue with wider advocacy that operated to direct change in policy.

In this regard, a range of largely London-based actors and networks were producing documents and statements about access to psychological therapies. For instance, one third-sector report, *We Need to Talk* (Mental Health Foundation et al., 2006), was published one month after *The Depression Report* and served as a de facto companion text to it. Commissioned by five major mental health charities (The Mental Health Foundation, Mind, Rethink, The Sainsbury Centre for Mental Health, and Young Minds), the report emphasised the effectiveness of psychological treatment, the long waiting times for accessing it, and the economic costs of lost work (for coverage, see Frauenfelder, 2006). A loose association of major figures in UK mental health research, policy, and practice also formed under the banner of the 'New Savoy Partnership'. This included social psychologist Pam Maras (then President of the British Psychological Society), clinical psychologist Peter Fonagy (Chief Executive of the prestigious Anna Freud Centre), and campaigner Paul Farmer (Chief Executive of the leading mental health charity Mind). In 2007, they released the 'New Savoy Declaration'; this called 'on the NHS to offer

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appropriate psychological therapies free at the point of delivery to all people who need them' (New Savoy Partnership, 2007). Hence, the widely circulated *Depression Report* served to publicise the goals and further the momentum of a diffuse and diverse undertaking that was already beginning to gain interest and investment within Westminster.

In sum, from 2003 to 2006, an intense campaign from elite metropolitan academics and clinicians and well-known organisations and charities sought to move mental health higher up the policy agenda. This also related to, and was reciprocally informed by, wider governmental strategy and commitments to work and (psychological) well-being (Edwards and Imrie, 2008; HM Government, 2005; Rick et al., 2010). These stakeholders – among whom Layard and Clark were significant – helped to set and propel a programme for expanding access to psychological care. In doing so, they contributed, via a particularly economic problematisation, to the reconfiguration of the mental health landscape from which IAPT emerged. At an early point in the campaigning, this landscape – configured through extant policy and clinical praxis – was one within which a thing called 'depression' could be straightforwardly delineated and operated upon by certain techniques, with those suffering from it understood to be disadvantaged by public health infrastructures that limited access to care. The activities of Layard and others helped to reshape it such that both economic and psychological rationalities became vital features. Depression itself was configured as something that should be treated primarily through psychological therapy, and which could be accounted for in terms of its economic costs (with calculations of cost also justifying psychological rather than pharmaceutical interventions). Accordingly, depression came to be increasingly understood as an object of concern not only to individuals categorised as living with the disorder but also to the State and the body politic more broadly.

Remaking Infrastructures and Expertise

Following their commitment to improve mental health services (The Labour Party, 2005), in 2006 the re-elected Labour government granted over £2 million for trialling a programme for enhancing access to therapy within primary care: IAPT (Department of Health, 2012). A few weeks prior to the dissemination of *The Depression Report* through *The Observer*, two IAPT pilots were launched, in the city of Doncaster and in Newham, East London. The Doncaster site focused on depression, with Newham dealing with depression and anxiety disorders. Newham was part of the

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geographic area covered by the East London and City Mental Health Trust, chaired by Baroness Molly Meacher, Layard's wife and a co-signatory of *The Depression Report*. The IAPT pilots were rapidly subject to various kinds of elaboration and attention, and in November 2006 a business case was advanced to expand IAPT nationally (Rick et al., 2010). Funding was then confirmed in 2007. By 2008, the vision of enhancing access to therapy outlined in *The Depression Report* (and elsewhere) was made manifest.

Though ostensibly a bounded initiative dedicated to improving primary mental health care in England, IAPT became, in the words of one Scottish mental health policy actor I spoke with, a '*hugely* influential' programme. This has been partly in light of what they termed the 'fundamental economic argument' that 'Richard Layard and Dave Clark put forward', and 'the way it's [IAPT] been done'. In this section and the next, I will sketch out the contours of IAPT and examine how its novelty and legitimacy were configured and accounted for to maximise the material and symbolic investment that generated such influence. In setting out 'the way it's been done', I demonstrate how the 'economic argument' justifying the initiative became tightly imbricated with the practices of care and accountability performed through the programme.

