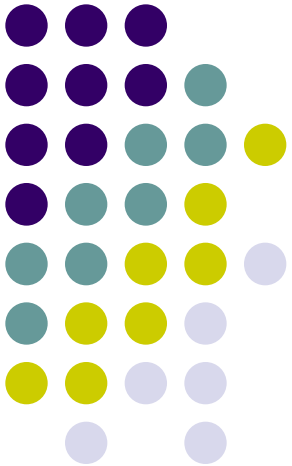
Educating Lancashire … & Some Other Northerners

The challenge and opportunities for a new Psychological Professions Network for the North West



Jeremy Clarke

Agenda

- Psychological therapists are a *singular* profession
- How policy drives change, or not, depends on the capacity for *professional behavior* also to change
- Whilst policy *mechanisms* for implementing the Coalition's mental health priorities are still unclear; policy *goals* are now very clear *& driven by welfare*
- *Partnership working* in the New Savoy Partnership:
  - What are the *lessons* for the new North West PP Network?
  - How can a *singular profession* seek to *embrace multiple disciplines* at a time when the profession must also develop a greater capacity to fundamentally *change itself*!?

Argument

- Since 2007 the psychological professions have undergone a radical albeit divisive transformation in the course of which the ‘scaffolding of a new evidence-based discipline has been erected’ and the vision of a new universal access service created
- What this change amounts to for our professions is not yet fully clear but by placing psychological therapies at the heart of a modern mental health and social care system, it represents the *fulfillment of a vision* of ‘care in the community’ that a previous generation of professionals, politicians, public and other stakeholders tried, **and failed**, to put in place

Argument

- The *primary* task for the *psychological professions,* collectively, is to improve mental wellbeing, which may - or may not - turn out to be achievable by reducing the burden of mental illness through access to evidence based talking therapies *but the scope and scale even of that task also stretches well beyond our existing collective capacity*
- Crucially, this coincides with a political debate taking place about the proper role of government, the health service, employers, the community, family and the individual about *future welfare provision*
- So whilst the *shape and identity* of the singular professional discipline that *we* are becoming is still in the process of formation, what is clear is that a collaborative response is called for so that a *coherent professional perspective is brought to this crucial debate*
- And at the heart of that perspective must be the day-to-day work of ordinary therapists in local services, embedded in and representing concerns and aspirations of their communities and neighborhoods

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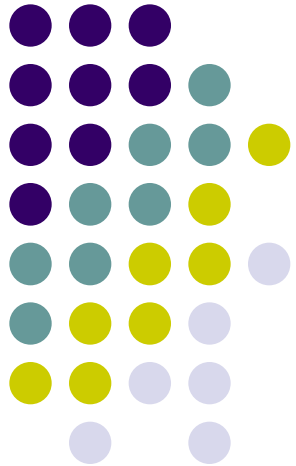


Psychological therapies

as a *profession: show video clips*

‘Our profession’

Two delegates arrive at a venue hosting several different events that day. One asks the other:

“So, what is it you do?”

Imagine you are the delegate who has just been asked this question.

Put up your hand if you would answer:

A. “Actually, I’m a Psychological Therapist”
B. “I’m a CBT therapist”
C. “I’m a Counselor”
D. “I’m a Clinical Psychologist”
E. “I’m a Psychological Wellbeing Practitioner” …

‘Our public’

The other delegate then asks:

“What’s that exactly?”

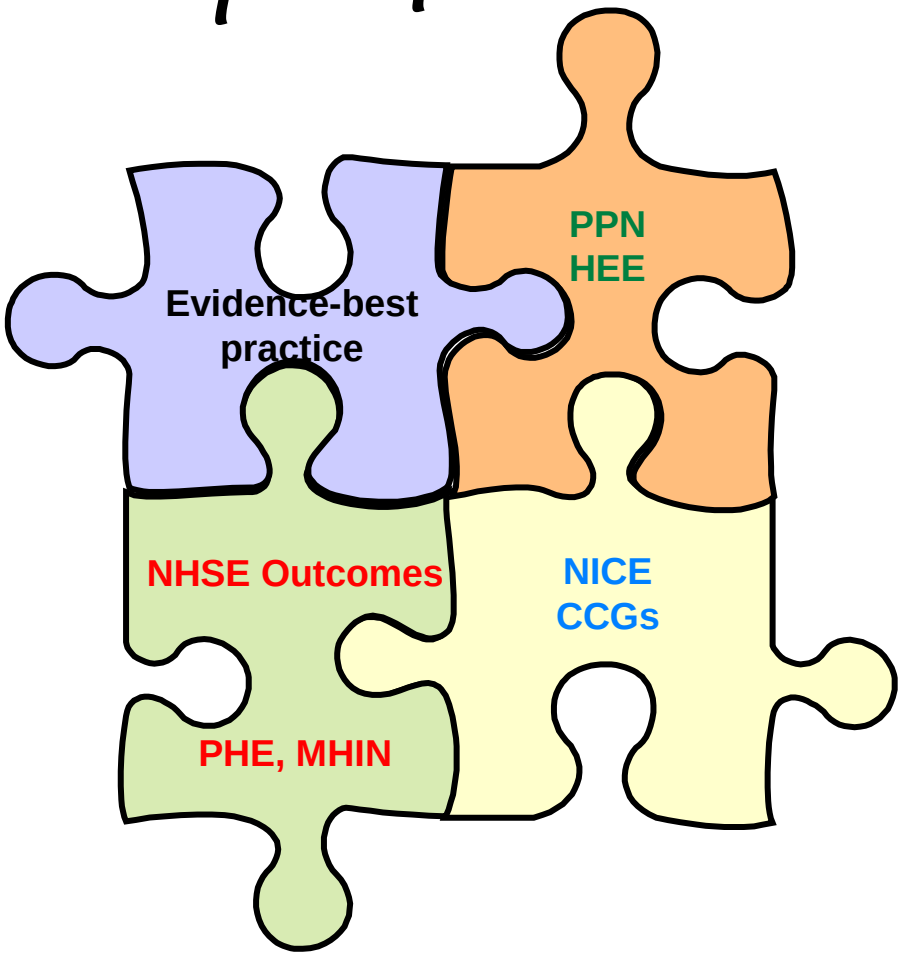
Q. What do you say next?

Do we all agree what the psychological professions are for?

Fitting the pieces together - towards:
A singular profession

Clinical excellence

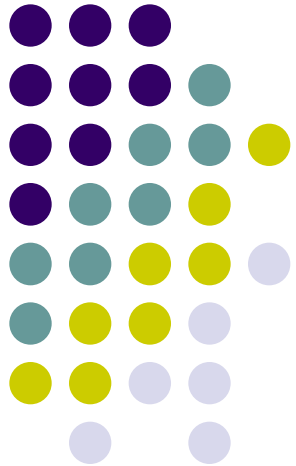
Improving Wellbeing



Education & Training

Research-based services

Educating Lancashire … & Some Other Northerners

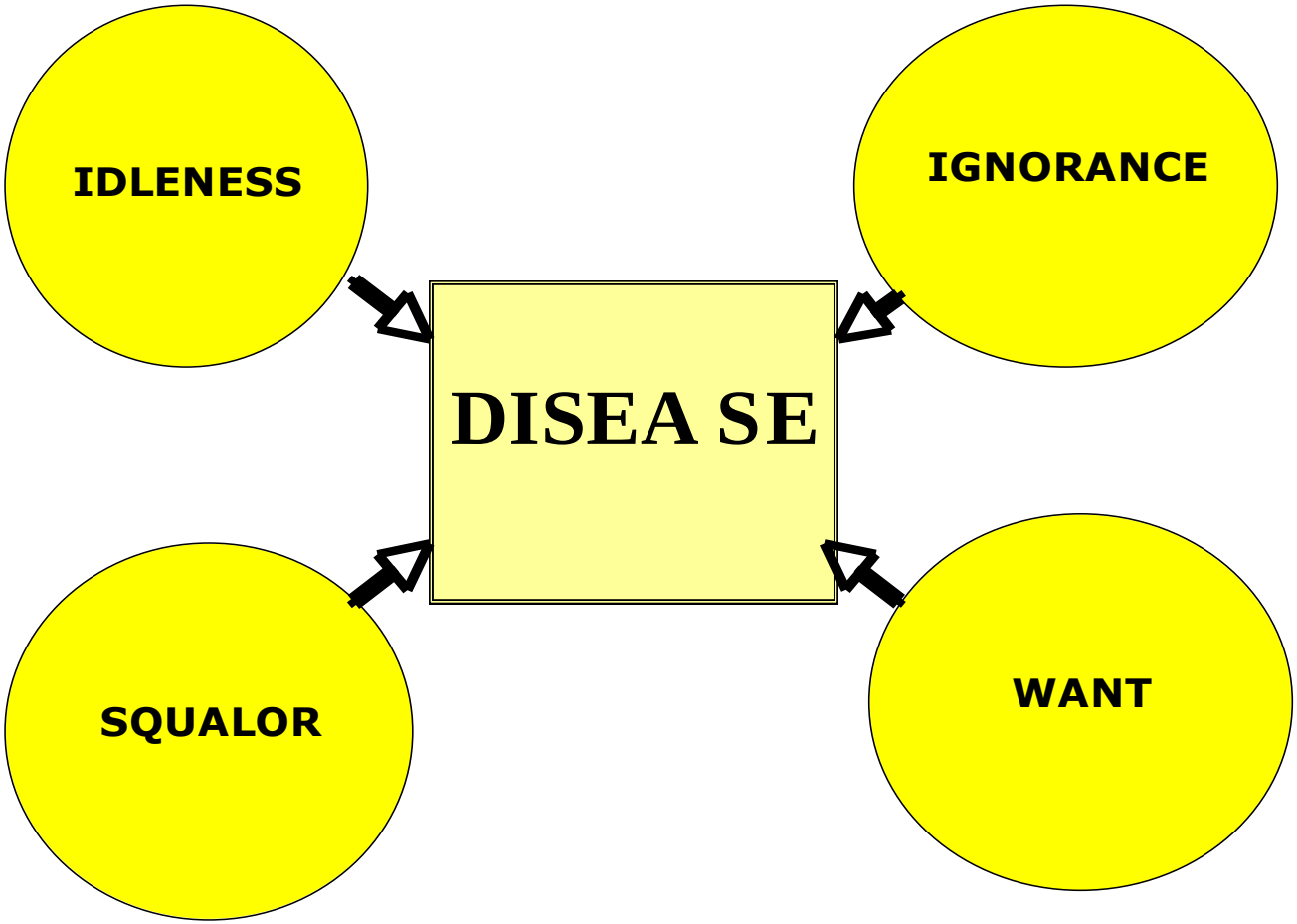


How policy drives change:

