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Improving Access to Psychological Therapies (IAPT) - The Need for Radical Reform

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Abstract

Improving Access to Psychological Therapies is a UK government-funded initiative to widen access to the psychological treatment of depression and anxiety disorders. The author has had the opportunity to independently assess 90 Improving Access to Psychological Therapies clients, using a standardised semi-structured interview, the Structured Clinical Diagnostic Interview for DSM Disorders (SCID) and to listen to their account of interaction with the service. The results suggest that only the tip of the iceberg fully recovers from their disorder (9.2%) whether or not they were treated before or after a personal injury claim. There is a pressing need to re-examine the modus operandi of the service.

Keywords

Clinical Commissioning Groups, Improving Access to Psychological Therapies, independent assessment, objective criteria, psychometric tests, standardised diagnostic interview, surrogate measures

Introduction

The PACE (pacing, graded activity, and cognitive behaviour therapy: a randomised evaluation) trial of the effectiveness of cognitive behaviour therapy (CBT) and graded exercise for chronic fatigue syndrome came in for fierce criticism in this journal on the grounds that when objective measures of outcome were used the effectiveness of CBT disappeared (Geraghty, 2017; Vink, 2017). The authors of the PACE trial relied on subjective self-report measures to 'promote' the cognitive behaviour therapy and graded exercise therapy protocols that they themselves had developed. This cast into doubt the wisdom of spending £5 million of the taxpayer's money on the trial (Marks, 2017). However, the UK Government's Improving Access to Psychological Therapies (IAPT) programme has similarly relied on subjective outcome measures (Layard and Clark, 2014) offering little by way of accountability for the £1 billion pound spent on IAPT since its inception. Furthermore, there has been a complete absence of published reports of independent evidence on the effectiveness of IAPT. In this study, the author, an Independent Expert Witness to the Court, has had the opportunity to audit the mental health trajectory of a sample of IAPT clients, both before and after the event that triggered their personal injury

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Table 1. Description of sample ($n = 90$).

Male/female	57.8% (52)/42.2% (38)
Age	40.5 (median), 42.6 (mean), range 17–84
Employed/unemployed	69.3% (61)/30.7% (27)
Number of disorders	1.6 (mean)

claim, such events ranged from slips to serious road traffic accidents.

Method

The prime duty of the Expert Witness is to the Court, but without reliable knowledge of the effectiveness of treatment in routine practise, the Expert will have difficulty in advising the Court on treatment options. The medico-legal context provides a window through which the effectiveness of interventions delivered by providers, such as IAPT, can be viewed. Unfortunately, the UK government prevented funds from the IAPT programme from being used for research. The author's medico-legal protocol follows the format detailed by Scott and Sembi (2002) involving an open-ended, semi-structured interview Structured Clinical Diagnostic Interview for DSM Disorders (SCID); First et al., 1997) using the DSMIV TR criteria (American Psychiatric Association, 2000), a screen for malingering and review of records.

Assessment using multiple sources of information is held to be the most reliable form of assessment for both medico-legal and clinical purposes; yet strangely IAPT (in evaluating itself) has relied entirely on just two sources of information, an open-ended interview and psychometric test results. IAPT clinicians rely on a non-standardised open-ended interview to chart client's treatment voyage. The administration of psychometric tests does not make this type of interview reliable. It is not that the psychometric tests per se are invalid, but client scores only have meaning in a carefully defined context. Clinical diagnoses in open-ended contexts have imperfect validity with kappas (levels of agreement) of 0.1–0.3 between routine open-ended interviews and the 'gold standard' research diagnoses achieved with a semi-structured standardised diagnostic interview (Rettew et al., 2009) such as the SCID (First et al., 1997). The SCID begins with an open-ended interview in which the client is encouraged to tell their 'story' but then questions are asked about each of the symptoms that comprise a diagnostic set and on the basis of the client's response and all the information available, including records, a judgement is made about whether a particular symptom can be regarded as present at a clinically significant level with regard to published guidelines, or to put it technically information and criterion variance are controlled for. No such controls are in place for routine open-ended interviews. Thus, the methodology employed in this study incorporated use of the SCID (First et al., 1997).

In the 90 cases considered in this article, there was no evidence of malingering and no challenge from opposing experts on the veracity of the clients' reports. The sample is described in Table 1.

