

Trends in psychotherapy in the UK

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Martin Pollecoff discusses trends in mental health across the western world and the role of UKCP in partnering user groups to create a new and relevant mental health discourse.

I am no Nostradamus but I do not have to be. The trends I am writing about here have already happened, even if we have not noticed or acknowledged these changes.

If I have one strategic aim it is to have the UKCP become pro-active rather than re-active; that is to say, we become creative in the face of change. So I would like you to see our psychotherapeutic state of play through my eyes so that in our deliberations you can see where I am coming from.

In this document I would like to discuss just four trends. These apply to mental health in the western world, not just in the UK, but I will give a UK illustrations for each one.

Those trends are:

1. The growth in interest in mental health and the self, creating an insatiable demand for services
2. The substitution of high quality (expensive) psychotherapy with brief interventions that promise quick easy solutions
3. The use of technology to satisfy these demands at low cost
4. The new patient: The changing attitudes of patients towards the bio/medical system and how those who have serious diagnoses are organising themselves.

The insatiable demand for therapy: Be careful what you wish for

We have rejoiced at how over the past decade mental health has become a political issue, one that is now discussed openly in Parliament with MPs and ex-MP's willing to reveal a history of troubles. It's also a gift to the media; as one producer said, "It could be the new cooking". This week you can take your pick between Channel 5's 'Me and my Eating Disorder' or Radio 4's 'In Therapy' with Suzie Orbach.

More and more people want help.

In 2015, 61 million anti-depressants were prescribed in the UK, 31.6 million more than 2005 (see www.theguardian.com/society/2016/jul/05/antidepressant-prescriptions-in-england-double-in-a-decade).

According to the Institute for Fiscal Studies in 2015, nearly half of all people claiming disability benefit in the UK were claiming because they have a mental illness rather than a physical condition. Six out of 10 claims by those aged between 25 and 34 are now related to mental illness, up from half in 1999. In 2014 1.1 million people were claiming disability benefits because of mental illness (see <http://bjpo.rcpsych.org/content/2/1/18>).

On a recent visit to Scotland I was assured that the rate of mental illness there was 16% in any given year. That is to say that at any one time 1 in 6 people in Scotland are mentally ill.

According to Mind one in every four people will suffer from mental illness in a year (see <http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/>).

In 1950 that figure was one in a hundred (see Davies J (2013) *Cracked: Why psychiatry is doing more harm than good*. London: Icon Books Ltd.)

As the human constitution has not changed much in my lifetime, I can only presume that this is the result of good marketing on behalf of the medical profession, and the pharmaceutical companies, combining with a new consumerist right to happiness and the no-cost availability of these medications. And of course we can add in the 'no-hope' economy.

This explosion of the concept of mental health has its consequence for talking therapies. In the UK we have social medicine – the NHS. In the US it's mostly private but funded via insurance schemes. Both the NHS and the US insurers seek to drive down costs.

Here is how an American healthcare supplier sees it:

“It will no longer be the high-intensity in person face-to-face that will dominate (it just cannot as there are not enough to meet the ever growing demands of mental health and behavioural health difficulties), therefore more graduate psychologists, social workers, nurses, and other professionals will come to the fore in being key supporters in the care delivered through technological innovation”.

(See www.silvercloudhealth.com/news/article/the-future-of-psychotherapy-the-delphi-poll-says-what)

And here he means that the traditional US doctoral level of practice will now be taken up by less well qualified staff. And with Improving Access to Psychological Therapies (IAPT) that prediction is now our everyday reality.

2. Substituting high quality therapy with a state solution

Richard Leyard (Baron Leyard) is a British Labour economist who is founder/Director of the Centre of Economic Performance at the London School of Economics (LSE).

In the 1970's he moved from being a classical economist to a pioneering behavioural economist, fascinated with what is called the 'Easterlin Paradox' – which is that increased affluence of a nation does not bring with it increased happiness.