In my interviews, informal conversations, and documents I inspected, five key features of IAPT were regularly foregrounded: the introduction of 'self-referral', the multiplication of therapists, the development of 'stepped care', a focus on evidence-based therapies, and the measurement of outcomes. To begin with, I attend to the first three of these significant characteristics of IAPT; these comprise the infrastructural innovations of the initiative most directly geared towards its stated aims of making psychological therapy 'accessible'. After that, the chapter turns to the design and nature of the therapeutic provision of IAPT, and how this was rendered (ac)countable. The use of evidence-based therapies and outcome measures were central to the construction, management, and maintenance of (what has been often regarded as) the success of IAPT. Hence, these features played a somewhat different, though seemingly vital, role in configuring and proliferating psychological care. As we will see, they also responded to – and had ramifications for – the broader psychological complex (Rose, 1985) within which it was situated.

In IAPT, and now NHS Talking Therapies, people can generally contact services directly to request an appointment. This process of 'self-referral' was regarded as significant by many of the policy and clinical actors I spoke with. Deemed to avoid the 'barriers' to accessing therapy that GPs were often (and still sometimes are) seen to impose, self-referral

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was widely perceived as a 'radical shift' (Brown et al., 2010, p. 365). The hope was that it would help many more individuals who understood themselves to be depressed and in need of treatment. So important was self-referral to the leaders of IAPT that the number of people self-referring served as a key performance indicator for services within the initiative (Department of Health, 2011). Hence, self-referral represented a means by which IAPT could simultaneously contribute to addressing its core problematic (i.e. enhancing access) and account for the extent to which this was achieved. In problematising referral and offering a targeted solution, the architects of IAPT were further able to present their initiative to policy and clinical communities as a logical, rational endeavour with respect to the managerial and therapeutic mores of UK healthcare. Subsequently, the apparent success of the self-referral processes of IAPT was argued to support the need for this mechanism in other UK mental health services (e.g. Brown et al., 2010). This is despite some evidence suggesting that self-referral can itself act as a barrier for potential service users (Thomas et al., 2019).

Alongside such efforts to make care more directly accessible, the IAPT initiative greatly increased the number of health professionals able to deliver treatment by positioning large numbers of clinicians within specially commissioned services. A considerable proportion of the IAPT investment was spent on training several thousand cognitive behaviour therapists and new 'psychological wellbeing practitioners' (PWPs) (Clark, 2011, p. 318). Today, they work across more than 100 NHS Talking Therapies services. As part of the increasingly complicated interplay between the public and private sectors within England, these are provided by a range of charitable and private healthcare organisations (including Mind) partnering with the NHS. Practitioners commonly deliver highly prescriptive forms of CBT, which can sometimes be referred to as 'manualised' therapy. Clinicians were initially tasked with treating individuals diagnosed with 'mild to moderate' anxiety and/or depression for a discrete (6–10) number of therapeutic encounters. Therapy was not regarded as requiring the expertise of doctorate-holding clinical psychologists, who were also more highly paid and demanded more autonomy. Hence, the training and employment of less expensive cognitive behaviour therapists and PWPs, who worked within closely defined clinical parameters, further optimised IAPTs economic outcomes.

The clinical foci and professional makeup of the IAPT/NHS Talking Therapies workforce are indicative of how the economic rationalities inherent in the conception of the initiative continued to be emphasised

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within programme delivery. IAPT – along with other NHS policy that enjoined so-called New Ways of Working (e.g. CSIP/NIMHE, 2007) – also affected how therapeutic expertise and therapy configured more widely. In IAPT and elsewhere, psychologists came to be decreasingly viewed as the primary professionals who should deliver psychological therapy. Rather, other psychologically trained clinicians were able to claim sufficient expertise, assuming therapeutic protocols were closely followed. This shift helped to shape the meanings of therapy beyond that delivered through IAPT per se. Gradually, therapy has become progressively characterised in a range of settings as a kind of pre-packaged tool that professionals, sometimes with relatively limited credentialed psychological expertise, can be trained to use in specific, predetermined ways.

Unsurprisingly, many working in clinical psychology have lamented this widespread recasting of expertise and therapy, resulting in various performances of professional boundary work. One senior psychologist told me how IAPT had 'caused a lot of disquiet' – something evident during my conversations with various mental health professionals – with, for instance, the 'deskilling' (in the words of another) of psychological services registering as a concern. In terms of the therapeutic orientation of IAPT, a policy advisor to the initiative described how he had been 'besieged' by criticisms about its focus on CBT. With the rising prominence of IAPT and restrictions in wider healthcare funding, clinical psychologists increasingly displayed their clinical and economic worth (as compared to PWPs, for example) by underscoring their skill in disassembling manualised therapies and recombining them on a patient-by-patient basis. This is in relation to a specific clinical formulation of a presenting problem and the psychosocial milieu inhabited by the person seeking therapy. Such reconfigurations of psychological knowledge and action are not reducible to IAPT; nevertheless, they have been propelled and authorised through the initiative, given its scale and the attention its architects have attracted and demanded.