Of the sample ($n = 90$), 58 per cent had one disorder, 31 per cent two disorders, 8.9 per cent three disorders, 1.1 per cent four disorders and 1 per cent five disorders. In a study of 2300 psychiatric outpatients, Zimmerman et al. (2008) found an average number of disorders per client of 1.9. The study covered IAPT services in the North West of England. The range of disorders is shown in Table 2.

From Table 2, it can be seen that if clinicians were adept at screening the four most prevalent disorders and accurately confirming diagnoses, then they would be on-target with 84.3 per cent of disorders. While population profiles may vary from location to location, Pareto's 'Law of the Vital Few' likely operates with 20 per cent of disorders contributing 80 per cent of the workload.

Table 2. Range of disorders ($n = 90$).

Depression	48
PTSD	36
Specific phobia	17
Panic disorder	11
GAD	5
Social anxiety disorder	4
OCD	3
Anxiety disorder not otherwise specified	2
Binge eating disorder	2
Alcohol dependence	2
Chronic adjustment disorder	2
Excoriation disorder	1

Ethical approval

This study did not fall under the UK National Patient Safety and National Research Ethics Service (NRES) definition of research (National Patient Safety Agency, 2010) as clinicians' treatment decisions were not manipulated nor were any experimental interventions used in this audit.

Results

The results of IAPT treatment are presented below, first in terms of IAPT's sole metric of success, psychometric test results administered in the context of an open-ended interview, and then in relation to the author's independent assessment using a standardised diagnostic interview.

Psychometric test results

In the current sample, IAPT furnished General Practitioners (GPs) with before and after psychometric test data on 29 (32.2%) of the sample. These were people who had had treatment in terms of IAPT's definition of attending at least two treatment sessions. Given that 26 people attended less than two sessions and there was missing data on session completion for two people, data could have been furnished on 62, so that IAPT is only furnishing data on 29/62 (46.8%) of those for whom they have data. IAPT claims treatment data completeness for 96.8 per cent of people who received treatment. There appears no accountability to GPs.

IAPT's chief outcome measures are the PHQ-9 and GAD-7 (Kroenke et al., 2001). Clinically reliable improvement is defined by IAPT as a reduction by six or more on the former and four or more on the latter. Recovery is defined as a reduction to below a score of 10 on the Patient Health Questionnaire (PHQ-9) (10 or more is regarded as a 'case') and a reduction to a score below 8 on the Generalised Anxiety Disorder (GAD-7). Three of the 29 were below the threshold for a 'case' of depression; excluding these from the analysis, the recovery rate on PHQ-9 alone was 6/26 (21.3%) and reliable improvement 3/26 (11.5%). On the GAD-7, there two initial missing values and one case below 'caseness'; excluding these from the analysis, the recovery rate was 12/26 (46.0%) and 3/26 (11.5%) reliably improved. Looking at recovery on both the PHQ-9 and GAD-7, two cases are excluded because of missing data and two because they were below 'casenes' leaving 25 cases for consideration and a recovery rate on both of 6/25 (24.0%). There were no cases (0.0%) of reliable improvement on both. The rate of recovery in this sample of 24.0 per cent is substantially less than the recovery rate of 40.0 per cent of clients that is claimed by IAPT (Gyani et al., 2013).

Results of independent assessment using a standardised semi-structured interview

Table 3 shows how clients fared following CBT treatment, as assessed using the SCID interview (First et al., 1997).

The overall mean recovery rate across all disorders was 9.2 per cent. Three people were excluded from the post-traumatic stress disorder (PTSD) analysis in Table 3 as PTSD treatment was incomplete at time of assessment. One person was excluded from the 'Disorders excluding PTSD and depression' category in Table 3 as treatment was incomplete at time of assessment. One quarter of the sample (23 people; 25.6%) had IAPT treatment before litigation and 67 people (74.4%) had IAPT treatment after the commencement of litigation (Table 4).

Table 3. Recovery following IAPT treatment ($n = 90$).

Category of case	Percentage recovered (n)
All disorders	9.2% (7)
PTSD ($n = 36$)	16.2% (6)
Depression ($n = 48$)	14.9% (7)
Disorders excluding PTSD and depression ($n = 49$)	2.2% (1)

Table 4. Recovery rates for people treated before and after beginning of litigation.