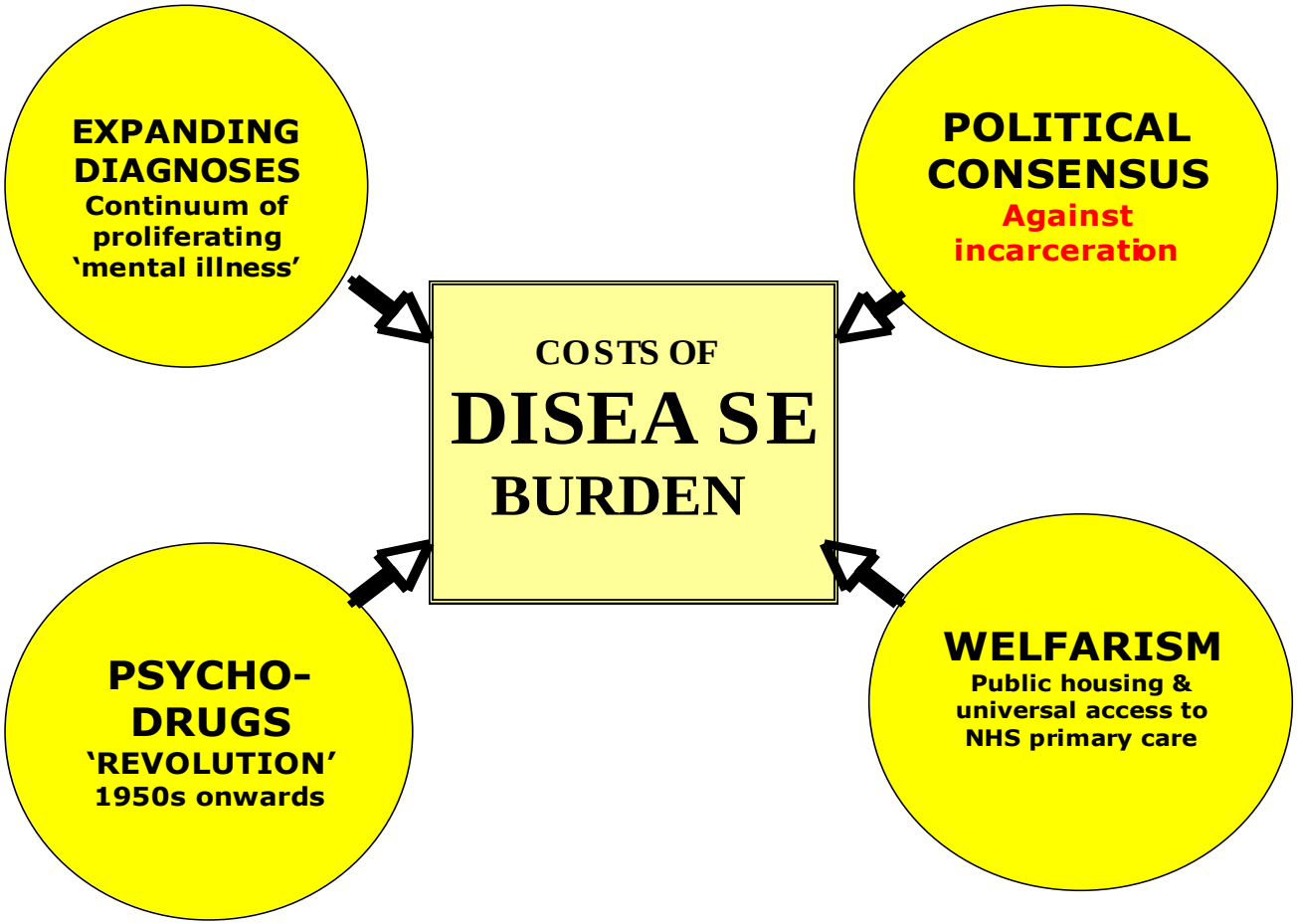
mental health reform 1961-2007

The man who launched a social model of care

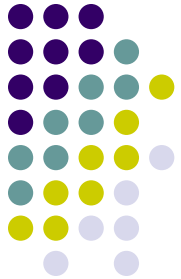
Key Social Drivers:
The Five Welfare Giants



Key Policy Drivers:
for care in the community



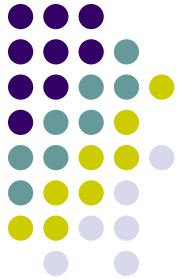
The Vision for Mental Health in 1961



From Enoch Powell's speech:

- "Few patients ought to be locked up in great isolated institutions … There they stand, isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined, rising unmistakable and daunting out of the countryside - the **asylums** which our forefathers built with such immense solidity to express the notions or their day. *Do not for a moment underestimate their powers of resistance to our assault* …"

The Vision for a new *mental health professional role* …

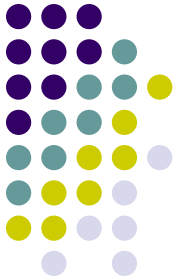


From Enoch Powell's speech:

"The transformation of the mental hospitals is not only a matter of buildings, the change of a physical pattern, it is also the transformation of a whole branch of the profession of medicine… Here also is a region as yet but partially mapped. In this year, 1961, we intend to erect the scaffolding of a professional training for the social worker. *But none of these changes, drastic and difficult, in the pattern of our provision for the mentally ill and afflicted can be brought about without a widespread public understanding and resolve.* Without this the planners may plan and the administrators may administer, but the face of the map will not be changed. ***And it wants a lot of changing***."

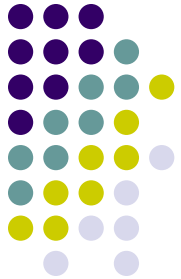
The Great Escape (1)?

The 1st revolution in mental health



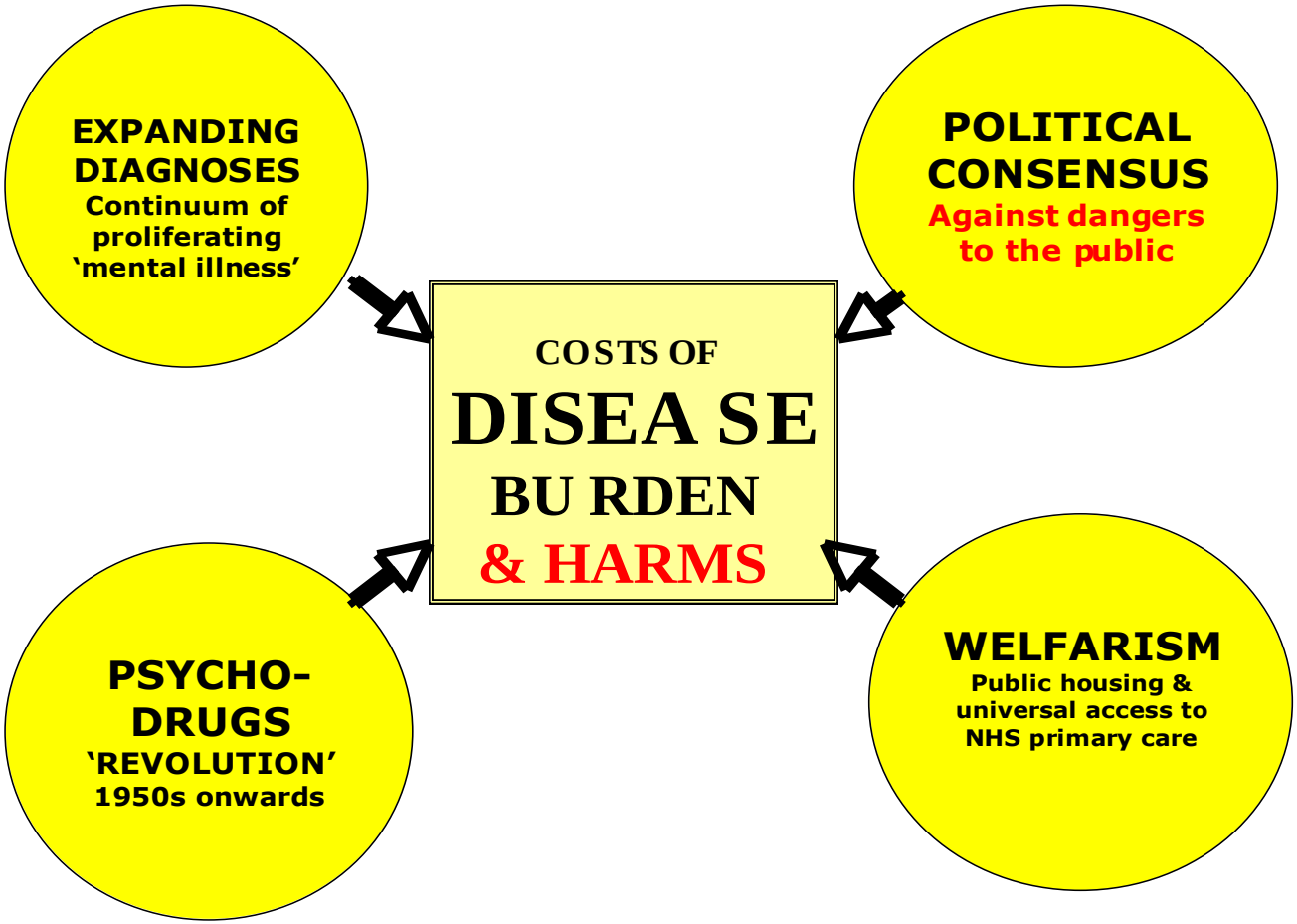
- 1914: 140,000 people in mental asylums
- 1954: 150,000 people in mental asylums
  - 1961: Enoch Powell's "*water towers"* speech
- Today: **based on Health & Social Care Information Centre data 2012/13*
  - Less than 7% of mental health service users are treated in a hospital setting (just over 105,000)
  - 50,000 of these patients are 'sectioned'
  - The average length of stay as an in-patient is 10 weeks per annum
    - **NB In 2012/13 there were just under 22,000,000 community and outpatient mental health contacts so by definition - *this is what our profession now is for***

What happened to the mental health profession?

