CHAIRMAN’S REPORT

The last year has been very interesting as far as the APP is concerned. The APP first ever Away Day in November 2007, facilitated by Anton Obholzer, was challenging and stimulating, driven by energy and ideas for change (see page 2). Discussion was heated and included a view that the APP should have a powerful lobbying voice for dynamic practice and analytical thinking in all NHS settings. There is a Sub-Committee of Council to implement the Away Day consensus for change and we will bring proposals to the AGM in May. They include:

- the abolition of the Associate membership, making everyone of equal status with everyone asked to pay an equal subscription fee.
- the sections need to be reconsidered in light of the streamlining of APP towards a clearer mission, to bring back split-off ‘semi-autonomous’ groups of members, to contribute towards overall strategy, and to close down sections that are clearly moribund.

A clearly very lively section, the Older Adults section, has contributed to this newsletter with 3 stimulating and thoughtful pieces about work with this group of patients (see pages 12-19).

The Lead for Research and development, Jeremy Clarke, will negotiate with sections as to what their future within APP should be.

We also need to consider how we relate to the external world of the NHS, and whether the image and identity we project serves us well or ill. We are clear about needing to be an inclusive organisation and one which values equally all its members. We must do whatever is needed to make APP an effective force, capable of representing the interests of all those who use and apply the whole spectrum of psychoanalytic thinking and practice across the NHS.

Jeremy Clarke led in organising a very successful conference “Psychological Therapies in the NHS” on the 30th Nov – 1st Dec 2007, at Savoy Place, London, bringing together ten organisations representing different stakeholders, (see conference report on pages 3-7). I, as Chair of the APP, invited Kathryn Tyson, the Head of Mental Health Policy for the Department of Health, and Greg Beales, the Prime Minister’s Special Adviser, to accept our New Savoy Declaration on behalf of the Government. A dedicated website is being built as I write to show the fruits of this truly creative and transformational project, which APP has led from the outset, and which continues to grow. Put the dates for this year’s follow up conference in your diaries now: 21st and 22nd November, Savoy Place.

Both Jeremy Clarke and I were invited by the Department of Health to a reception on the 26th February 2008 to mark the publication of the IAPT (Improving access to psychological therapies) Implementation Plan – National Guidelines for Regional Delivery, and to celebrate the difference the new money will make over the next three years. The Parliamentary Under-Secretary for Care Services, Ivan Lewis and the Secretary of State for Health, Alan Johnson, attended to roll out the IAPT plan. Jeremy, as Chair of the New Savoy Partnership, replied on behalf of professions in psychological psychotherapies. This was a real honour, which APP shares in (see photograph on page 7).

There are strategic issues that the APP will have to consider, for example, statutory regulation of professional groups including Psychoanalytical Psychotherapists. In my opinion, in order to protect their interests in the future, we can only do this by working in partnership with others. When I became Chair, I inherited a “Lonely Hearts Club” to quote Anton Obholzer, describing our dwindling and ageing membership. I think we are on the cusp of a new era in the new NHS and I want APP not just to be dragged along as part of that, but right at the heart of progressive change. We began APP’s life with an idealistic zeal, as our 25th anniversary celebrations last year reminded us. If we stand still, our influence on anything other than our small circle, impotent in the face of serious challenge to the future of psychoanalytic psychotherapy in the NHS, will be nil. But working in partnership, as we are doing increasingly, with the Tavistock and Portman NHS Foundation Trust and the BPC, for example, is beginning to give us a real voice. I am sure this will involve painful change. It will certainly require leadership, which Council, and myself, fully intend to provide.

RONALD DOCTOR
REPORT FROM THE FIRST APP AWAY DAY

Sat 3rd November 2007
32 delegates attended the first ever Away Day of the APP at the Holiday Inn at Camden Lock. Anton Obholzer facilitated the event, describing himself as more of a “visiting anthropologist”. The day's format was that of a short introductory session, and morning and afternoon discussions either in small groups or a plenary.

Introduction:
Jeremy Clarke (Lead for Research & Development) began by describing how, after seeing a recent film about Elizabeth I, he realised that the APP's dilemma is who to get into bed with? and how to play it? He asked if we had been left behind as an organisation within the NHS. Psychoanalysis and psychoanalytic psychotherapy are under pressure in comparison to newer and more “marketable” therapies such as Cognitive Behaviour Therapy (CBT).