	Percentage recovered before beginning of litigation	Percentage recovered after beginning of litigation
Recovered from at least one disorder	14.3% ($n = 3$)	12.7% ($n = 8$)
PTSD	25% ($n = 1$)	16.1% ($n = 5$)
Depression	15.4% ($n = 2$)	14.7% ($n = 5$)
Disorders excluding PTSD and depression	14.2% ($n = 1$)	0% ($n = 0$)

Table 5. IAPT's engagement and retention of clients ($n = 90$).

1. 23.6% of clients either did not initiate contact with IAPT (an opt-in arrangement) or IAPT were unable to contact them to arrange an assessment
2. 13.3% attended only an initial assessment
3. The mean number of treatment sessions attended was 5.5 with a median of 4.0 sessions, with missing data on one client
4. 39.3% attended 2 or less treatment sessions
5. 57.3% attended less than 6 treatment sessions
6. 23.6% attended 6–8 treatment sessions
7. 80.9% attended 8 treatment sessions or less
8. 4.5% attended 20 more treatment sessions

IAPT: Improving Access to Psychological Therapies.

Table 4 indicates that litigation makes no difference to recovery rates. It may be anticipated that the recovery rate post personal injury claim would be less as litigants may have a vested interest in exaggerating debility but inspection of Table 4 does not support this. Further it could be argued that litigants would minimise their distress prior to the personal injury claim and if they had had treatment before exaggerating how useful it had been i.e. that recovery rates would be higher before than after but Table 4 does not support this. IAPT's ability to engage and sustain client involvement is summarised in Table 5.

From Table 5, it can be seen that one in four clients fell at the first organisational hurdle. The number of sessions attended did not differ significantly between those who recovered from all disorders and those who did not. However, there was a significant difference ($p < 0.05$) between the mean number of sessions attended before personal injury 3.5 (4.0) and the mean number of sessions 6.2 (6.1) attended after personal injury.

Forty-eight of the 69 clients (missing value on number of sessions attended by one client) who attended one or more treatment sessions (69.6%) had a sub-therapeutic dose of treatment (defined as attending less than eight sessions – Layard and Clark (2014) state that clients need to receive an average of at least eight sessions).

A total of 68 of the 89 clients (76.4%; missing value in one case) had either a sub-therapeutic dose of treatment or did not engage in the treatment process.

Discussion

Inspection of the psychometric test data that was supplied for this study via GPs revealed a recovery rate of 23.0 per cent. This is consistent with the University of Chester's Centre for Psychological Therapies almost identical figure of 22.0 per cent 'moving to recovery' for those who started therapy (Griffiths and Steen, 2013) whereas IAPT's claim of 44.0 per cent 'moving to recovery' was for those completing treatment. Griffiths and Steen (2013) observed that, when all patients 'referred' to the IAPT programme are considered, the comparable figure is 12.0 per cent.

IAPT routinely administers the PHQ-9 and GAD-7 at weekly treatment sessions but scores on measures can decrease due to repeated test administration (Longwell and Truax, 2015), it is very doubtful whether these measures are suitable for weekly administration, casting into doubt IAPT's method of assessing its own effectiveness. Psychometric tests are a measure of the severity of a disorder, so applying tests to a patient's disorder that is unknown, is problematic and using it as a yardstick for recovery hazardous. Psychometric tests can reasonably be used as a surrogate outcome measure after it is first demonstrated that an intervention (in this case the IAPT service) is effective in routine practice using a 'gold standard assessment', but not before. There is a distinction between hard outcome measures, for example, how many people die following a cardiovascular intervention, and surrogate measures, for example, lowering of cholesterol. The danger is that the marketing of products/services is based on the surrogate measures that have a loose association with the hard measure. Surrogate measures ease the research burden but can be very misleading

Clients typically present to a service at their worst and there will necessarily be some regression to the mean on any psychometric test, and distinguishing such changes from the impact of a service is inherently problematic. It is possible to employ measures such as how many patients show clinically significant reliable change (Jacobson and Truax, 1991), but such metrics were developed for use in randomised controlled trials where the diagnostic status of the client is very precisely determined. Applying such metrics to a heterogeneous client population is highly questionable.