If you wish to understand his stance look no further than his book, 'Happiness, Lessons from a new Science' (Leyard R (2011) *Happiness: Lessons from a New Science* (Second Edition). London: Penguin Books). He is also the co-editor of 'The World Happiness Report' which will give you the gist of this issue (see http://worldhappiness.report/wp-content/uploads/sites/2/2016/03/HR-V1_web.pdf).

The son of Jungian analyst, and anthropologist, John Layard, he appreciated the promise of psychotherapy but for his purposes – this old fashioned therapy was just too cumbersome, time-consuming, messy and arcane – the property of a difficult father. Individualisation was not his aim; not for him a deeper understanding of the selves, or issues of meaning. All that was far too ephemeral for, at base, Leyard is a macro-economist; a practical man who likes the concrete, the measurable, and the big solution.

Leyard's drive is a world free from misery. To wage his war on misery he needed an army and a therapy that could really 'scale'.

And then by chance he met Professor David Clarke, Britain's leading expert on cognitive behavioural therapy (CBT). Both men were being elected as fellows of the British Academy and there, over a cup of tea, they began talking about mental health and that elusive route to 'national happiness'. Clarke pointed out his own gripe, that from 2004 The National Institute for Health and Care Excellence (NICE) had published guidelines to effective treatment, yet the public were not getting access to these treatments. The two men gelled. In their own ways both are brilliant and visionary.

If psychotherapy is an art, think of them as the first modernists. Where others saw complexity, uncertainty, nuance, depth, and ornamentation – they saw simplicity, logic, clean lines, certainty, value and measurement.

In their model, bad thoughts created bad feelings. Change those thoughts to good thoughts and the bad feeling disappear – simple. No more backward looking therapies, no guff about your mother or transference – here's a therapy in which we look to the future.

Nothing expresses their style better than Leyard's 2006 paper on depression and benefits. It's a brilliant read and simple, modern and logical (see <http://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf>). And it provides a solution to a very practical political problem.

Up until the 1980s the classic cause of disability, and therefore disability claimants, was the 'bad back'. Now mental health had taken the lead and the number one cause of disability claims is depression. Leyard's paper proposed the recruitment of a new kind of mental health worker who would be trained in Clarke's CBT techniques. They would create an army recruiting 10,000 wellness practitioners and that army would go to war against depression and anxiety. One in every two claimants with depression would be cured in six weeks and return to work for no more than the cost of a couple of month's disability payment.

Leyard was offering a revolution in mental health that was self-funding, paid for by the cuts in benefits payments. What politician would not grasp at that? And they did.

But even before this Clarke and Leyard had been busy. In 2004 they put a paper to the government which, alongside other arguments, led to the 2005 Labour election manifesto to increase access to NICE and recommended psychological treatments. The 2006 report was merely putting their ideas into action, but for good reason it never happened.

For the first time the mental health approach of a nation was being spearheaded by an economist. But by September 2008, the time when the Clark/Leyard anti-depression plan was all due for implementation, a global financial crisis ensured that there were no jobs for those coming off disability to fill, and that was the whole point - so no jobs – no therapy, and no one saw this coming – not the politicians, the pundits and talking heads, and certainly not the economists.

However, the army of low-cost CBT therapists idea quickly re-surfaced as the future of psychotherapy in the UK: IAPT. It was a coup. A hundred years of research in psychotherapy forgotten, dumped. This was a Pol Pot experience with the psychotherapeutic clock being reset to Year Zero. What mattered now was not the unconscious or transference, but happiness and productivity.

It may seem to us that this was a plot by the psychologists, however this is what the British Psychological Society (BPS) said about the new IAPT concept:

'Put starkly, the analysis is predicated on a naive view of mental health problems (essentially a simplistic "illness model" and of an overly optimistic assessment of how effective psychological treatments may be.'

(See <https://thepsychologist.bps.org.uk/volume-22/edition-5/challenge-layard-initiative>)

But perhaps in 2008 after this global financial meltdown, this was the only optimistic plan that any government had. It was and remains a flagship project. The notion of therapy for all was billed as a 'socialist revolution'. It is largest investment made by any government in the world in mental health.