The NICE Guidelines for several psychiatric or psychological conditions are not sympathetic towards psychoanalytic therapies. CBT has been granted considerable funding for the treatment of depression and we need to make the case for a share of investment in NHS psychological therapies. The APP has been involved in discussions with NICE and has collaborated, along with several organisations, in the promotion and sponsorship of the 2 day Conference, “Psychological Therapies in the NHS”.

Phil Lucas (Treasurer) expressed some reservations and reminded us of APP history: in 1980 a group of psychiatrists met to discuss an NHS training in psychotherapy for psychiatrists. The APP was formed by Consultant Psychotherapists and has always been an elitist organisation. Our aim is to work with the NHS and Balint Groups are an example of this for GPs. On average, a maximum of 40% of NHS senior clinicians’ time is spent seeing patients, most of their time is used for facilitating, consultation and management.

Morning plenary discussion: key points raised:
- The APP was started within the Royal College of Psychiatrists precisely to introduce an alternative approach to organic psychiatry.
- We are not a training organisation and should not have a 2-tier membership, especially given that our constitution only permits full members to vote.
- The APP was formed by Consultant Psychotherapists and has always been an elitist organisation.
- Our aim is to work with the NHS and Balint Groups are an example of this for GPs.
- The name of our organisation is too long and not accurate as we are not just about psychotherapy.
- Do people really want evidence? What news is there of the APP Psychotherapy Research Project?

In conclusion, Anton Obholzer stated that the Away Day could disappear into in-house arguments. The APP needs to address its role in the NHS and society. After all, it began as a missionary organisation.

Afternoon session:
Small group discussions concluded broadly that the aims of the APP are:
- To provide support for people working psychoanalytically in the NHS
- To facilitate connectedness and networking
- To promote psychoanalytic ideas within NHS work
- To facilitate discussion and debate and provide consultation and information

Anton Obholzer asked delegates if the APP has transformed from a missionary organisation to a Lonely Hearts Club? He questioned why the APP insists on using the term “psychoanalytic” when it knows it is “toxic”.

Small group and plenary sessions were convened to consider the following questions concerning the issue of modernisation:
- What changes do we need to make to the APP’s internal structure, such as name, membership criteria or the structure and function of the Sections?
- What external changes should APP make, such as collaborating with other like-minded organisations?
Afternoon plenary discussion: key points raised:

- Can APP lose the name “psychoanalytic” and still retain integrity?
- Can APP have a new main title and include “psychoanalytic” in a sub-heading, again without loss of integrity?
- Would APP regional representatives facilitate networking and facilitate aims being met across the country, not just in London? Some scepticism expressed here, as, for example, hitherto the APP council cannot manage to meet except late in the evening in central London.
- Some people join APP because of the sections. However, some sections are barely functioning, if at all. APP leadership does not have a clear overview of the sections and communication is patchy. If APP changed the Section structure, what would be put in its place?
- APP is already engaged in exploring external relationships:
  - Links with the BPC
  - The Association of Adult Psychotherapists (AAP) has done important work in the area of Agenda For Change
  - The Society for Psychotherapy Research (SPR) should be approached.
- One proposal was that there should be two Conferences a year, one academic and one political. However it would be a shame to lose the smaller Conferences run by Sections which do not make large profits, but disseminate information.
- It was widely agreed that APP should abolish the distinction between Associate and Full Membership. Such a change would have to go through an Extraordinary General Meeting or be voted on at the AGM.
- One name proposed for our organisation was ADAPT...The Association for Dynamic and Psychological Therapies in the NHS.

Some Pearls from the Facilitator:

- There is an assumption that every change put forward should be unanimous: this is a recipe for stagnation.
- To plug the word “psychoanalytic” may have an adverse effect.
- Do not present yourself as offering the ideal and others as being ignorant.
- Some people are concerned that if you abolish border controls (such as membership distinction) you will get more outsiders coming in. Let them in, you need interested people to join the APP.
- If you want to retain your identity, you have to risk giving up your identity.
- When there are problems in psychoanalytic organisations, there tend to be psychoanalytic ways of coming up with solutions. These tend to be based on passive dependency and trust.