IAPT clients routinely complete the PHQ-9, GAD-7 and devices to measure the extent of phobic avoidance. However, such devices can be very misleading, for example, one client with a phobia of travelling by car was discharged on the basis that her Specific Phobia score had gone down to 0 but she still met DSM criteria for a phobia, and while she was not avoiding travelling by car, she was still highly anxious in it.

Layard and Clark (2014) assert that each client receives a professional assessment. However, notes from IAPT Services often arrive at the Expert Witnesses desk with a disclaimer that they do not make a diagnosis and their findings cannot be relied on for medico-legal purposes. The author knows of no other body that makes such a disclaimer.

IAPT therapists are encouraged to make 'provisional diagnoses' but do not employ a standardised semi-structured interview in making their 'professional assessments'. It is therefore unsurprising that there is a gap between IAPT assessments and the results of a SCID interview. To illustrate the point one person was identified by the IAPT therapist as suffering from PTSD following a car accident but the therapist missed that he was also suffering from depression and discharged him from treatment on the grounds that his flashbacks were not as disturbing. However, a comprehensive SCID interview revealed that he was still suffering from PTSD. This case example shows how comorbidity has been missed by the arbitrary nature of criteria used for discharge, whereas the SCID interview has a built-in criterion threshold above which a symptom can be considered present.

Unstructured interviews miss comorbidity (Zimmerman and Mattia, 1999) and IAPT assessments fall into this category. This will result in failure to treat additional disorders while clients wish for treatment for all the disorders for which they present (Zimmerman and Mattia, 2000). A standardised interview such as the SCID ensures that a clinician is looking for disorders so that nothing is overlooked. By contrast, in an unstructured interview, the clinician is likely to stop at the first disorder that they come across.

NICE recommendations are diagnosis specific. Given the vagaries of IAPT's diagnostic procedures, it is not possible to assess whether the IAPT therapists are National Institute for Health and Clinical Excellence compliant (NICE-compliant) (Gyani et al., 2013). This means that it is not possible to determine whether an appropriate evidence-based treatment protocol has been used, raising an important accountability issue. Confronted with a client, the IAPT clinician literally does not know what he is dealing with and can make no prediction as to the likely best pathway.

IAPT does not employ any measure of treatment fidelity. Fidelity has two components: (a) a measure of adherence, the extent of a focus on identified targets for a disorder and the matching treatment strategy; (b) a measure of competence – how skilfully treatment is conducted. Competence without adherence is meaningless (Scott, 2013).

The IAPT goal has been to have weekly supervision, with 70 hours of supervision a year, far more supervision than is found anywhere else in routine practice. However, the outcome results for IAPT suggest that although supervision may be a necessary condition for the delivery of an evidence-based treatment, it is not sufficient. Close attention has also to be paid to fidelity in supervision. Supervisors are responsible for ensuring that the therapeutic processes followed by the supervisee produce a real-world difference in client's lives. In this, they have clearly failed. The prime function of a supervisor should be to ensure the translation of an evidence-based treatment into routine practice.

In the absence of a standardised diagnostic interview, it is impossible for IAPT to accurately determine its treatment population. Clients could easily have a personality disorder for which their clinicians are neither trained to identify nor treat. Current IAPT assessments typically involve a 30-minute telephone assessment, which is not fit for reliable diagnosis and should be replaced by the administration of a comprehensive standardised semi-structured interview. Clients would be directed to the appropriate clinician and the initial assessor would be tasked with tracking how the client fared in treatment and monitoring whether there had been fidelity to treatment.

Group intervention and computer-assisted CBT is a rarity. Given that the avowed intention of IAPT is to provide treatment for as many clients as possible, it is surprising that only one of the 90 participants in this audit underwent a group intervention within IAPT, with two others having been offered group CBT but declined. Group interventions for depression and some anxiety disorders appear as effective as individual therapy (Scott, 2009) and it is surprising that consideration appears not to have been given to at least some judicious combination of individual and group intervention. Furthermore, none of the 90 participants in this audit had undergone computer-assisted CBT, although one was offered it and declined.

Client testimonies

The recorded testimonies of clients are contained in Appendix 1. They testify to difficulties with the 'opt in' system, problems with the telephone assessment, with little evidence that treatment made a real-world difference to their problems, albeit that a small proportion of clients found the interventions 'helpful'.