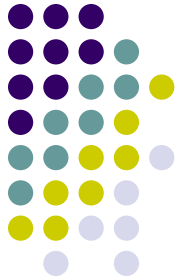


- The primary task of psychiatry in the community became ‘risk management’ (with services in hospital settings reserved for medium/high risk patients)
- Other professionals (psychiatric social workers, community MH workers) were co-opted into support roles in multi-disciplinary teams, e.g. monitoring risk, medication compliance, providing crisis response
- **BUT** investment in prevention, support, rehabilitation remained a low priority - and this is generally seen as the key reason that care in the community failed
  - See chapter by Nikolas Rose in Oxford Textbook of Community Mental Health 2011, eds. Thornicroft, Szmukler, Mueser & Drake

Policy / Professions stand-off
over 'care in the community'



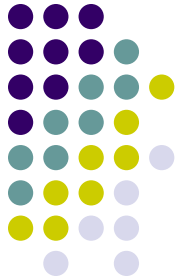
Why did Great Escape (1) fail?



- *"Do not for a moment underestimate their powers of resistance to our assault* …"
- Who or what is Powell talking about? Could it be *us?*
- A **social** model of care requires a fundamental re-thinking of the nature of our professional discipline - 22M *community* contacts must *count for something*
- The 2 key professions, Psychiatry & Social Work, failed to *integrate their respective bio-psycho-social models in response to changing policy needs* - thus, both underwent an 'identity crisis' faced with serious problems of recruitment, retention & burn-out

The consequence of failure:

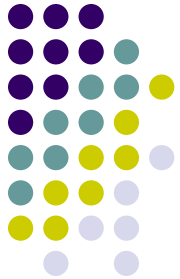
breakdown of the consensus against compulsion



- “Care in the community has failed because it left far too many people who were mentally ill walking the streets, often at risk to themselves, and a small but significant number have become a danger to the public as well … We are going to ensure that patients who might otherwise be a danger to themselves and others are no longer able to refuse to comply with the treatment they need.”

Frank Dobson, Health Secretary, House of Commons, 29th July, 1998

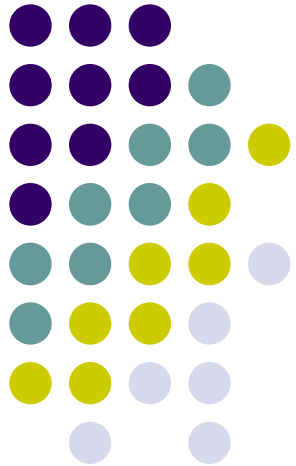
A decade of conflict: *failure to reform mental health prior to the Coalition, 2010*



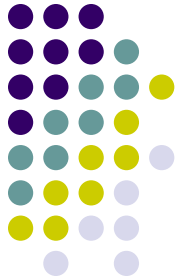
- Thus, when National Service Frameworks were introduced in 1999, mental health was the first in line for reform. The NSF set out 5 new priority areas:
  - Mental health promotion and illness prevention
  - Primary care services and greater access
  - Effective services for people with serious mental illness (as to be defined by NICE's new evidence-based guidance)
  - Support for those who undertake a caring role
  - Preventing suicide
- **But** whilst there was broad support for this agenda, in the event reform was overshadowed by a decade-long battle over the 2007 MH Act, *led by psychiatry*

Educating Lancashire … & Some Other Northerners

The Coalition's mental health strategy *and the centrality of WELFARE REFORM for success*



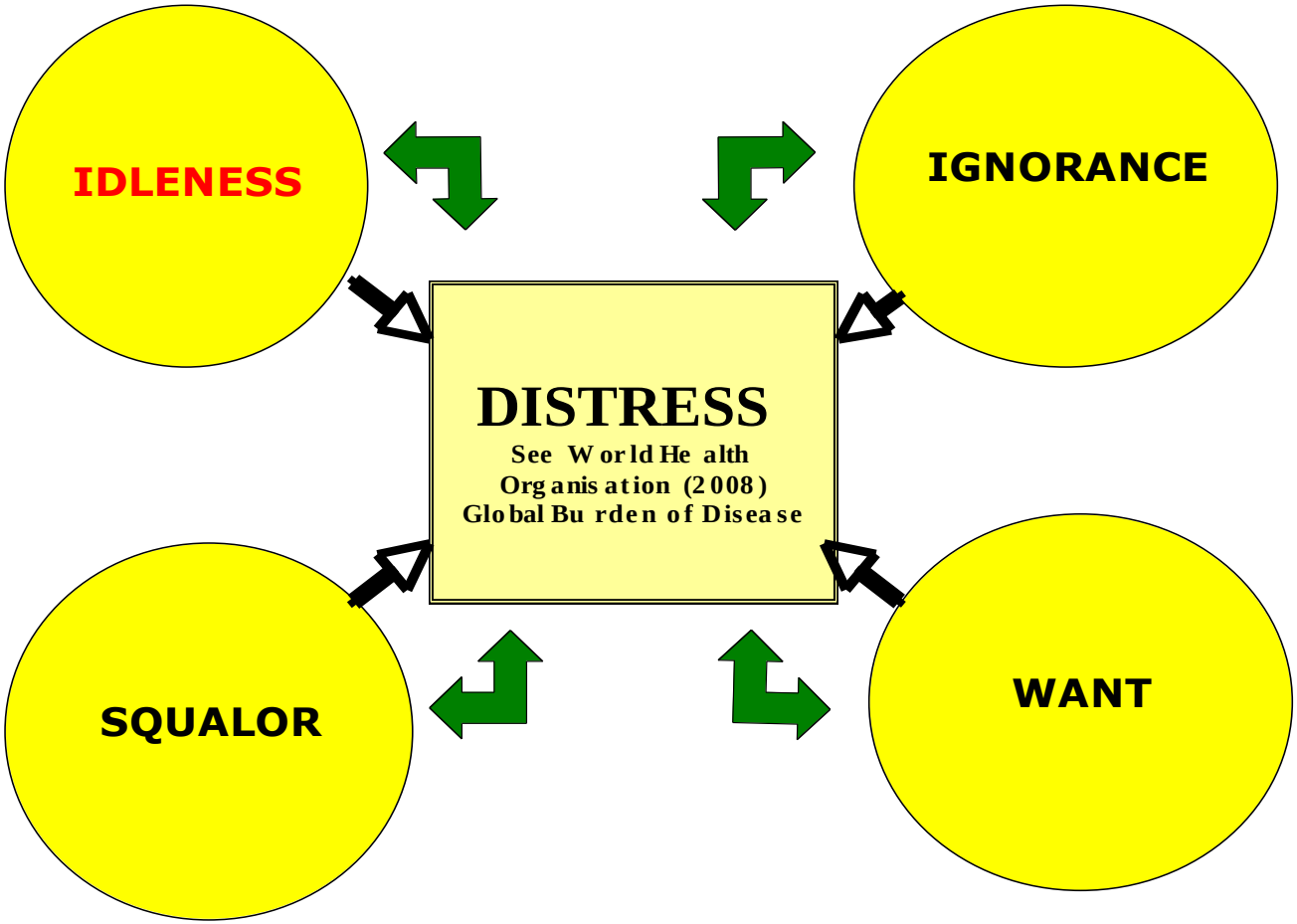
The Great Escape (2)?
IAPT - the 2nd revolution