Connected to shifts in therapists and therapy were reconfigured institutional logics regarding the subjectification (Rose, 1996) of populations suitable for therapy. Since the inception of IAPT, the care apportioned through its services has been undertaken in a self-consciously ration(alis)ed fashion that is ubiquitously described as 'stepped'. For example, a 'low-intensity' CBT intervention (such as guided self-help, including computerised CBT) can be initially provided to patients, who might then be 'stepped up' to a more 'high intensity' treatment in the absence of recovery. Levels of care relate to different kinds of intervention administered by professionals with differing (kinds and degrees of) expertise. Seen as sitting

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'at the heart of the IAPT clinical model' (Gyani et al., 2013, p. 605), stepped care was constituted through a conception of what we might term therapeutic wastage. It is deployed to prevent the loss of expertise, time, and, consequently, money to the treatment of mild depression, when these could be more swiftly applied and purportedly better spent (and accounted for) to and on other individuals understood to be experiencing more severe forms of distress.

IAPT did not, in fact, introduce the notion of stepped-care (e.g. Bower and Gilbody, 2005). However, its use was significantly extended through the salience of this model in what has been a very well-resourced and highly promoted programme. Many of my interlocutors were employed by psychological services structured through a kind of stepped-care approach, with implications for managing waiting lists. This form of care generally relates closely to values of cost effectiveness. While these have long been part of British clinical life (e.g. Department of Health, 1999a), their presence has been particularly apparent since the austerity policies enacted by the Conservative Government in the wake of the 2008 financial crisis, and almost every psychologist with whom I spoke expressed anxiety regarding service capacity vis-à-vis post-2008 budget restrictions. It was around this time that the infrastructures of IAPT were being touted as therapeutically and economically effective by key clinical proponents, such as Clark (e.g. Clark et al., 2009).

Stepped care, then, represented an answer to more than one problem. Through it, economic practices of accounting and clinical practices of accountability could entwine to synthesise the same ends: in principle, more people could be seen for therapy at ostensibly lower costs. Stepped-care systems also resonate with a certain notion of mental ill-health, one in which severity is not an abstract dimension of distress but is quantifiable through diagnostic language (e.g. 'mild to moderate' and 'severe and enduring' depression). Hence, stepped care represents a further example of how, through IAPT, economic understandings of care provision became increasingly enmeshed within clinical considerations.

Knowing What Works

In my interviews and conversations with policy actors, IAPT was commonly presented as a rational approach for intervening in a concrete economic, social, and clinical problem. Increasing access to psychological therapies was 'the sensible thing to do', as one policy advisor put it, not least because it would generate 'a cross-ministry saving'. Relating to such

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economic rationalism, the stated goal of IAPT was 'to greatly increase the availability of *NICE recommended* psychological treatment' (Clark, 2011, p. 318; emphasis added) – not therapy in general. A public body, NICE was originally the National Institute for Clinical Excellence before becoming the National Institute for Health and Clinical Excellence and, from 2013, the National Institute for Health and Care Excellence. It has a significant role within England (with implications for the wider United Kingdom) as a producer of NHS clinical guidelines. These are authored by expert Guideline Development Groups, and within them RCT evidence and assessments of cost effectiveness are salient (Moreira, 2011). Key to how the organisation presents and performs accountable action are the visibility of its processes of knowledge production and the managerial and clinical applicability, scientific veracity, and public and political palatability of its recommendations.

By framing the operations of IAPT as mandated by NICE, its advocates were enabled and emboldened to make claims about the clinical and epistemic legitimacy of the initiative. In doing so, the programme could be constructed as economically and politically durable. As the policy adviser above put it, NICE had 'an authority that goes beyond the authority of any particular professional group'. Another interviewee described how, by following NICE, IAPT could deliver 'treatments that we *know work*'. A further senior policy actor told me that although 'not everyone welcomes or *accepts*' NICE, it 'is the only show in town, at least at this stage, to keep the investment flowing'. Indeed, Layard and Clark (2014, p. 206) have asserted that 'the expansion of psychological therapy would never have happened at all without NICE'. CBT was prominent within the 2004 NICE guidelines for depression (and the subsequent 2009 and 2022 guidelines), and the architects of IAPT elected to emphasise this modality in their initiative. By ascribing dominance and import to NICE, this decision-making can be reframed as no choice at all: as the previously quoted interviewee asserted, 'in terms of a largescale programme we are almost *obliged* to go from where the evidence sits'.