Friends and family test

The UK Government (2013) have suggested that National Health Service (NHS) users are asked 'How likely are you to recommend our (service) to friends and family if they needed

similar treatment?' with six possible responses: 1: extremely likely; 2: likely; 3: neither likely nor unlikely; 4: unlikely; 5: extremely unlikely; 6: do not know. It would be interesting to know the answers given to this question not only by clients but also those given by IAPT staff.

Limitations

This audit is limited to a sample of IAPT clients whose difficulties have been triggered or exacerbated by some trauma, and as such, the sample may not be representative of all IAPT clients. An independent study using a standardised semi-structured interview of consecutive attenders at IAPT would be needed to confirm the present findings. In the absence of such a study, there are serious doubts as to whether the 'Emperor has any clothes'. Clinical Commissioning Groups should see IAPT as just one model of service delivery and for which evidence of effectiveness is not proven.

Conclusion

From the present findings, it must be concluded that only the tip of the iceberg of IAPT clients recover when assessed independently using a 'gold standard' diagnostic interview. IAPT claims that almost half recover (based on the administration of weekly repeated psychometric tests) appears inflated, and even using their own metric the more likely figure is a quarter. However, care has to be taken in interpreting the psychometric test results in this study as GPs were furnished with only half the test data. IAPT needs to address major issues of independent assessment and accountability. Three-quarters of IAPT clients either had a sub-therapeutic dose of treatment or did not engage in treatment.

IAPT employs the most junior members of staff at the front-end of assessment and pays lip service to diagnosis, which is an integral part of predicting the best treatment for a particular client. There should be a shift to employing more senior staff at the front-end, skilled at least to assess reliably the 20 per cent of disorders that probably make up 80 per cent of the workload. The existing 30-minute telephone consultation is wholly inadequate for predicting the best course of treatment for an individual. Senior staff, including Supervisors, should be involved in monitoring the prescribed treatment to ensure fidelity to an evidence-based treatment protocol, with appropriate targets and matching treatment strategies. In the current regimen, it is unsurprising to find that 68.6 per cent of low intensity workers (responsible for seeing 70% of referrals) and 50 per cent of high intensity therapists are reported to be suffering from burnout (Westwood et al., 2017). There is likely to be poor job satisfaction if therapists do not feel that they are making a real-world difference in client's lives.

Both for the sake of its staff and its clients, IAPT has to undergo radical reform. Given the high levels of stress in IAPT, it is doubtful as to whether the present Service would pass a 'Friends and Families Test'. The IAPT Service has been very top-down with little evidence of really listening to either therapists or clients at the coalface. There is a pressing need for both top-down and bottom-up processing.

Given that for depression and many anxiety disorders, group CBT appears as effective as individual CBT, it was surprising to find it was virtually non-existent in this study. IAPT has to move beyond providing occasional workshops for its staff on group CBT and capitalise on the improved access that group work would facilitate. Likewise, there was virtually no evidence of the use of technology (e.g. CBT software) to help enhance outcomes, which needs reappraisal. This author wholeheartedly supports the concept of IAPT, but the implementation of evidence-based treatment has gone badly awry under its auspices.

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Appendix 1

Testimony of IAPT clients

Initiating contact

sent me a letter asking me to ring them for a telephone assessment but did not do this, I can't just talk to strangers on the phone, I am not good with words, the thought of talking to someone I can't even see

they first contacted me by telephone and gave me the option of a telephone or face to face assessment they were pushing for me to have a telephone assessment but I insisted on a face to face assessment.

The initial assessment

Letter from GP … saw me I was extremely worried seen last week by colleague of yours issued with a number of leaflets on managing anxiety and depression not had the motivation to read the leaflet concerned that this approach should be used to people who are already depressed and lack motivation next appointment was arranged in by telephone in 3 weeks further intervention would have been more appropriate she appears to have lost confidence in the system

very rushed and the lady was abrupt. She said that subsequently received a letter offering her a face to face appointment but this was at 5.30pm and she was afraid of taking her children into heavy traffic and did not attend but rang to cancel … the telephone assessment took place hours after the time it was supposed to

the assessment focussed on my military history which I did not think was an issue and I declined treatment because they said probably 5 month wait for individual cbt and said would seek private treatment

had telephone assessment with IAPT which I felt was ok but couldn't recall a diagnosis they contacted me about appointments and I asked for appointments after working hours and they never got back to me it is a year since the telephone assessment

telephone assessment … cried throughout the assessment … felt that the person at the other end was reading a script and asking me questions about whether I was going to harm himself and if he had anyone with him … felt like he was talking to a 'call centre' and thought the experience was a waste of time. I think they promised to ring him again to have further telephone therapy but they did not do so