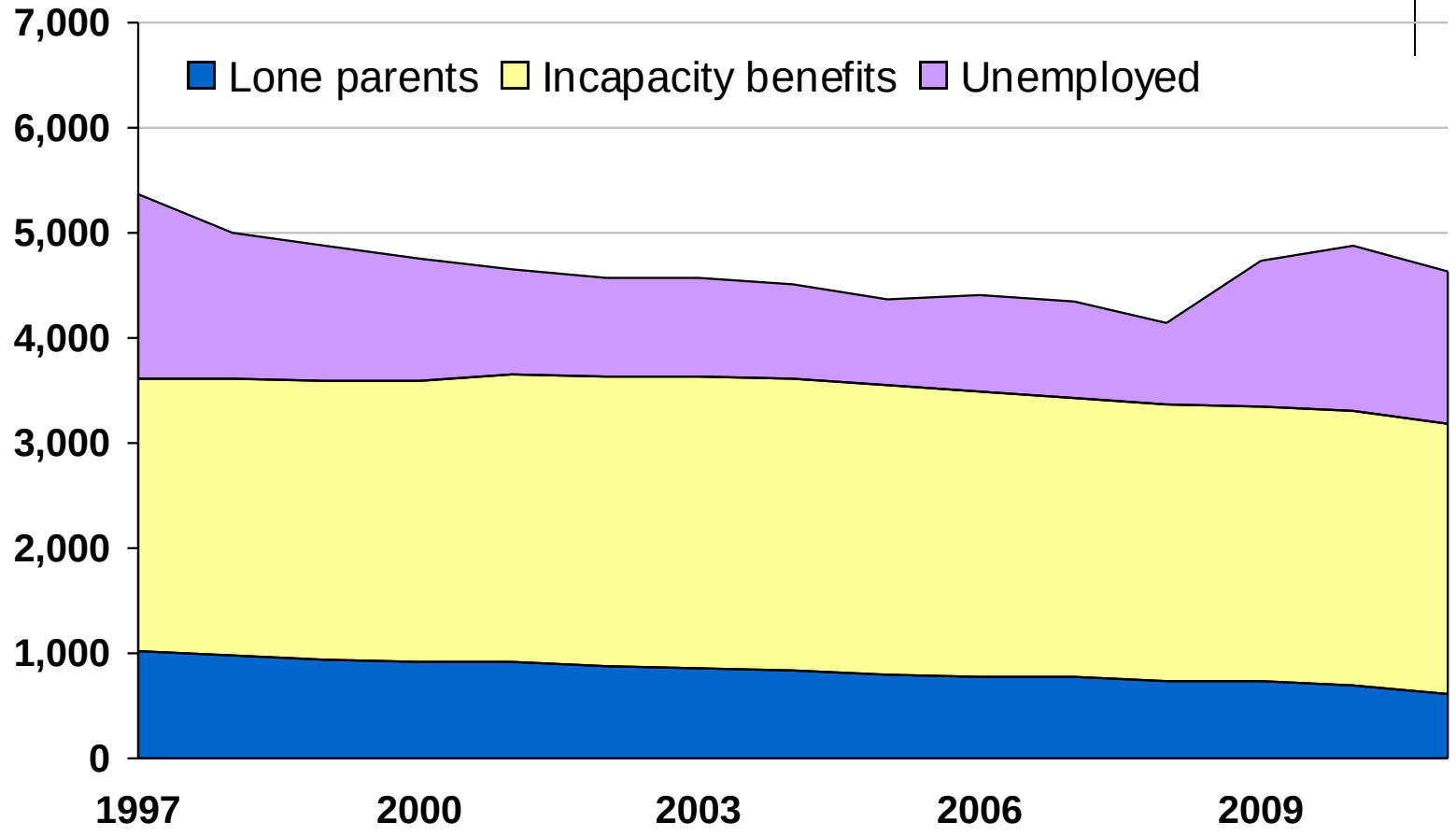
- 2008 - New Savoy Partnership welcomes the commitment from Alan Johnson & Ivan Lewis for £300M investment in talking therapies
  - "Life really does now begin at 60!" NHS b.1948
- 2010 - Coalition Government announces a further £400M investment through to 2015
  - Based on cross-party manifesto commitments

- Based also on a shift in policy: *Depression: Britain's Biggest Social Problem, 2005, Lord Layard LSE*
- With an explicit promise to help people on benefits

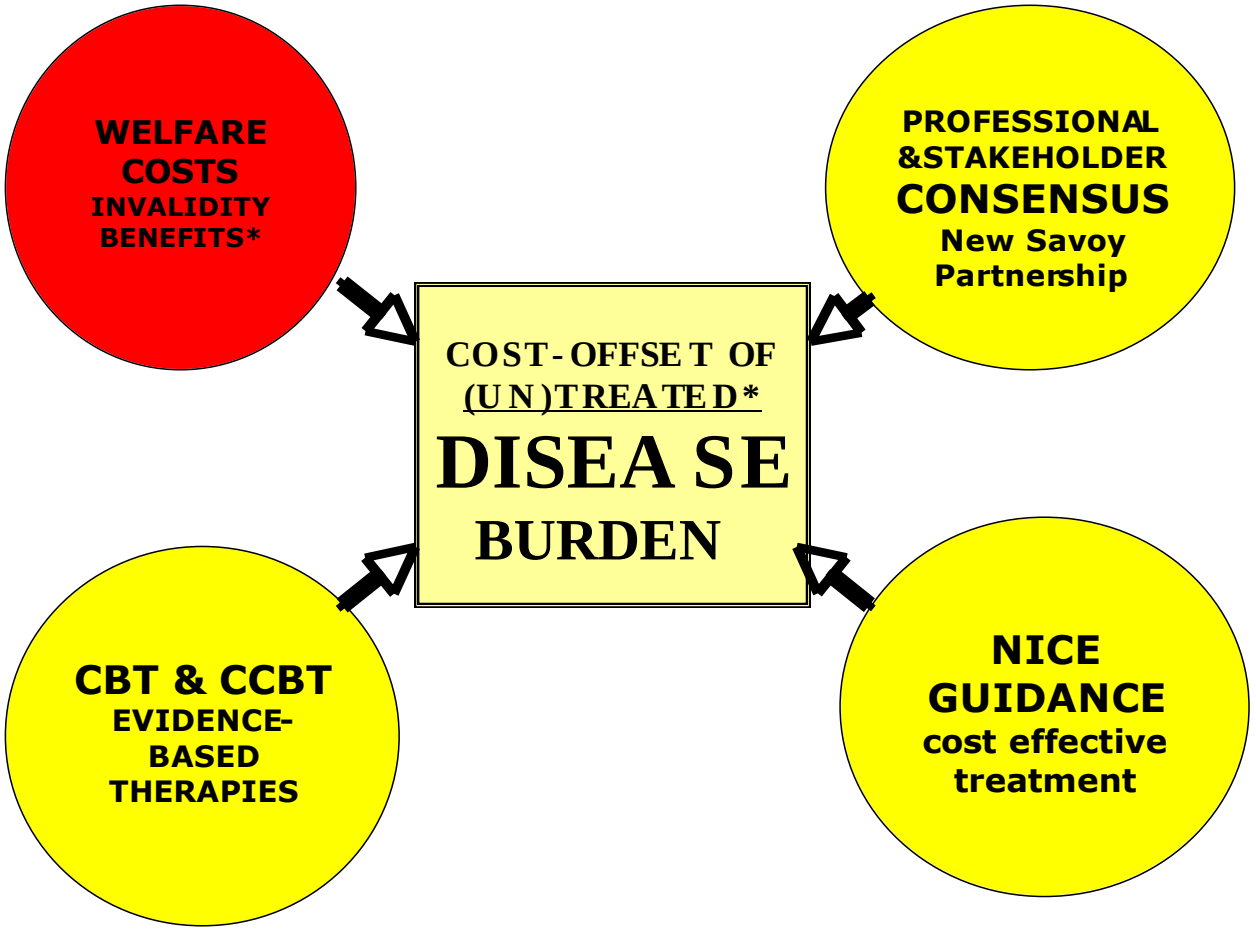
Key Social & Economic Drivers:
The Five Welfare (Dependency) Giants



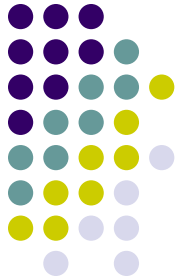
The problem – around 5 million on out of work benefits