(See www.philosophyforlife.org/david-clark-on-improving-access-for-psychological-therapy-iapt/)

Now in 2016, despite or perhaps because of fortunes being pumped into IAPT, they are overwhelmed by demand. When Freud promised 'ordinary misery' the take-up was low but now the agenda is 'happiness' and mental health has become a consumer must have.

IAPT cannot reach their targets and tend to fudge results. Actually that's not fair – let's just say it is difficult to match their figures from one year to the next. It is simply not delivering. Here is a link to their 2015-16 report:

<http://content.digital.nhs.uk/catalogue/PUB22110/psych-ther-ann-rep-2015-16.pdf>

On page 6 there's a highlighted box that claims 46% of eligible referrals 'recover', but let's take a closer look at their numbers. The figures you want are on page 5 but here they are anyway:

We learn that, of the 1,399,088 new referrals, 953,522 enter treatment, 537,131 finish and 226,850 move to recovery. So out of those who enter treatment 24% move to recovery and out of the initial 1,399,088 referrals only 16.2% get better. It's all very well highlighting this 46% recovery figure like its gold, but that's only for those who finished the therapy.

What happens to the 1,172,238 referrals who did not benefit? Each one of those is a taxpayer whose doctor said they needed help; for their taxes they got nothing but disappointment. An 83.8% failure rate is little to boast about. Can you imagine the stigma had they built their nationwide back-to-work scheme and got results like a 16.2% success rate rather than the promised 50%? But in the NHS such results are simply ignored.

Offering free therapy is terrific but it's like building new motorways – the more you offer the more people want. Here supply increases demand and IAPT is caught in its own trap. By making 'happiness' the end-point of 'wellness' it has made all of us 'sick'. And it is not without irony that those delivering such happiness, the wellness practitioners, were themselves getting depressed. Which goes to show that you can always ignore transference, but transference may not ignore you (see

www.bps.org.uk/system/files/Public%20files/ar_v10_resetting_the_balance_160516.docx.pdf).

So back to 2008. Remember, that was when the world changed, when the money and that good-good future ran out. That year started with the Northern Rock experience and then we watched as established banks worldwide proved themselves to be hollow. Government economists and experts proved themselves incompetent and taxpayers' money was drained to bail out the shareholders of those too-big-to-fail banks.

Since then we have been on a journey of low or no interest on savings, an impossible housing and rental market (where else would you put those savings) a real drop in wages, massive cuts in benefits and a very precarious future. Yes, there has been a climb back from recession but the benefits of this small prosperity never reached far down into society. Much of the country has had a real cut in their standards of living. The new money was – no money. Anxiety and depression comes with that territory.

I can easily assume that the social system I grew up with is still there but it's not; the welfare support system has been hollowed out. When I was at school the welfare state was described as a safety blanket there to help you when you fall, but since 2008 that safety net is more holes than blanket.

Although there was a promise that IAPT funding was extra funding and this would not interfere with other mental health services, the rest of the mental health service is in trouble. Important services have been cut and the number of qualified nurses working in psychiatry dropped by 10.8% from 41,320 in 2010 to 36,870 in 2015. (see www.theguardian.com/society/2016/jan/25/number-of-mental-health-nurses-falls-10)

To detail all the cuts would take too long but let's look at the best vote winner in mental health – and that has to be child mental health. After all, with adult mental health you can always think: 'You've had it tough but hey, haven't we all. If I can cope you can.' But a kid with mental health problems? Even the hardest heart would have to help? Or perhaps not.

I was surprised to find that even that had been cut, and when it came to local government contribution, 34 out of 51 English local authorities contacted for the YoungMinds report (www.youngminds.org.uk/about/our_campaigns/cuts_to_camhs_services) have reduced their Child and Adolescent Mental Health Services (CAMHS) budget since 2010. One council reported a drop of 41% in their CAMHS budget from 2010.

Mental Health support is complicated as there are so many different agencies involved. Patients may use the NHS but they actually rely on services supplied by local authorities and charities. In my area alone we have lost the Citizens Advice Bureau, two drop-in centers, the local Mind where I trained, the Soho Community Mental Health Team (where I worked) and an arts workshop, Portobello Prints, which provided a couple of hours of distraction and socialisation for people with experience of mental health issues, as well as the Christmas Cards for the London NHS.