Treatment

I find it helps me a lot I am having a very difficult time and I always feel better after seeing my therapist.

didn't like attitude of therapist decided cbt not for me

very helpful

attended on three occasions … told the CBT therapist that she was not taking my antidepressant medication and the therapist informed my GP of this … 'trust violated', became afraid that her son might be taken off her and stopped attending treatment … the therapist was a trainee.

had five or six therapy sessions … the sessions were a little helpful in that more able to talk about this incident without upset … tasked with listening at home to an audio recording of the trauma until I became less distressed by it … it was proposed that this was discussed at the next therapy session but at the next session the therapist simply wanted to make a new recording and no explanation was provided for this … after this she did not rebook a session and then she received a letter to say that she had been dropped from treatment.

had had six to seven sessions of CBT … the sessions had helped but that they were about four weeks apart and by the time I attended a session I had forgotten much of the material from the previous session and felt that I was constantly at the beginning … missed the last two or three sessions because she was getting gradually less help from them

did benefit from the counselling sessions she I had previously

had ten sessions of counselling following the incident … the counselling was helpful … at about three sessions the therapist asked me to recount the incident in detail … told that the goal was to reduce subjective units of distress (SUDS) by half … found the procedure very distressing but during it did recall aspects of the incident I

had not remembered such as being a spectator to what was happening at the time of the incident … said he was unsure if he told the therapist that the SUDS had reduced in order to stop the procedure because it was so painful or if he genuinely believed the stress of recounting the story had in fact reduced … felt at the end of the treatment that though it helped 'left in limbo'.

had about seven to eight sessions of CBT but stopped going because I found it so awful, talked about it, it would all be dragged out of me, hated every minute of the CBT … asked to write about the incident at home just before I dropped out of treatment.

had cognitive behaviour therapy and EMDR since the incident in question – about ten sessions in total … not been back to treatment for the past two months because she was unhappy about the EMDR and found it made her very uncomfortable and she could not understand the reason for the treatment.

had CBT from about four months post the incident in question, this is ongoing and to date I have had had some twenty sessions and believe will be finishing treatment shortly … found the CBT extremely helpful and was fearful of it coming to an end

found the treatment very stressful and was tempted several times to drop out

mixed feelings about the usefulness of the therapy in that it did become repetitive and some of her questions were not answered but she did learn a breathing technique

thought it was 'fantastic'

hopeless, advised by young girl to be active and put 'smiley faces' on activities completed did become more active lost wght but soon relapsed into depression attended 3 appointments dropped out

counselling really helpful

helpful

helpful

attended one face to face session felt judged and that therapist didn't really understand and dropped out

helping

helpful

offered 6 sessions counselling which found helpful to talk but made no diff to depression, was desperate for further sessions and was offered one further session.

had about seven or eight therapy sessions since the incident. … but he never felt comfortable enough with the therapist to volunteer the fact that he had nearly made a suicide attempt … began with a telephone assessment but he felt uncomfortable with the therapist and could not understand her explanation of his difficulties … therapist talked to me about my belief system, asked me did i 'believe in Santa Claus', felt demeaned but not confident enough to complain. … therapist focused on relationship with his father who had been somewhat heavy handed on occasions when he needed to be and there was an implication that my father was somehow responsible for the way he was currently. He said that this made me very angry because he is very fond of his father but did not feel able to voice this to the therapist … therapist also focused on his first name which is unusual in the area where he lives and though he did experience some bullying in relation to this … it was not significant but the therapist seemed to make much of this … tempted to make a complaint about the therapy but could not face a confrontation and dropped out of treatment

two face to face contacts. at my first appointment he did not have the opportunity to talk, rather the therapist talked about the proposed cognitive behavioural programme and gave me leaflets. I was not keen to attend a second appointment but with his girlfriend's encouragement I did s. But the therapist was more concerned to talk about himself and the fact that he would be leaving. I said that I did not think the sessions were going to be profitable and so said that I was OK and completed a questionnaire for the therapist. I was given no diagnosis or clear plan of action. Had misgivings about the treatment, which I expressed at the second session, were not answered and the therapist was more concerned about the fact that he would be leaving and advised that if Mr X wanted any further therapy there would be a wait and he could not say how long the wait would be or by whom he would be treated. … therapist more concerned to give me a variety of leaflets indicating where he could listen to relaxing music

on the internet … the consultation took place in a very small room with little furniture. … about the time of these appointments he had begun to feel he was turning a corner.