Key Pre-Crash Policy Drivers:
for the original IAPT program 2008

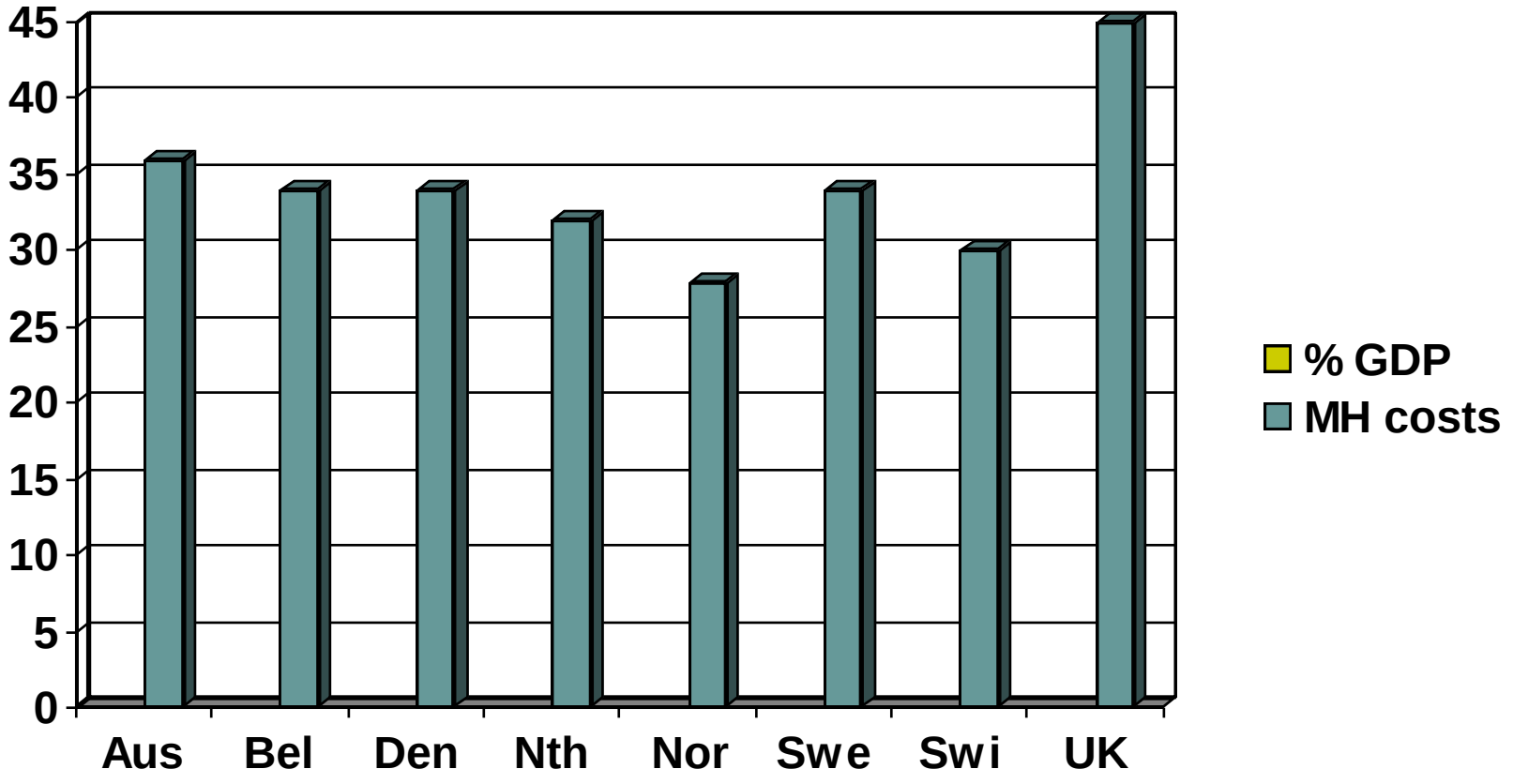


The scale of the challenge *The Great Escape 2 (from welfare dependency)*

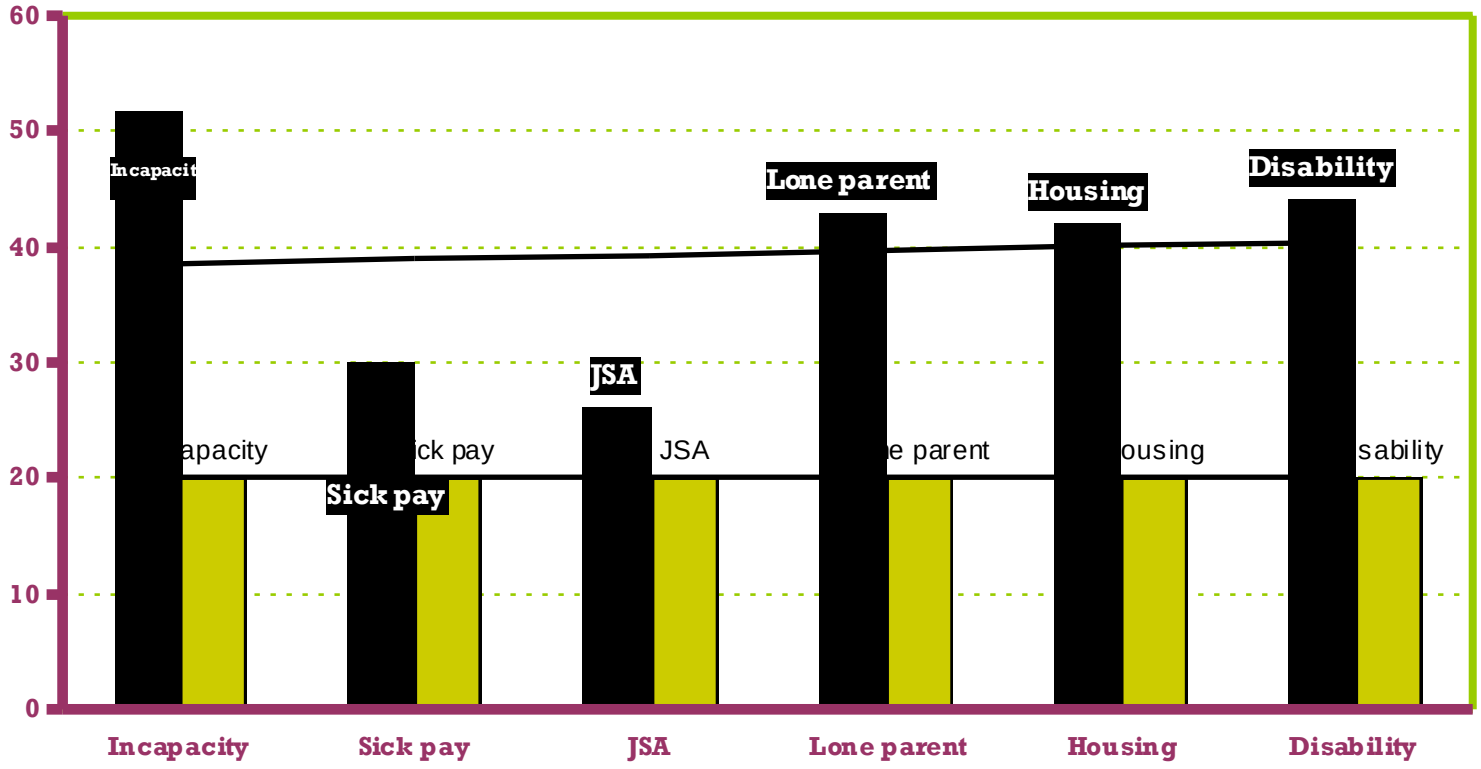


- Mental illness costs the UK economy £70 billion per annum (4.5% GDP) [some estimates say the cost is nearer £100 billion]
- 370,000 people move onto disability benefits every year in the UK (1% of the working age population)
- Mental illness is the single most common reason for claiming disability benefits = 40% of all *new* claims
- By the end of 2012 more than 2.5M people (6.8% of the working age population) were on disability benefits, and 1.5M (4%) on unemployment benefits - with the UK being 10th highest spender on disability benefits as a proportion of out-of-work benefits across 28 OECD countries
- Risk of poverty for people with mental illness in the UK is highest anywhere in the developed world
  - **See OECD (2014) *Mental Health and Work: United Kingdom* Singh et al.**

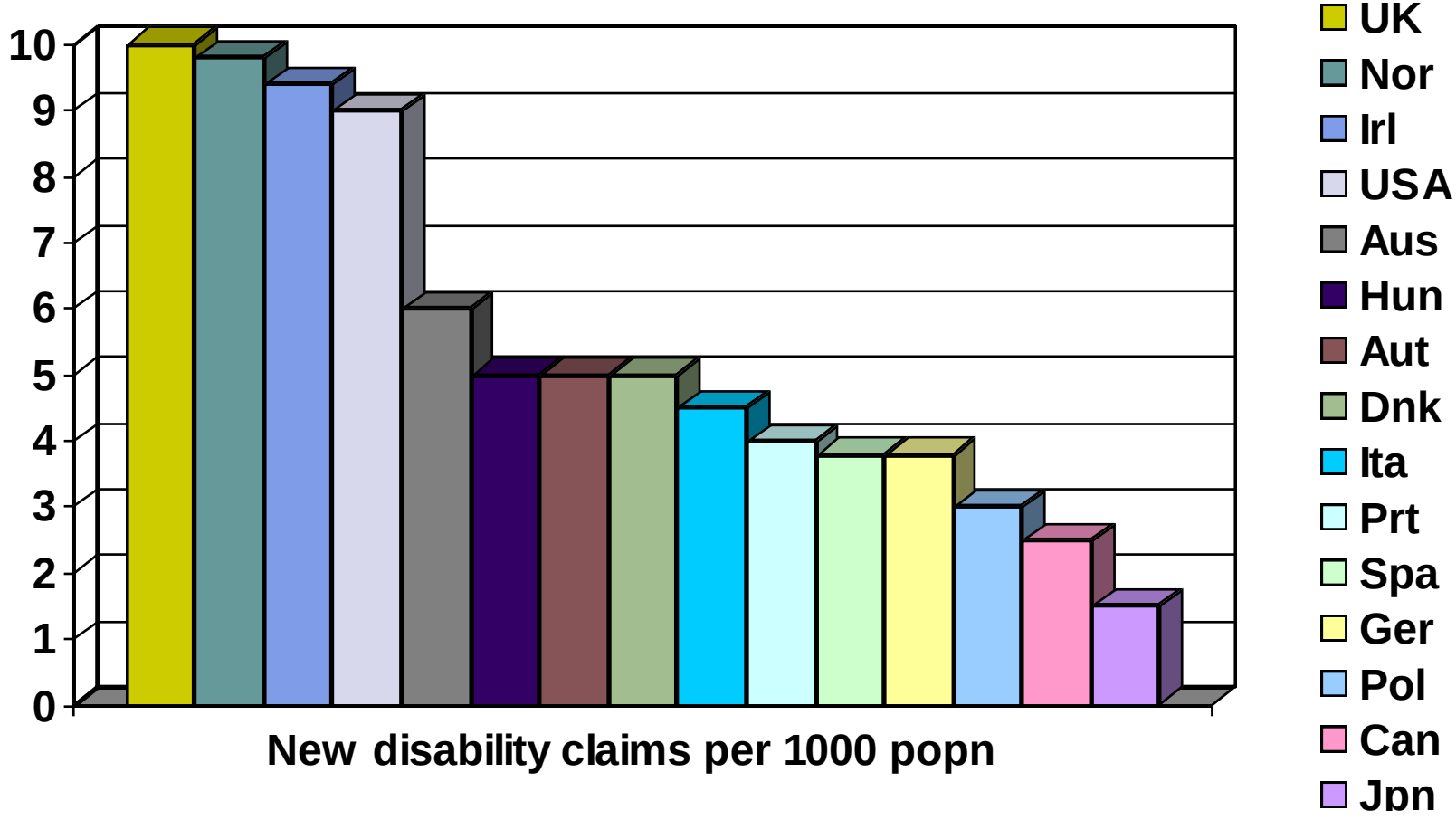
Costs of mental illness as % of GDP, 2010 Gustavson et al (2011)