Nevertheless, NICE is not an uncontested organisation. Over the last decade or so I have encountered wide-ranging dissatisfaction about it from clinical psychologists and others working in mental health. One senior figure associated with NICE noted, for instance, that 'a number of people' have regarded it as being 'too focused on CBT, to the exclusion of other psychological therapies'. Concerns have been, and continue to be, advanced within peer-reviewed and more informal literatures, with frustration about the calculative style of NICE commonly articulated. One

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critical journal article nicely summarises some of the concerns in its title: 'The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help' (Mollon, 2009). Part of a wider critique of NICE (Moreira, 2011; Syrett, 2003), these debates have developed a certain character through their refraction across the mental health professions. This relates especially to the occlusion of non-RCT treatment studies by the Guideline Development Groups, long-standing debates about the role diagnostic constructs (e.g. 'major depression') should play within clinical psychology, and the related use of manualised therapeutic approaches to CBT targeting categorical pathologies (Pilgrim, 2011). Despite these critiques, logics of quantification of the kind NICE is underpinned by and contributes to reifying are increasingly configuring UK psychological and wider mental health praxis.

The framework of evidence-based medicine (EBM) has long had traction within the United Kingdom (Armstrong, 2007); likewise, health economics has shaped healthcare delivery for many years (Mulkay et al., 1987). Still, these trends towards EBM and the deployment of economic expertise have intensified. Early in the 21st century, NICE – then a young organisation – operated at some distance from the everyday concerns of clinicians at the coalface of practice (cf. Hedgecoe, 2004). The first depression guidelines were only produced in 2004; prior to this, just three guidelines in mental health were available: on schizophrenia, eating disorders, and self-harm. In 2004, key players within NICE felt the need to write an article for the Royal College of Psychiatrist's *Psychiatric Bulletin* introducing their organisation and its activities (Kendall et al., 2004). Suffice it to say, these days NICE requires no introduction to UK-based clinicians whose practice is marked deeply by its recommendations.

The import of NICE in mental health has thus grown alongside the expansion of IAPT itself, with both increasingly interacting with one another. For example, Clark chaired the Guideline Development Group for the 2013 NICE social anxiety disorder guidance, which also emphasised the cognitive model of this construct (and subsequent treatment regimens) that Clark developed with Adrien Wells (Clark and Wells, 1995; NICE, 2013). Further, the perceived successes and practices of IAPT informed the evidence examined and generated by subsequent NICE Guideline Development Groups (e.g. BPS/RCPsych, 2011; NICE, 2011). More than two decades since Kendall and colleagues sought to raise awareness of NICE, its dominance can still inspire voluble criticism. Through this, health professionals reassert their authority to define subjective distress and therapeutic expertise in the face of the organisation

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doing so on their behalf, and following the expansion IAPT and the trumpeting of the styles of practice associated with it.

With the endorsement and encouragement of NICE, CBT has come to be widely promoted and operationalised within clinical psychology and mental health services across the United Kingdom. Over the years I have asked dozens of clinical psychologists about their therapeutic practice; they almost always reply that, at minimum, they draw on CBT, even as they generally integrate these with other approaches. IAPT itself has regularly been taken to task for its perceived (over-)reliance on this modality. One frequent criticism I encountered related to the notion that CBT has a good evidence base (which was seen to explain its promotion through NICE guidelines). Critics argue that trials for therapies that already indicate effectiveness in some populations are more likely to be sponsored for further research than untested modalities are. Accordingly, further evidence is generated, with which NICE's Guideline Development Groups might engage. In effect, knowledge about the effectiveness of CBT is presented as partly an artefact of a positive feedback loop. This is further accelerated by the readiness to which manualised forms of CBT could be subjected to evaluation through RCTs. Again, such critiques illustrate a shifting landscape in which 'evidence' (of a particular sort) has come to be central to the configuration of practice; hence, the nature of that evidence is reflexively subject to uncertainty and debate.