This is Central London, the richest part of the UK, and these are just the services that I can point at. Or perhaps it's more accurate to say – these are the services I can no longer point at.

All this should be good news for the UKCP members. After all, 80% of our members are employed in the private and charity sectors. And, as Uber says, "demand is off the clock". But who will pay for this? The people who are in most need are at the bottom of the financial ladder.

How should we prepare our members and trainees to work in this new world and how can we make a meaningful contribution? Should we be teaching and lecturing to the public?

But before we move on we might ask, is there any likelihood of this 'cuts approach' being abandoned or can more money be pumped into Mental Health?

There are no votes in abandoning the IAPT scheme or even in making different kinds of investment in Mental Health. If IAPT stopped today there would need to be a replacement. It's easier just to expand IAPT and try and make it work better, but even that expansion is in doubt.

I know that everyone says, "We are a rich country we can afford this!" But that's not so. We have the potential for wealth, but right now we are a country in debt. GDP may be up, but that's just a survey based on a few thousand responses. When it comes to government spending there is only one figure to look at - tax receipts, the government's real income, their housekeeping money. And, according to The Times dated Friday 28 October 2016, those receipts that were forecast to be rising at 5.9% are only rising at 3.6%.

There is the defence budget (Russia has just produced a new tank that can eat any of ours for breakfast) then there are the prisons and the schools, the uncertainties of Brexit, Trump and NATO ... need I go on. I am sure there will be increased social spending and plasters offered to some broken parts but I do not expect big NHS spending splurges for non-IAPT services.

We are left with a broken welfare system. We have communities that are hurting. There is an enormous need for high quality psychotherapy and someone will have to fill it, but right now that's up to the private sector and charities.

How should or could we respond? Our view is needed. We can complain and raise merry hell about it but I don't think there is anyone there to listen. We are the grown ups. If we care we have to act. Or do we turn away? After all, no one expects us to act. Right now no one is looking to UKCP for solutions.

A welcome pause

So, let's pause here to see where high quality psychotherapy stands verses state therapy, and this is not about delivery systems like Skype or your smartphone but fundamental philosophical differences.

Where we really differ is that IAPT follows a 'wellness agenda'. In scientific terms 'wellness' means 'freedom from disease' and disease is defined by a Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) category.

In this State approach of 'wellness meets CBT' the context of the patient's life has little or no relevance. This is mental health that echoes notions of physical health in that, if two people have flu the circumstance of their lives are not really relevant – rich or poor, the patient is suffering from a disease which must be cured and the cure is disease specific and it will be the same. So think of each IAPT session as being a dose of medicine, the delivery of a conceptual pill.

In IAPT the work is manualised so that one size fits all, and the therapist is a technician delivering a specific script. The process is above-all scientific and objective. It's all

measurable and manageable and that's the point - it's this empirical measurability that aids research and statistical reporting, and therefore funding.

In contrast, much of the evidence for high quality psychotherapy is qualitative. Empirical science does not research first-person experience, instead science marginalizes it.

Within the State System the road to health is realising that you are thinking wrongly and therefore you are feeling wrong. The object is to correct that thinking so that the feeling changes. It's an oppressive system because the individual takes the blame for their circumstances.

High quality psychotherapy takes into account the circumstances of the patient's life both in the present and the past. State therapy records culture, race and religion but does not include them as issues in the work. It records diversity but does not act on diversity because diversity is not there to understand the client, but more to understand the sections of society within which this approach works. And so in the report it shows that Christian, Jews and Jains get the best results whilst, Muslims do not fare as well. There is no attempt to mold the work to these different groups.

High quality psychotherapy recognises the power of shifting cultural norms and political pressures. It includes the effects of intergenerational trauma, genocide, cultural destruction and forced assimilation. It values issues like meaning, freedom and autonomy. It appreciates the precarious nature of a working life in today's society. It also recognizes that a person can hold two contrasting truths at once; one conscious, and another, unconscious (the unconscious has no part to play in CBT). High quality psychotherapy challenges the client, as does state therapy, but most of all it supports the client, and that support is something that state therapy seems to neglect.