Mental health needs are prevalent across all claimants

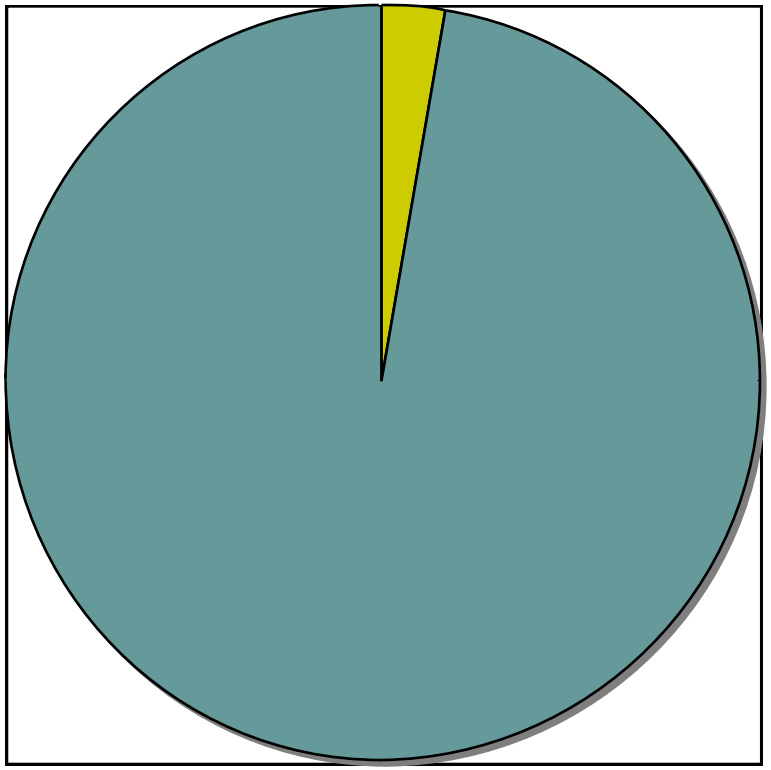


INFLOW: Imperative for early intervention support OECD 2014



OUTFLOW: Employment outcomes for people with MH problems OECD 2014

based on data from DWP Work Program 1st Year Performance to June 2013



NSP / WP 2011 Joint pledge on work & mental wellbeing

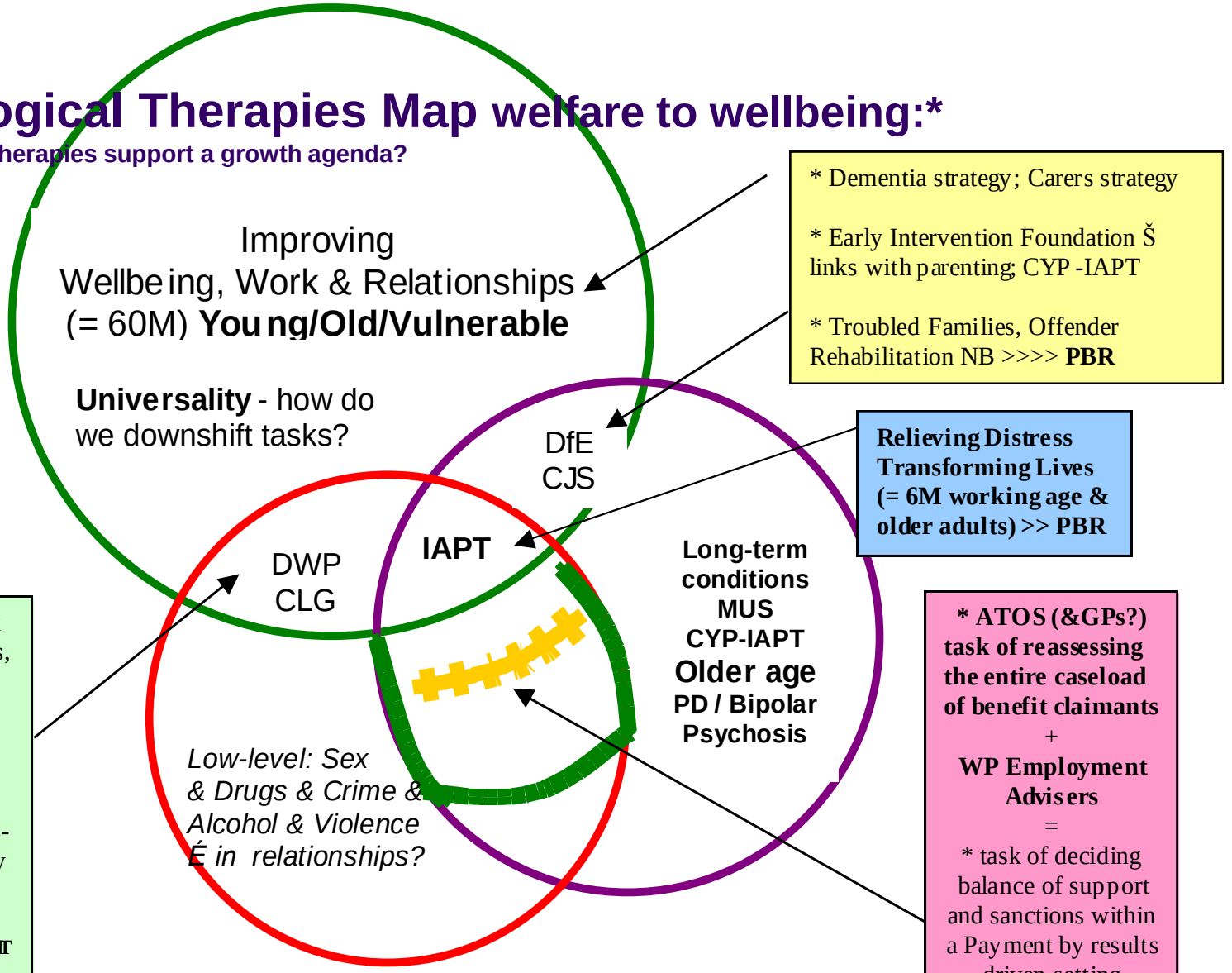
“Too many people are disadvantaged by a combination of mental ill health and unemployment. Too many are left to deal alone with combined worry about their mental health, and the demoralising impact of being out of work for too long, due to lack of access to the support that would help them obtain employment and improve their mental wellbeing.

We will work with experts across employment and mental health sectors to deliver best outcomes for both, and listen to our service users to understand what they say helps them most. We will strive to align our services so that employment support, clinical care, psychological therapy, housing and other support are organised seamlessly around each person’s needs.

We will work sensitively with people with mental health problems so that our support builds confidence, avoids harm and responds to people’s changing needs. Finally, we will continue to evolve the ways we support people so that fewer face the combined impact of mental distress and unemployment."

Psychological Therapies Map welfare to wellbeing:*

How can talking therapies support a growth agenda?



* Dementia strategy; Carers strategy

* Early Intervention Foundation Š links with parenting; CYP -IAPT

* Troubled Families, Offender Rehabilitation NB >>>> **PBR**

Relieving Distress Transforming Lives (= 6M working age & older adults) >> PBR

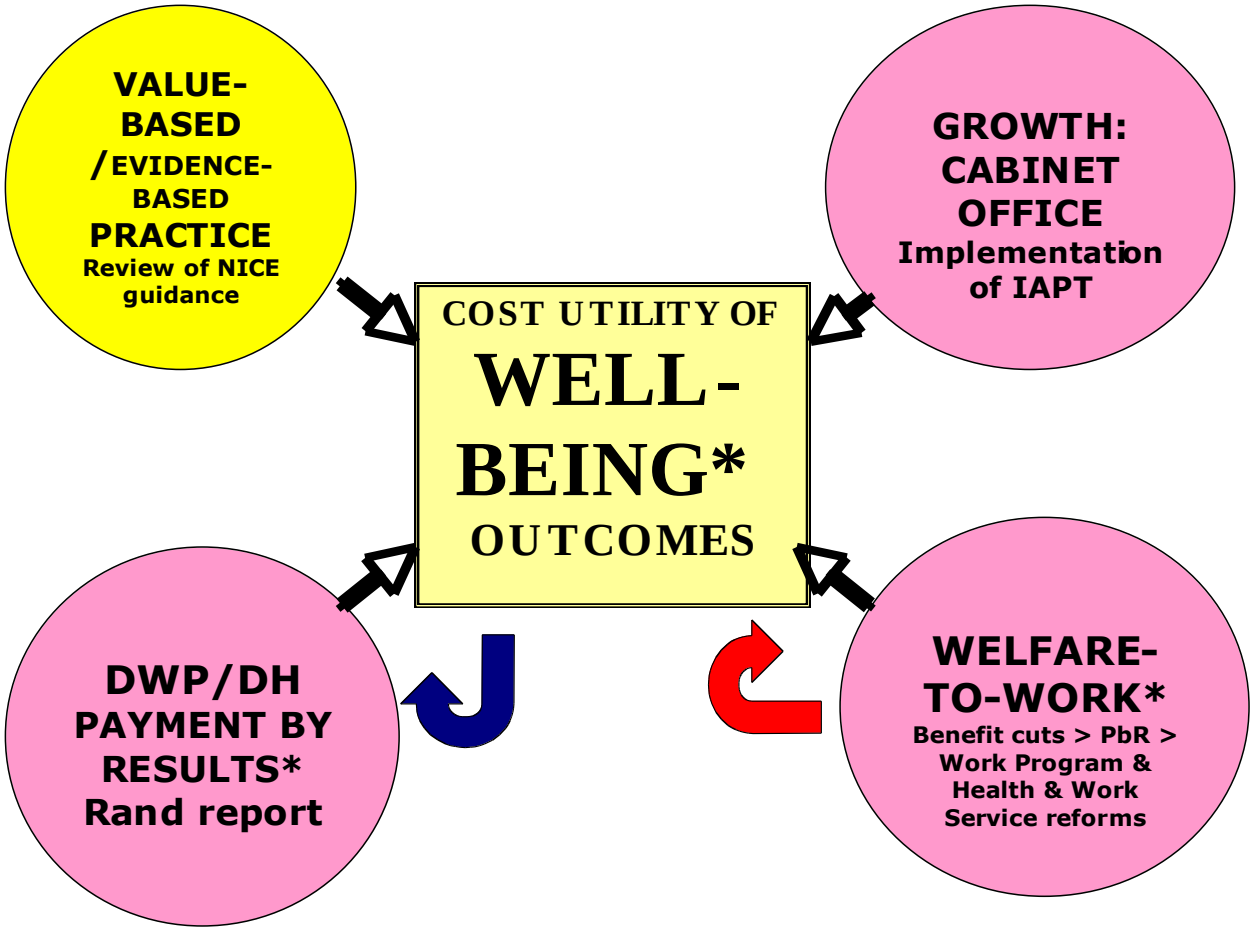
* Health & Work Service - fit notes, GP assessments and occupational support at work
* Work Programme - long-term jobless-ness & incapacity NB >>>> **PBR**
* **SEE MENTAL HEALTH TOOLKIT & RAND REPORT (= 2-5 M people!)**

*** ATOS (&GPs?) task of reassessing the entire caseload of benefit claimants**
+
WP Employment Advisers
=
* task of deciding balance of support and sanctions within a Payment by results driven setting

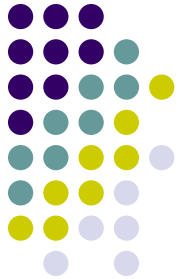
WHY ARE WE NOT ON THIS FRONTLINE?