In interviews with policymakers, policy advisers, and key clinicians, I sometimes invited reflections on the criticisms that IAPT, CBT, and NICE had attracted. These interlocutors largely responded by presenting the widespread instantiation of CBT, the import of NICE, and the necessity of IAPT operationalising NICE guidelines as rational and reasoned. One asserted: 'if you think you should be trying to invest in evidence-based things then you need to be pushing the things that have evidence'. A senior member of the British Psychological Society asked, rhetorically: 'If one draws on the evidence base . . . what else could you do?' Concerns about CBT were sometimes reframed as an indication that those working in other therapeutic traditions needed to generate evidence for their preferred interventions in ways that NICE would recognise as legitimate. A more diverse array of therapies might then be included in future recommendations, and thus within IAPT. One interviewee argued that this perspective was 'not *unreasonable*, particularly in these straitened circumstances'. Even as evidence around CBT is decoupled from the social, technical, and economic contexts of its generation to justify its deployment, the reality that evidence must be actively made is therefore

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used as a means to critique the critics. This kind of shifting register was, I found, common in defences of IAPT: criticised on epistemic, economic, or humanitarian grounds, responses could readily be assembled from one of the other dimensions of the programme that reconstructed challenges as unreasonable or ill-informed.

Quantifying Success

Clark and Layard, as well as other IAPT leaders, have articulated the import and originality of their initiative through health economic forecasts, the synthesis of clinical guidelines, invocations of human need, and evaluation via the monitoring of clinical and socio-economic outcomes. Healthcare evaluation represents a key means of establishing intervention efficacy and demonstrating political and economic accountability (Broer et al., 2017), and was leveraged extensively within IAPT. During the programme rollout, for instance, various projects were developed to adjudicate its success, including an evaluation led by Clark et al. (2008) (see also Clark et al., 2009). Information collection was codified within the IAPT Data Standard (i.e. the list of data each IAPT service must collect), and voluminous monthly data collection continues to enable the comparison and evaluation of individual NHS Talking Therapy services. This has long been publicly available, and currently so through the NHS Digital webpages (NHS Digital, 2024). Data include referral dates for calculating waiting times, the number of referrals who have completed a course of treatment, and the average number of treatment sessions (Clark et al., 2009; Department of Health, 2011). Submitting data is itself a complicated process which involves considerable work in terms of the collection, anonymisation, and authorisation of the data and decision-making with regards to who monitors and controls this. Though this mass collection of data, the effectiveness of IAPT was made quantifiable.

Quantification can represent a solution to enduring issues of legitimacy and accountability in healthcare (Hogle, 2019) and beyond (Porter, 1995), and patients within mental health settings have long been subject to diverse forms of calculation (Grob, 2009; Hirshbein, 2009). Within IAPT, though, the variety and consistency of data collected on the characteristics of individuals engaged in therapy and their 'outcomes' from this was commonly argued to be unprecedented. Initially communicated to practitioners through the *IAPT Data Handbook*, the rationales for data collection indicated the range of intertwining clinical, economic, and political uses to which metrics are put (Department of Health, 2011, p. 10):

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1. Ensure equitable use of IAPT . . . by people experiencing depression and anxiety disorders from all communities within the local population, actively advancing equality [. . .]
2. Actively use data collection as part of the clinical process . . . to enhance patients' and IAPT workers' engagement in collaborative decision making and treatment plan reviews [. . .]
3. Provide objective case-load and outcomes data for supervisors to enable them to review the clinical work of IAPT workers [. . .]
4. Provide IAPT workers with information that will help identify appropriate targets for intervention in the next therapy session [. . .]
5. Monitor the extent to which IAPT workers and services are providing evidence-based treatments which are consistently applied in the manner recommended by NICE
6. Measure people's experience and benefits from IAPT services
7. Assist commissioners and service providers in monitoring and improving the quality and cost effectiveness of their services for all communities
8. Build a robust data archive to inform evolving service improvement strategies [. . .]

The production and harnessing of data for different but connected ends also served to represent IAPT as a departure from more traditional means of undertaking and evaluating psychological therapy. One senior psychologist involved in the programme, for instance, told me how therapy delivered outside of IAPT could be 'very ineffective and very poorly monitored'. He claimed that this 'shouldn't really be allowed to carry on', given the risk of 'adverse effects' from poor practice. Such morally laden talk about the potential negative effects of therapy – and hence the need to scrutinise the expertise and performance of professionals – was also articulated in formal IAPT policy (e.g. Department of Health, 2011). Indeed, the very fact that measures were taken at all, notwithstanding the nature of the data itself or the uses to which it is put, helped to perform the novelty and legitimacy of IAPT.