The conclusions reached are that change is both inevitable and necessary. Any thoughts, comments or suggestions that you have will be more than welcome. Please send them in by email to editor or via the website.

STEVE ISAACS

CONFERENCE REPORT:
PSYCHOLOGICAL THERAPIES IN THE NHS:

SCIENCE PRACTICE AND POLICY, SAVOY PLACE,
30TH NOVEMBER & 1ST DECEMBER 2007

Day 1

The opening address to the Conference was given by Tony Roth who highlighted an issue that was to be a central theme throughout the Conference. This concerned the need to draw upon a plurality of research methods to establish a viable evidence base for the practice of Psychological therapies in the NHS.

He recognised that randomised controlled trials (RCT’s) trials have an important place in research, as in determining issues of causality, such as whether a positive therapeutic outcome has actually resulted from a particular treatment modality or from some other variable. However, he also emphasised that an over reliance upon this particular method of research could result in a skewing of the evidence base. He acknowledged that, for example, there was a need for more process research to identify who does well from a therapeutic intervention and how change has actually come about. He also referred to a need for research to establish whether particular therapeutic interventions might in certain situations cause harm.

Panel Discussion
Richard Layard chaired and Alison Faulkner, a mental health service user, consultant and researcher made the opening presentation. She emphasised the need for a humane service that can include a capacity to listen to the views and opinions of those who have a direct experience of mental health problems. She suggested that RCT’s may not be asking the right questions, and that they needed to be augmented by other research methods, as well as a listening partnership with users. One size or one therapeutic modality does not fit all.
Peter Hobson, Tavistock Professor of Developmental Psychopathology, highlighted another key theme that ran through the conference: the need to resist an oversimplification in approaches to psychological disorder. He referred to the stepped care model and how there is a focus in each step upon levels of severity as if about one entity, whereas in everyday practice the clinician will invariably face patients who present with a complex interweaving of co-morbidities. The oversimplification in relation to the NICE guideline on depression has resulted from the adoption of an essentially medical model. He emphasised the transformative power of interpersonal engagement and understanding, and concluded that an unreflective view of the evidence base is dangerous to the practice of therapy.

He also made a request that a greater commitment be made to developing work with ethnic minority groups. He highlighted a need for more provision and research into cross-cultural therapy.

Susie Orbach, psychotherapist and writer, highlighted the need for an ethical stance based upon the patient’s needs as a cornerstone principle of assessment to enable patients to receive the help that they require.

David Veale, consultant psychiatrist in CBT, pointed out that CBT is evolving and developing and that the way it will be practiced in ten years time will be significantly different from currently practice. He also indicated that CBT is integrating techniques from other therapeutic modalities such as gestalt.

Keynote Address

Louis Appleby, National Director for Mental Health in England, presented the case for the roll out of the stepped-care approach within the NICE guidelines, and its particular application to Primary care.

He noted that in secondary mental health care the development of crisis resolution and home treatment teams had brought significant improvements to patient care. He also emphasised that those services which had adopted the new approach early had seen the greatest improvements in patient care. He considered that the same principle would apply to the roll out of stepped care, and by implication urged services to adopt the model quickly to increase the likelihood of achieving maximum benefit to patients.

There was some recognition of the evidence base for a range of therapies, and of the need to integrate therapy within a broader range of social care. He acknowledged that there was a need to take into account the expressed wishes of patients alongside of the evidence base in the delivery of services. He did not demonstrate a clear appreciation of differences between primary and secondary care services, or of the unique contribution of the primary care setting itself to mental health care.

In the discussion after this address it was pointed out by delegates that there have been problems with the development of home treatment teams, for example a lack of continuity of care so that a patient would be seen by a different member of the team each day. Stepped care runs a similar risk as patients may be passed from one part of stepped care to another.

Patient Perspective

David Crepaz-Keay of the Medical Health Foundation gave an engaging and witty account of his own experience of being a mental health service user, the main theme of which seemed to be to urge all mental health professionals to practice with some humility. He had received many different diagnoses and promises of cure for the phenomenon of hearing voices, but the symptom persisted.