attacked … after a face to face assessment put on a waiting list, after 3 months began treatment, 20 mins into the session the therapist declared he was in the wrong category an put on another waiting list after 3 months on this waiting list was invited to attend group CBt I declined and I was then offered online CBt about which I was very ambivalent and probably will decline

had fifteen to twenty sessions of CBT found the sessions very helpful … asked to record and listen to an audio tape of the trauma and to write about the trauma … treatment sessions finished because the therapist was going on maternity leave but the therapist acknowledged that I was probably still suffering from PTSD. She said that the therapist told her that if her symptoms did not resolve she could re-refer herself in six months' time

found the initial sessions helpful but the last six sessions were repetitive … the sessions finished because the therapist was ill and she was not assigned to another therapist, however I was happy to end therapy at that point because I felt I was not getting any further benefit. … because my symptoms were persisting made contact with the Service again and my therapist had, by that time, returned to work and she had two further sessions with him but it was very difficult to coordinate their diaries and she received a letter from the Service discharging her. I need further therapy

very helpful

the first four or five sessions were with a male therapist who left and I then saw a female therapist … given lots of leaflets and mid-way through the sessions the therapist mentioned that he had post-traumatic stress disorder … asked to write about the accident on a daily basis and to rate his response to memories of the accident on an hourly basis throughout the day and was also asked to make a recording about the incident and listen to that and record his levels of distress … overall by the end of therapy my levels of distress at listening to or reading about the incident in question did reduce … sometimes it was 'too much to write about or listen to the tape' … expressed these concerns to the therapist but she was more focused on the fact that his scores were changing … also asked to keep a diary of events such as getting into a car and encouraged to drive more often … no focus on overcoming his avoidance of travelling as a passenger … strong feelings of guilt over having asked his son to drive were not addressed … always glad he had attended the sessions but overall there has been no significant change in how I have been feeling. He said that the sessions ended because he had had the number of sessions offered by the agency and he was referred to Hospital for a six sessions group class which focused on exercise and then he was referred to further exercise classes … these sessions were helpful from a physical point of view but not from an emotional point of view.

dropped out after one session of guided self help 'waste of time'

6 sessions of face to face because this was all available and felt a 'burden'. Therapist initially not sure it could be PTSD because of unconsciousness then PTSD mentioned 130 mins of telephone contact at low intensity including doing behavioural activation material

after a very brief telephone assessment was passed onto a different person who conducted 4 face to face sessions. Unfortunately the therapist only wanted to talk about the rapes and so I told them I was better and I discharged myself

had six sessions of counselling … did not find the treatment at all helpful and felt that the therapist did not really know what to do and at various sessions would ask me what she thought she was suffering from and canvased obsessive compulsive disorder and body dysmorphic disorder … also mentioned that he thought I was suffering from depression … in therapy she felt like I was at school and was given lots of homework and handouts … therapist said that she should consider taking antidepressants, even though she had expressed a desire not to do this. She said that the therapist said that she should take them because other people take them. She added that when she mentioned that she had put on weight the therapist said that she looked alright.

had 6 sessions, was asked to complete a mood diary and to vividly recall and record one good event each day, which I found difficult and did so on only one day. … then referred within the Service for 12 sessions of couples therapy but

these never took place, the sessions were cancelled by the Service on the day of the appointment, either because the therapist was off sick or on a training course. She asked that they ring her so that she could express her concern but they never did so, it was 'no good'.

counselling sessions therapist suggested that he had post-traumatic stress symptoms. He said that he found the first couple of sessions useful in that he was taught some breathing techniques but after this he said that the sessions focused on going over the incident, he was asked to record the incident and listen to it at home but he only managed to do this on one occasion and at the therapy sessions he would have to go over the incident. He said that he began dreading the sessions and at the end of the sessions the therapist said that there were restrictions on the availability of therapy and the sessions ended … could tell a friend or family member in an hour what I had learned

helpful