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PAUL'S POLITICAL COLUMN

With **Paul Atkinson**

This year, I celebrate the thirtieth anniversary of my first meeting of therapists who were moved to political action by the threat of state regulation. It was the early days of the UKSCP, forerunner of the UK Council for Psychotherapy (UKCP).[1] Someone at the meeting warned that organising ourselves in response to the threat of external regulation would likely lead to self-regulation, the setting up of authoritarian intra-professional structures and policing our own psychotherapy training and practice. 'And probably most therapists want all this', they added. A prescient reading of the group psyche.

A generation later, our professional bodies *are* our regulators; organisations claiming to represent tens of thousands of counsellors and psychotherapists, with a dearth of democratic process and a terrible hunger to be players in the power-mongering of national mental health politics and funding.

The current campaign by mainly British Association for Counselling and Psychotherapy (BACP) members to stop the SCoPEd project being pushed through by the big three therapy gatekeepers (BACP, UKCP and the British Psychoanalytic Council [BPC]) parallels the campaign to oppose state regulation a decade or more ago. Neither project has much to do with the declared aims of the reformers – protecting the public and promoting decent therapy. Both are more about the capture of independent practice for the neoliberal markets of mental health provision, and the political ambitions of our 'voluntary' bosses.

SCoPEd promoters have been clear enough on this point. 'If agreed, this shared framework would be extremely helpful and important in enabling BACP and the wider profession to engage effectively with employers, commissioners and government.'[2] It is also clear that state regulation of counselling and psychotherapy a decade ago was supported by our professional bodies on the same basis.

In a recent reflection on his experience of SCoPEd negotiations, Andy Rogers talks about the ghosts haunting the project. 'IAPT... is the first real spectre we encounter, invoked… to unleash its ghostly cry that we weren't good enough (i.e. didn't agree to be regulated a decade ago), that we squandered a golden future of jobs and status in the loving arms of the NHS because we were too caught up in petty sibling rivalries. It is a potent tale... that speaks to an anxious professional reality of our times, that there's little if any paid work on the near horizon for many counsellors.'[3]

The irony of demanding more access to NHS jobs with a qualification in relational therapy is palpable. Improving Access to the Psychological Therapies (IAPT), and its hypocritical definition of 'evidence-based' practice, is committed to the demise of relational therapy and to the demise of the NHS as a publicly provided service. It is a

creature of the market – the market of financialised transactions and the denial of care.

I am writing this the day after the new Health and Care bill received its second reading in the UK Parliament. The implications of this latest top-down reorganisation of the NHS are largely unrecognised outside campaigning circles. Under cover of slogans like local integration of services, patient-led care and personalised budgets, the NHS in England is being split up into 42 regional bodies called 'Integrated Care Systems' (ICSs), each of which will have responsibility for organising and commissioning the health and social care of its population. ICSs are modelled on Accountable Care Organisations in the US – a model NHS leaders, UK politicians and the private health lobby have been enthralled with for the past two decades.[4]

In practice, the underlying intention of the bill is 'first and foremost about making the organisations within an ICS work together in order to reduce patients' use of NHS services and save money'.[5] The bill allows private providers to sit on, and in principle chair, ICS boards. It is in fact a major further step to privatising and financialising health services, expanding the two-tier provision of health and social care, and pushing on towards a US-style Medicaid health insurance system, where the state provides only the basics and only for the old and poor.

Since the government will not be providing the significant increases in funding and staffing the NHS, local authority and community services would need to make a success of the more progressive goals of integrated care and user-led provision, the reorganisation becomes an exercise in rationalising and disguising the denial of care to more and more people.

What we therapists are not necessarily interested in recognising is that the 'mental health industry' of which we are part, like the term or not, has for some time been on the leading edge of many of these political developments.

Before Layard and Clark, counselling and psychotherapy already constituted something of a two-tier provision. Many, but not all, GP practices employed therapists, but usually with restrictions on session frequency and duration. Fee-paying clients got what they could afford. Since IAPT colonised primary care, we have seen a dramatic split between second-class therapy and the denial of care for the many, and the bespoke attention of private practice for the wealthier few.[6]

It is too easy to list examples of denial of care under IAPT:

- only a third of referrals each year complete a course of treatment, and only 16 per cent achieve the gold standard of 'reliable recovery';
- the average number of sessions is between six and seven;
- many courses of treatment consist of two sessions;
- less than half of IAPT sessions involve a therapist and client sitting in a room together;
- there is little choice of therapies or therapists;
- there are virtually no follow-up studies;
- digital IAPT is mushrooming;
- the number of clients who are deemed unsuitable for treatment is growing;
- waiting lists of over three months are common.

Many IAPT services, up to 50 per cent, are outsourced to private companies and the third sector. Conditions of work and pay, and levels of training in the workforce, have been consistently deteriorating. And the empire of the IAPT model of short-term behavioural therapies has been steadily growing to treat children and young persons, the elderly, people suffering psychosis, diabetes, obesity, and lack of workplace well-being….

An even more dramatic picture of denial of care is provided by the story of secondary mental health services in the UK. Most NHS mental health hospitals have closed since the late 1980s, in favour of a policy of care in the community that has never been properly funded or staffed. Mental health problems account for 23 per cent

of the 'burden of disease' in the United Kingdom, but spending on mental health services consumes only 11 per cent of the NHS budget. Staff shortages of mental health workers are catastrophic. Between June 2017 and May 2018, 23,686 mental health staff left the NHS – one eighth of the total workforce in mental health. By the end of June 2018, one in ten mental health positions were unfilled, and net recruitment of mental health nurses is getting worse.[7]

Almost every adult suffering from severe mental ill-health I have spoken to over the last decade has said there is almost no mental health service available to them. It is the same story and worse for children and young adults.[8]

Under the auspices of the new health bill, University College London (UCL) and the Royal College of Psychiatrists have drawn up a magnificently golden framework to transform community mental health services, to be located within the ICS reorganisation:

> The framework offers a structure for doing this by dissolving the barriers that currently exist between (1) mental health and physical health, (2) health, social care, voluntary and community social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care for adults and older adults.[9]

To deliver this framework, Peter Fonagy, psychoanalyst and UCL impresario of manualised therapy, has recently estimated that

> if every psychologist worked 50 hours a week they would still only meet 12% of the current demand. A clear solution is to train a new workforce, potentially on the boundary between formal and informal care. This type of training at scale would be costly but, by using a digital approach, this could be overcome.[10]

It is not hard to read in all this a deepening of the trends across mental health services in this country – a growing two-tier system between the haves and have-nots; a continuing reduction in person-to-person talking therapies generally, and a total absence of longer-term relational therapy; massive shortages of staff, massive increases in de-skilling and in voluntary work; the privatisation of anything from which a profit can be extracted; and a devastating acceleration of denial of real care.

So what is the relevance of all this to our independent sector of psychotherapists and counsellors? Suggesting answers to this question is going to be one of the recurring themes in this column. One answer, of course, is 'nothing much', as long as we have a private practice of clients paying us a decent income, and we are free to work in the relational modality in which we trained and want to practise. After all, we have a powerful investment, as a profession, in many of the key aspirations in the modern market-place of achieving a successful and satisfying life. But surely most of us can sense that without a critical eye on the political processes driving our society and a commitment to asking what we are going to do about it, one way or another many of those aspirations are threatening to destroy us.

References

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