An independent Evaluation of the IAPT Experiment

Glenys Parry gave a very detailed outline of the extensive evaluation of the effectiveness of the IAPT (Improving Access to Psychological therapies) in both pilot localities, Doncaster and Newham.

She emphasised that the evaluation is very much in its formative stages and that they are not as yet in a position to publish their findings. The evidence of the effectiveness or otherwise of the IAPT pilot projects has yet to be accumulated and processed.

Conference Splits – Debate on the NICE guidelines

Participants of the Conference had three options at this point in the day

1. Evidence Base: The state of the Art in treating common mental health problems.
2. How to design ‘stepped care pathways’
3. Debate on the NICE guidelines

Advances in Evidence Based Practice in the USA

Jacques Barber from the Centre for Psychotherapy Research, University of Pennsylvania, presented evidence from recent meta-analyses that indicated that short-term dynamic psychotherapy is effective for Depression, PTSD and Social Phobia.

He noted a lack of a tradition of conducting RCT’s in psychodynamic psychotherapy, and also highlighted some
within the NHS. The complexity of mental health issues faced by practitioners was identified in the pioneering studies of Brown in the 1970’s. He referred to the social causes of depression and ill health. He referred to the social causes of depression and ill health. He stated that there has been a one-sided discussion of evidence which has omitted to include an examination of the causes of mental illness. He referred to the social causes of depression identified in the pioneering studies of Brown in the 1970’s. He also questioned whether RCT’s are suitable for the complexity of mental health issues faced by practitioners within the NHS.

Barbara Milrod, a researcher from Cornell University, New York City, outlined her RCT of Panic focussed psychoanalytic psychotherapy (PFPP), a manualised therapy of twenty-four sessions, demonstrating its effectiveness.

Day 2

Opening Panel Discussion: What is the future for state funded Psychotherapy services?

Richard Layard opened the panel discussion. Improving access to psychological therapies (IAPT) will be embedded as a top priority in the NHS. There will be pressure on every PCT to increase the provision of psychological therapies from existing resources, they will have to come up with a 3 year plan to improve access to psychological therapies, and there will be ongoing pressure from NICE to do so. Primary care psychological therapy services will be central as much therapy is envisaged as provided in GP practices.

The IAPT programme will see £173 million invested over 3 years for psychological therapies in anxiety and depression. Strategic health authorities (SHAs) will establish training programmes to expand the workforce in psychological therapies, focussing on low-intensity CBT training. There will be a gradual expansion of services in a small number of PCTs first, to provide on-the-job training for workforce. SHAs will decide how to allocate funding in the first year in conjunction with the Department of Health. Psychological therapies can be provided outside of hospital settings, including GP practices, jobcentres and other community settings.

Andrew Cooper, director of research and development at the Tavistock & Portman NHS Trust, drew attention to the social model of mental health. He stated that there has been a one-sided discussion of evidence which has omitted to include an examination of the causes of mental illness. He referred to the social causes of depression identified in the pioneering studies of Brown in the 1970’s. He also questioned whether RCT’s are suitable for the complexity of mental health issues faced by practitioners within the NHS.

Gillian Finch, Co-ordinator of CIS'ters, and a service user, argued that there was a wealth of experience within the voluntary sector which needed to be brought into the NHS to contribute to planning and decision making about psychological therapies. She also emphasised the high percentage of patients with mental health problems who have been sexually abused. She suggested that the implications of this connection for preventative mental health care needed to be more fully explored and addressed.

Michael Rawlins, Chairman of NICE, criticised delegates who were questioning the direction that IAPT was taking. As the conference had been oversubscribed by psychodynamic clinicians, a concern expressed repeatedly in different ways, was the place of psychodynamic therapies in this plan. Rawlins expressed exasperation, regarding such views as negative, complaining, not evidence-based and self-interested. He suggested that professionals should be focussing upon the increase in spending on psychological therapies resulting from the IAPT initiative, and benefits to patients.

However, some cynicism prevailed in the discussion which followed. Several delegates expressed concern about possible disinvestment in specialist secondary care services and treatment of complex cases, despite the investment in IAPT. Dr Andrew Elder, GP and member of the APP, pointed out that 90% of mental health problems are currently contained by the GP in the primary care setting. There seemed to be little acknowledgement of this, or thought about how to capitalise upon this resource in the process of IAPT.