One means through which different forms of accountability came to be enmeshed in IAPT was through the ongoing employment of a tool called the Patient Health Questionnaire (PHQ-9). Designed in the United States in the late 1990s to screen for and assess depression (Kroenke et al., 2001), it asks a series of questions about aspects and occurrences of depressed mood. Possible responses are 'not at all', 'several days', 'more than half the days', and 'nearly every day'. These correspond to a number, with

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responses summed to produce an overall severity score: 0–5 is taken to indicate mild depression, 6–10 is moderate, 11–15 is moderately severe, and 16–20 is severe. Following their (self-)referral to IAPT/NHS Talking Therapies, an individual hoping to access therapy will often be sent the PHQ-9 to complete. The score produced confirms suitability for the service, provides the therapist a starting point for the first appointment, and acts as a benchmark for therapeutic progress. By rendering depression quantifiable, the PHQ-9 enables judgements of severity to be deemed reasonable and therapeutic gains to be recordable, rendering clinical action accountable (to patients and service leads). Accordingly, the PHQ-9 acts as a significant apparatus for consolidating understandings of 'depression' as a bounded and discrete disorder, and hence has subjectivising effects on individuals completing it (Hacking, 1995, 2002). It aligns well with CBT, which as Stark (2017, p. 70) has observed, itself intertwines 'an emphasis on numerical quantification with an ordinal schema of rationality, clarity and self-fashioning'. By configuring patent subjectivities as calculable and surveillable, the PHQ-9 also enabled the evaluation of the therapist, the service, and ultimately IAPT (and now NHS Talking Therapies) itself.

Layard and Clark (2014, p. 205) stated that 'outcome measurement is probably the most important single feature of IAPT', arguing that it 'is really the only ultimate guarantee of quality'. Presented as descriptive statements, such comments are normative proclamations. An interviewee closely involved with the initiative told me that one reason why IAPT was 'successful' was 'because from the start' it was decided 'you have to actually demonstrate that what you do is worthwhile'. This meant 'that we just *had* to be able to have outcome data on more or less everyone who was treated'. Outcomes measures continue to be framed as providing epistemic and procedural credibility, which translates into political legitimacy. Without them, I was told, 'I don't think [IAPT] would have continued political support'. Despite clinical and normative claims about the import of outcome measures in IAPT, it is the economic and (consequently) political accountabilities relating to these that leaders of the initiative have often portrayed as particularly significant.

Given the salience of outcomes monitoring to IAPT – and their subsequent promotion by initiative leaders and other key healthcare figures and institutions – it is worth noting that this practice was not introduced by the programme. Rather, monitoring and evaluation have been advocated since at least the 1990s (e.g. Department of Health, 1999a; see also Roth and Fonagy, 1996). This has often been on the grounds of (political pushes towards) clinical accountability (e.g. Margison et al., 2000; NIMHE,

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2008), generating tension and conflict within therapy communities (Power, 1999). IAPT was thus constituted within a landscape where measurement was already encouraged.

The calculation of outcomes has come to be even more forcefully mandated by policymakers, including as a key element to service commissioning and provider reimbursement (so-called payment by results) in an increasingly privatised English NHS (Department of Health, 2013). My interviews and conversation with clinical psychologists outside of IAPT/NHS Talking Therapies indicated that routine, systematic, and standardised outcomes measurements have become common following the advent of the initiative (such as the Clinical Outcomes in Routine Evaluation (CORE) framework; Evans et al,, 2000, 2002). I was even sometimes told (e.g. by one key civil servant associated with IAPT, as well as by various clinicians) that people engaged in psychological therapy 'like' outcome measures. Hence, outcome measures do not just ensure that the direction of accountability travels "up" to service and initiative leaders, and ultimately policymakers and politicians, but also "down" to patients themselves. Given policy emphases on patient choice (Greener, 2009), augmenting accountability to service users also enhances its political legitimacy.

The implications of IAPT for mental healthcare do not, then, lie in the introduction of outcomes monitoring per se. Rather, the ramifications of the English IAPT initiative can be seen in how it has contributed to establishing data collection in a range of mental health services across the United Kingdom as a necessary and ever more routine practical task for psychological practitioners and services to build and demonstrate clinical and economic legitimacy. Consequently, though generally presented by IAPT leaders as appropriately responsive to the demands of technocratic governance (Porter, 1995), claims about the collection and evaluation of therapeutic outcomes have also contributed to the consolidation of this authority.