*** Psychological support has expanded across health via IAPT – but patchily; and not yet in Welfare, Social Care & CJS**

Key Post-Crash Policy Drivers:
for Talking Therapies under the Coalition



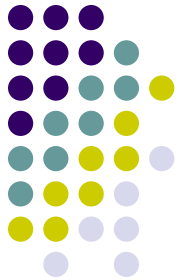
QED - welfare is central to current policy: so do we have a coherent collective response?



- There's no more money
- Public services must do more with less
- **Unsustainable costs of invalidity benefits are even more unsustainable now**
- Political consensus supports welfare cuts
- Depression is the single biggest contributor …
- The focus on subjective wellbeing is good for mental health parity
  - & a new focus on joint commissioning is good for further investment in talking therapies
- **IF SUPPORT IS BALANCED AGAINST SANCTIONS**
- **… NB the primary task itself has shifted …**
  - *and whose task is it now anyway?*

2 decades on from the failure of care in the community will we be asking:

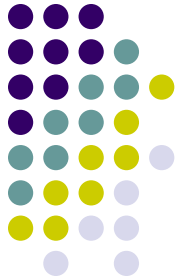
Why did Great Escape (2) fail?



- *"Do not for a moment underestimate their powers of resistance to our assault …"*
- Whilst the scale of the welfare challenge is huge, it is down to *our profession* to step up to responding that challenge
- A **social *wellbeing*** model of care will require a fundamental re-thinking of the nature of our professional discipline - IAPT is on track by 2015 to have helped 400,000 people into recovery BUT it is the 1.6M left behind who must *count for something*
- The psychological therapy professions, with CBT leading the way, have managed to *update and converge their respective models around a singular concept of evidence-best practice* - what I have argued is that our 'identity' must now develop further by integrating evidence based practice around *the pressing social wellbeing needs of diverse local communities*

NB the consequence of failure:

breakdown of consensus against health sanctions

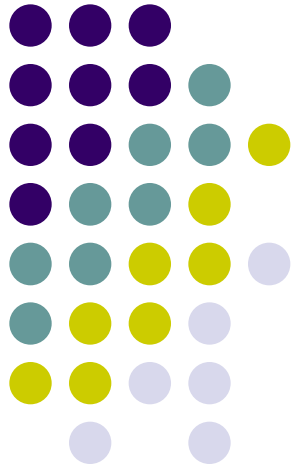


- "Welfare to work has failed because it has left far too many people who were mentally ill in continued receipt of benefits and without jobs, often without any other return to society, and a not-so-small significant number who appear to be feigning depression at the public expense … We are going to ensure that benefit claimants with mental illness who are assessed as capable of work are no longer able to refuse to comply with the treatment they need."

Jeremy Hunt / Andy Burnham, Health Secretary, House of Commons, 29th July, 2018

Educating Lancashire … & Some Other Northerners

Partnership working in the New Savoy Partnership

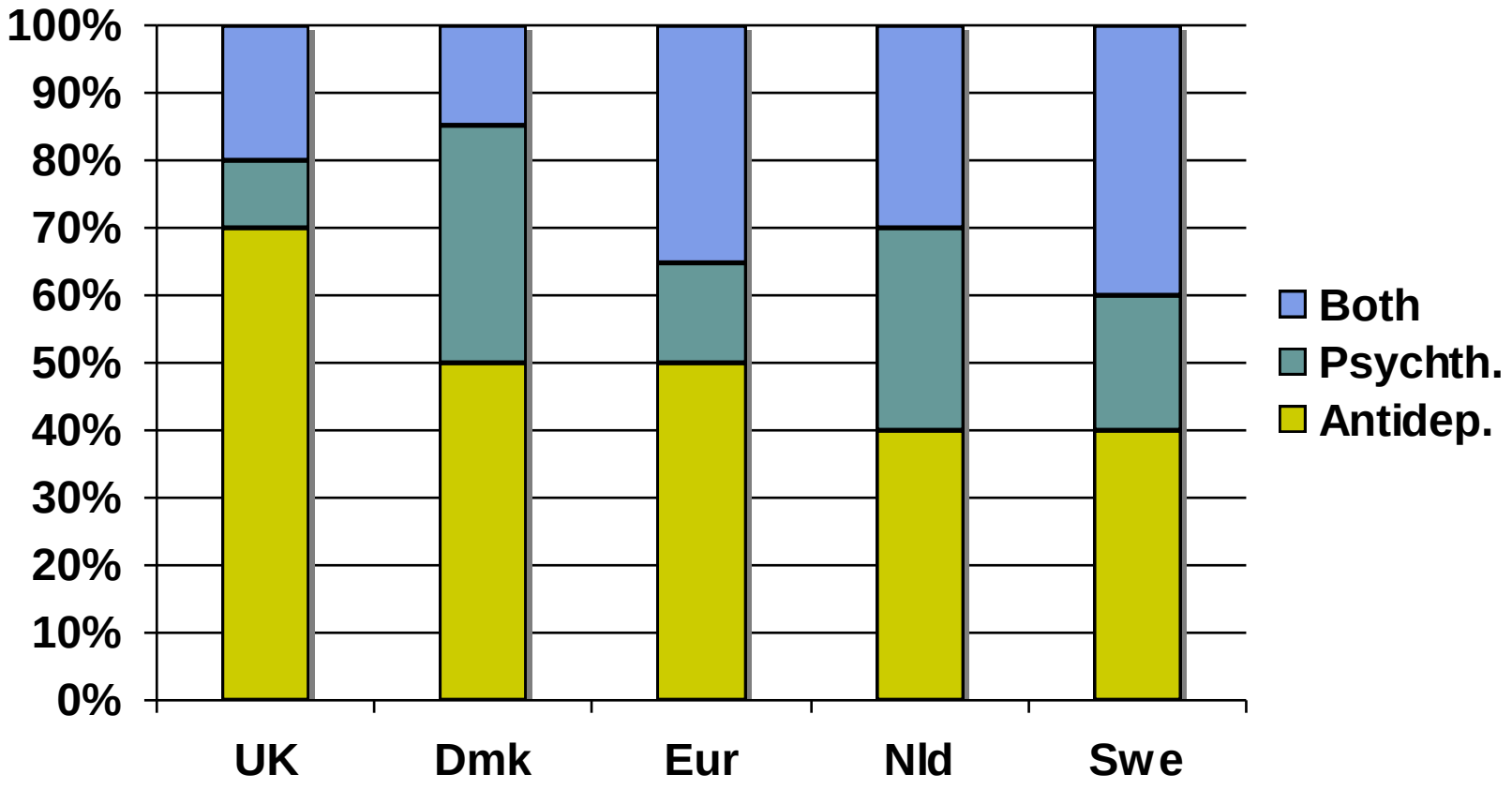


What we agreed on in the New Savoy Partnership

- New Savoy Declaration
- Consensus Statement on NICE & evidence
- Joint Pledge on Work and Welfare
- New Technologies Network …
  - And an annual conference where we can continue to disagree!

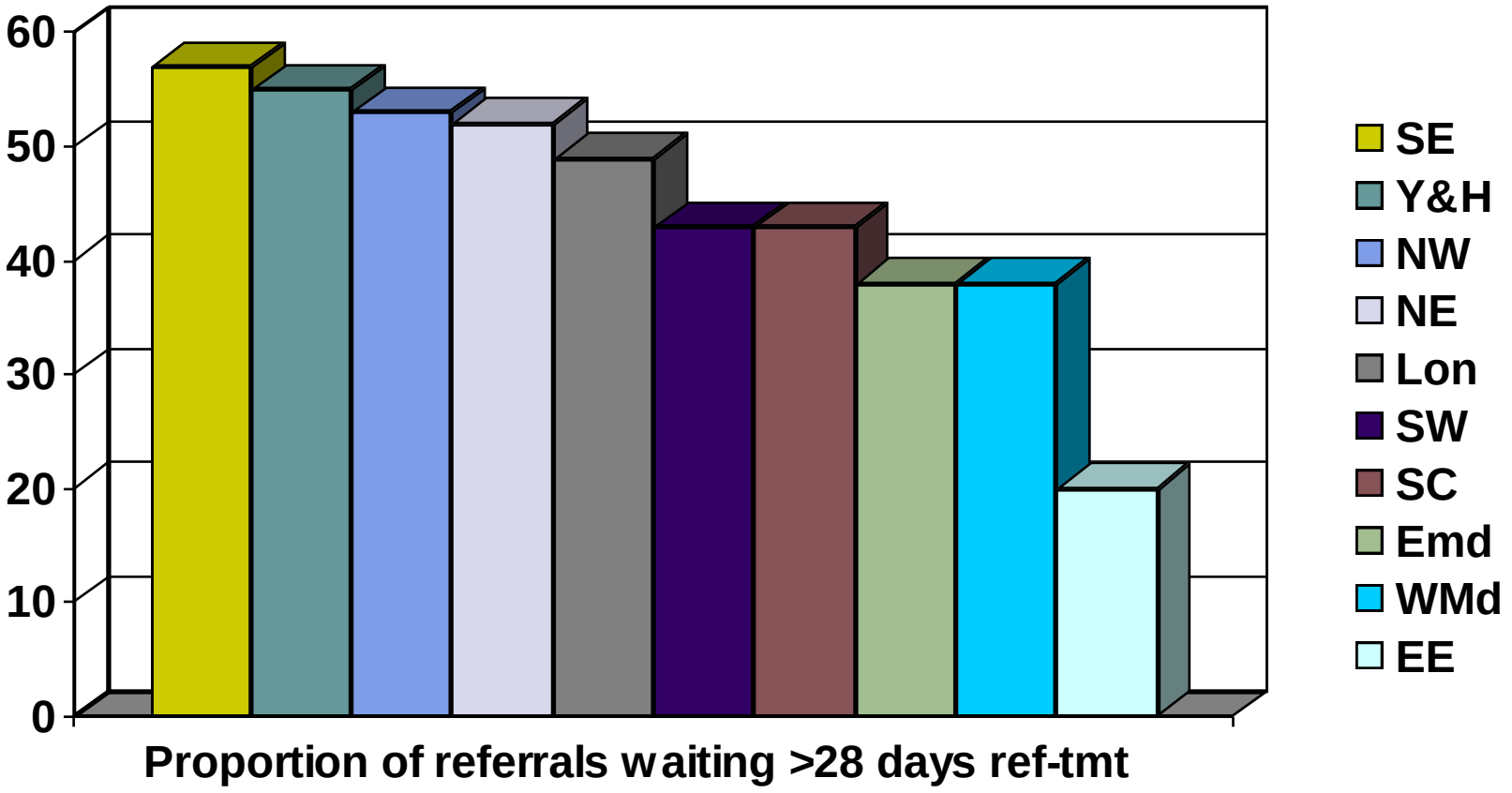
In 2007, UK lagged behind other European countries in access to therapy