In high quality psychotherapy, depression and anxiety are symptoms of something and they have meaning – they point towards changes that the client may need to make in their lives and issues that they need to come to terms with. They are not the disorder itself. It's true that we tend to take more time to do our work, but issues that have been created over a lifetime seldom disappear overnight and I think that it's an unfair promise that real change is so swift. Indeed, the results of the IAPT endeavor bear that out.

High quality psychotherapy is not aiming at the cure for some conceptual disease but rather at the growth of the client; having the client gain new strengths, deeper insight, gaining new knowledge about relationships, being able to move on from, or come to terms with terrible loss, create meaning out of their life experiences. In many cases, through the relationship with the therapist, the patient gains a fresh trust in other people and learns to love and relate to others.

In high quality psychotherapy the psychotherapist's use of 'self' matters. The patient/therapist relationship is integral to healing. In IAPT it's irrelevant because the whole idea is to provide an objective treatment, one that is not dependent on the skill of the person delivering it. Delivery in person or by computer does not matter, for this is the industrialisation of care.

When people ask why our training lasts so long, I always say that we are training our graduates to be able to deal with complexity. You see, there are three kinds of problems:

The first is a simple problem like mending a tire or making a milkshake.

The second is a complicated problem, like taking a rocket to the moon. It's complicated because there are hundreds of thousands of steps to follow but we have done this before and we have manuals for every step. This is what IAPT tries to do by creating manuals for each step.

The third is a complex problem – that means there are whole areas of 'not known'. If every person brought their own manual to therapy that would be great, but of course they do not – and bringing your own manual of disease along means that you are not dealing with the person in front of you, but rather a concept of disorder.

Just as a diagnosis is not the person, average is not the individual. Here's the science:

Take 10 stones picked up from a beach. In total they weigh 4 kilos. The average stone is therefore 400 grams but if you weigh them individually then it is unlikely that any one of those stones will be that average weight. We do not work with 'average people' we work with individuals, they don't arrive with a manual and that means you have to stay with 'not-knowing' until something emerges. It's this complexity issue and the ability to stay with not knowing that is the hallmark of high quality psychotherapy and good science, and it distinguishes us from the offering of the state.

We have to admit that issues that we hold as vital, the issues that we fight for, are no longer valued in state care. We are the torchbearers for something – is that worth fighting for?

3. The use of technology to deliver therapy

In 2013 researcher John Norcross led a new Delphic Study entitled 'The Future of Psychotherapy 2022'. It's his fourth survey - he has done this every decade since 1980. And the findings? Well, up until now, these studies found that the main driver to change in Psychotherapy was cash - how can we lower costs? In this new study the driver is technology with the substitution of face-to face psychotherapy with a range of different tools. That's smartphones, virtual reality, social media, and of course psychotherapy delivered by telephone, text and over 'Skype like' systems.

You can download this report here: <http://opensample.info/psychotherapy-in-2022-a-delphi-poll-on-its-future>

It's a free PDF and it contains a host of interesting ideas. But to save you the time let me put it this way, these guys believe the future belongs to self-help and very low-cost delivery of therapies.

This technology thing is not 'Tomorrow's World'. We know that IAPT offers computerised therapy and that the Scottish 10 Year plan for Mental Health is heavy on promise, but light on detail outside of the guarantee of computerised CBT. New mental health call-centers offer help by phone, as The Samaritans have done for decades.

(See www.theguardian.com/society/2016/jan/25/call-centre-counselling-treating-mental-illness-therapy-iapt-cbt-nhs)

What should our approach be to this? Is it something we embrace or do we dig in and wait for retirement because there will be enough 'in the room face-to-face work' to see our present members out – but what then? Will we just become a non-evidence based anachronism like homeopathy?