Contextification

Almost two decades after its emergence, the reach of IAPT continues to be extensive, not least through its 2023 renaming as NHS Taking Therapies and subsequent promises of further expansion (HM Treasury, 2023). Its operations have been held up as examples from which other psychological services might learn, and policymakers and clinicians beyond the United Kingdom have expressed considerable interest in embedding similar models within their own health systems (not least Australia and Norway; Cromarty et al., 2016; Knapstad et al., 2018). In England and the wider

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United Kingdom, many researchers, clinicians, and patients have praised IAPT for attending to both scientific evidence and human need. Layard and Clark (2014) followed up the 2006 *Depression Report* with a book for a general readership, *Thrive*, in which IAPT was presented as a 'great humanitarian project' (p. 207) and 'has shown that it is possible in a short time to make big improvements in the lives of hundreds of thousands of people' (p. 201). Perhaps unsurprisingly given their earlier messaging, Layard and Clark described prompt access to therapy as simultaneously 'morally right' and 'vital for our economy' (p. ix).

Nevertheless, criticisms of IAPT have been plentiful. Many clinical psychologists and other mental health professionals – including IAPT therapists and managers – have expressed concerns about the programme: to me directly in interviews and casual conversations, and across the academic and professional literature, blogs, and social media (see also Bruun, 2023; Marks, 2012). Their disquiet relates to the widespread use of CBT (and sometimes to its elite advocates), challenges to therapeutic quality that might result from prioritising particular kinds of outcomes measures, and how economic rationales impinge upon – and reconfigure – clinical care. Even some of the key health economic claims made about psychological therapy have been contested (McCrone, 2013), and antidepressant prescriptions continue to rise (Health and Social Care Information Centre, 2016; NHS Business Services Authority, 2022).

When IAPT was criticised, its advocates framed the various choices made during the development of the initiative as almost inevitable. Justifications related to the accountabilities that Clark, Layard, and colleagues emphasised through the initiative, and the measures and means chosen to demonstrate them. The accountabilities constitutive of IAPT were, chiefly, economic, epistemic, and clinical. They were built into the operations of the programme in ways that enabled its advocates to present it as reasonable and rational, and hence any naysayers as uninformed, misguided, or even self-interested (e.g. Fonagy and Clark, 2015). Their integration with the programme has served as a robust shield with which to deflect critique.

The decisions made by IAPT leaders when responding to the broader healthcare landscape during the development phase of the initiative have come, to a significant extent, to be reified as not merely *a* way of developing public mental health, but as *the* way to proliferate therapy. Elegantly advanced justifications for and defences of IAPT align closely and resonate with a seemingly ever more economistic framing of the public good by successive UK governments, further closing down spaces within which the

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problematisations that might propel alternative therapeutic futures can be developed. This discourse of inevitability (Leonardi, 2008; Pickersgill, 2024) has helped to authorise and legitimate the decisions of the early IAPT proponents and leaders, and consequently the situation of the initiative has itself morphed. From being but one feature of a wider public health ecosystem with roots in some existing practices, IAPT reshaped its environment and emerged as a principal entity to which other services must respond. It is in this sense that the imitative moved from 'content to context' (MacKenzie, 2015; MacKenzie and Pardo-Guerra, 2014).

Such "contextification" has been highly reliant on an economic problematisation of ill-health. This underscores: (1) a certain kind of psychological ontology for subjective distress, (2) the operationalising of this in categorical terms (e.g. depression, anxiety) that are off-putting to traditions like clinical psychology, (3) the possibility of swiftly quantifying such constructs in terms of severity, (4) the necessity of standardised and readily applicable forms of therapy, and (5) the significance of therapists of varying kinds with assorted psychological credentials. This economic problematisation also foregrounds the vital role of measurement in simultaneously evidencing clinical need, therapeutic efficacy, and prudent expenditure. These features are exemplified by IAPT and, while not wholly reducible to the initiative, have become ever more characteristic of other mental healthcare settings. This is in part due to the lauding that IAPT has widely received and its casting as an exemplar programme by bodies such as NICE (the influence of which itself has grown with and through the initiative). As psychological expertise helped to configure IAPT, so too has IAPT reconfigured the psychological complex.

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