OECD Eurobarometer (2005 & 2010) in UK 70% receive medication only; 10% talking therapy & 20% both; the Europe column below shows average data for 21 European OECD member countries



What under-investment means for waiting times to access therapy HSCIC

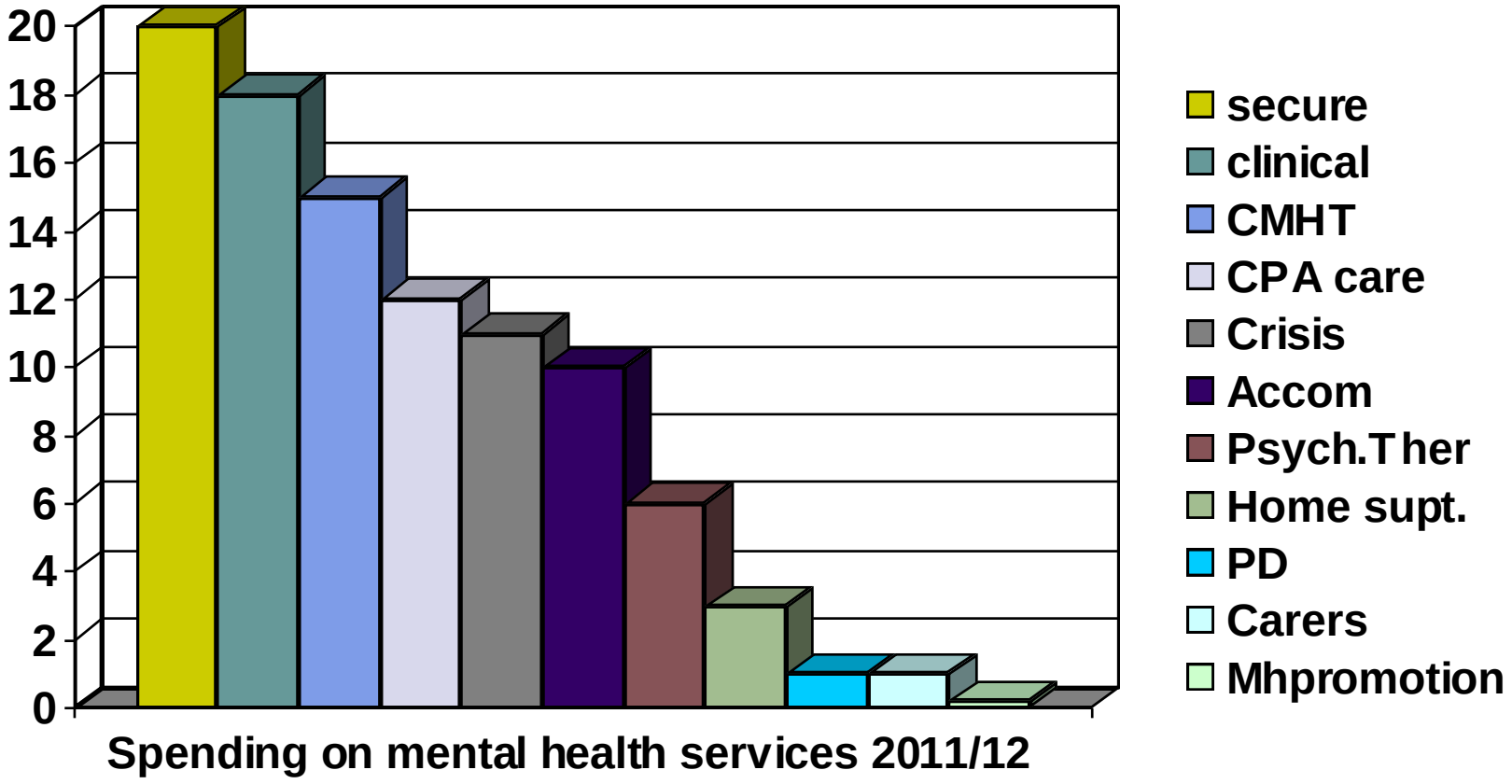
2013 (Spending on talking therapies amounts to only 7% of total MH spend)



What we *dis*agreed on in the New Savoy Partnership

- IAPT
- NICE & evidence based practice
- Work Program & payment by results
- CCBT - & whether it works …
  - When we tried to agree a Declaration in 2012, we couldn't … hand over to:
  - **We Still Need to Talk**

Spending on mental health services in the UK: parity of esteem? Department of Health 2012, National Survey of Investment in Adult Mental Health Services



What lessons are there for the new NW PP network?

NB "Epistemic Hell" is when there is no evidence for what works because no one agrees what the evidence can prove!

- ✓ Decide what you agree on
- ✓ Decide what you disagree on
- ✓ Start from where you **disagree** …
  - ✓ Providing you can still agree *'in public'* when it comes to the bigger picture policy agenda

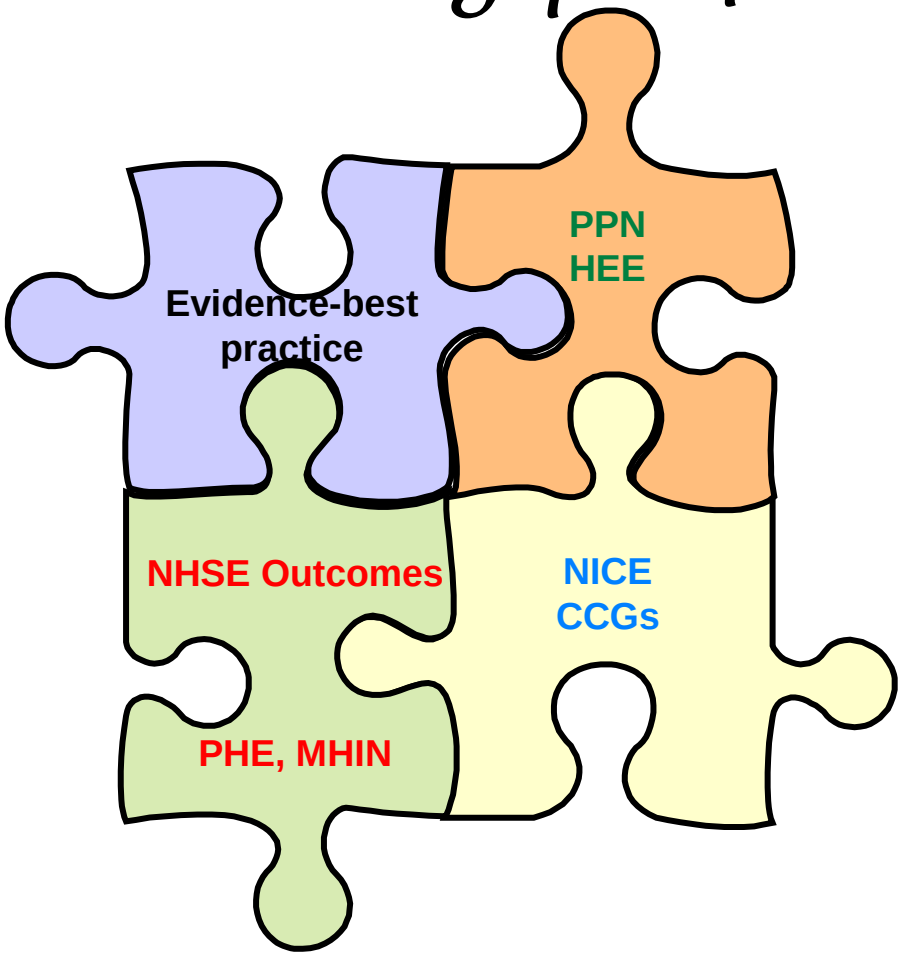
= Build a forum for *inter-disciplinary* as well as *multi-disciplinary* **adversarial collaboration**

See Tetlock & Gregory (2009) Implicit Bias and Accountability Systems: what must organisations do to prevent discrimination?

Fitting the pieces together - towards:
A social wellbeing profession

Clinical excellence

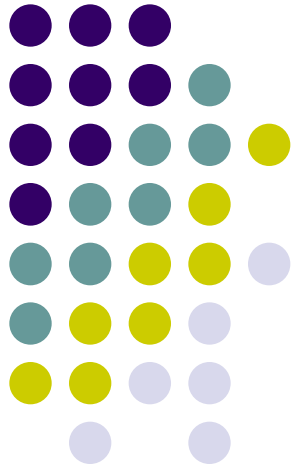
Improving **Social** Wellbeing



Education & Training

Research-based services

Educating Lancashire … & Some Other Northerners - final thoughts



In the film the Great Escape, 250 PoW were led out of Stalag Luft III by a daring RAF officer, Roger Bushell.
All but 3 of them were re-captured.
Bushell was executed on direct orders from Hitler.

If we agree that evidence-based talking therapies have a vital contribution to freeing people from welfare dependency, then we must not only put ourselves on the front line of welfare reform … we must find a way as a profession to care about those left behind.