4. The new patient: The changing attitudes of patients towards the bio/medical system and how those who have serious diagnoses are organising themselves

It may seem strange to young people, but up until relatively recently LGBTQ people have been pathologised. Homosexuality was part of the DSM, it was not only illegal, it was a mental illness.

It is only through their own political organisation that they have had that pathology removed. (Not through a scientific re-evaluation, for there is nothing scientific about the DSM). Thirty years ago Gay Marriage would have seemed impossible. That change has been made by the gays and lesbian community saying “we are not mad, we are just different, this is not a pathology – get over it”. That community has created a new model of Civil Rights. And it’s a model that others are following.

Look at this great quote from Jacqui Dillon, Chair of the UK Hearing-Voices Network:

“I am not mentally ill. Never have been never will be, I am a survivor of abuse; I have a perfectly natural response to serious trauma, to name my response as an illness is offensive. We spend too much time talking about what’s going on in people’s brains and not enough time on what’s going on in people’s lives.

She goes on to say: “Society makes me ask myself, what is wrong with me? I want that question instead to be what happened to me?”

They are fighting for a new model of consciousness.

Or how about this statement from the Autistic Advocacy Network: <http://autisticadvocacy.org/>

They are sick of experts telling them how they should live, how they could become normal. They consider themselves not to be ill but to be different, they are diverse and are sick of being considered defective and so their powerful statement is: “Nothing about us – without us”

And here is my favourite collection of this kind of rebellion www.madnessradio.net

Here you will find there are literally hundreds of programmes on alternatives to a life under psychiatry. This is the true front-line of diversity, change and civil rights and it’s all there on the internet.

The internet is used not just campaign for rights, its used to educate and enroll.

Where LGBTQ people have it worse than other disadvantaged minorities is that most minorities are part of a community and a family who are all rejected by society, however LGBTQ people are not only rejected by society they are often rejected by the their own family. So here is a website that is designed for young LGBTQ people growing up in small towns where there are no role models and no one understands in their family: <https://imfromdriftwood.com/>

Here you will find first-person narrative accounts of the experience of being LGBTQ. These are just great little films. I can imagine plenty of people who we may describe as ‘diverse’ making such films. Could we organise things like this? What would happen if we actually championed such patient rights?

You cannot lower the stigma of a disease, that's an oxymoron, but what if we dropped the disease idea altogether; not 'what is wrong with you?' but 'what happened to you?'

Some of you may have been wondering why I am so keen on online-programmes, interviews and workshops – it's because I believe it is where the future of mental health is being shaped and created. We are 'behind the curve' on this but now we have a [new] website, we have an opportunity to do our own programming.

I can imagine plenty of people who we may describe as 'diverse' making such films. Could we organize things like this? Can we use our website to heal?

These 'user' groups have enormous political potential and are our natural allies. Their voice has to be listened to by politicians. We can be ignored as being partisan, a sort of trade union for a privileged group of practitioners, but no politician can ignore a mental-health user group, or a civil-rights issues.

I feel that if we win the heart and minds of 'users' we will win the hearts of the public, and it will be the road back into relevancy for high quality psychotherapy. After all (at the risk of boring you I shall say it again) you do not change minds by fighting the existing reality, to change something build a new model that makes the existing model obsolete. The patient groups are doing just that, and we should become their allies.

Right now our communities need healing, and frankly I can think of no better group to do that work with than our members. It is true that individually they may be bolshie, mad and difficult but their work is something else and is something worth backing.

We can make a real difference, and we should. All we have to do is to work out the financing of such schemes or change our methodologies and approaches to suit the budgets.

Finally, I would like to leave you with a remarkable document on mental health. On October 20 this year Deborah Danner, a 66-year-old Black woman from New York, was shot dead by police who did not understand how to handle or subdue her when she was in a schizophrenic rage.

This is an essay that she left behind. It's her experience of living with mental health issues and it's the best account I have ever read of the stigma. It's a delight.

<https://assets.documentcloud.org/documents/3146953/Living-With-Schizophrenia-by-Deborah-Danner.pdf>

Now, more than ever, the UK needs the UKCP. When we meet, let's see if we can use our imagination to re-engage with the needs of our people and delight our members.