Keynote Address – A Cognitive Science approach to developing effective new treatments

Professor David Clarke, Professor at the Institute of Psychiatry, and Director of the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital, gave an outline of CBT methodology and how its development has been intrinsically based upon a close monitoring of the research from RCT’s. He illustrated this with research upon the efficacy of CBT for Post Traumatic Stress Disorder: to offer therapy before three months have elapsed since the trauma can be counter-therapeutic, resulting in a change in practice.

Science meets Psychological Therapist: Investigating the effective practitioner

Michael Barkham, Professor of Clinical Psychology, Director, Centre for Psychological Services Research, University of Sheffield, highlighted the need to explore the qualities that contribute to therapeutic effectiveness. Within the same modality there will be good and poor therapeutic practitioners and CORE data can be employed
to demonstrate this.

Additionally he demonstrated that RCT’s often employ a very small number of practitioners, which can skew their external validity.

He also drew attention to Stiles’ 2007 study, and pointed out the importance of the client-therapist alliance as a key variable in predicting therapeutic effectiveness across modalities.

**Conference Splits**

The conference split into three groups:

1. Debate: This house believes that the existing health infrastructure and NHS management will not be able to deliver improved mental well being.
2. Towards best practice: How to design ‘Stepped Care pathways’
3. Evidence Based Practice: The state of the art in treating complex mental illness.

In group 3, the focus was upon the treatment of Borderline Personality Disorder.

Arnoud Arntz, Professor of Clinical and Experimental Psychology at Riaag Maastricht Netherlands, outlined his research comparing schema focussed cognitive therapy with transference focussed psychotherapy for borderline personality disorders. The research demonstrated that both forms of treatment were effective, schema-focussed therapy marginally more so.

Professor Anthony Bateman, of the Halliwick Centre, St. Anne’s Hospital, London, stated that the key factor in the effectiveness of any therapy with patients with borderline personality disorders is whether it promotes the patient’s capacity to mentalise. He defined mentalisation as the implicit or explicit perception or interpretation of the actions of others or oneself as intentional, that is, mediated by mental states or mental processes.

Dr Janet Feigenbaum, Consultant Clinical Psychologist in N. E. London Mental Health Trust, illustrated the developing evidence base for Dialectical Behaviour Therapy for borderline personality disorder.

**Joint Closing Plenary Session - what we have learned, and what do we still not know**

Peter Fonagy, Professor of Psychoanalysis and Director of the Sub-Department of Clinical Health Psychology University College London & Chief Executive of the Anna Freud Centre gave the closing address.

He summarised the key points that emerged from the Conference. In particular he noted:

1. The need for a plurality of research methods
2. The dangers of oversimplification in the formulation of Mental Health problems as the Stepped care programme is rolled out
3. RCT’s both contribute to knowledge but also have significant limitations
4. Where CBT has been compared to Psychodynamic therapy or other therapeutic modalities the outcomes have been roughly equal
5. CBT currently evokes anxiety in the practitioners of other modalities because of its prominent position in the NHS
6. The NICE guidelines may result in ossification in therapeutic practice, stifling the organic development of creative therapeutic practice.

**Jonathan Smith**

**Psychological Therapies in the NHS Conference**

There is a report from Jonathan Smith, who attended as an APP delegate, so I shall offer a brief perspective as Chair and main organiser. First, it is very gratifying to have received overwhelmingly positive feedback from delegates: on the evaluation forms 96% thought the event was either ‘excellent’ (50%) or ‘good’. Our ambition was that this should be a landmark event, which would change the climate of discourse around evidence-based practice, and begin to influence public policy. High ambitions. In my view, we achieved both. The fact is we have opened up a space for dialogue across the whole profession where there was none. This is evidenced by an increased number of partners who wish to be involved this year. In terms of influencing public policy I would cite the decision to invest over £300M in psychological therapies, as one of the NHS’ top priorities now. And you don’t get the Prime Minister’s Special Adviser making a speech at such an event, without first having succeeded in convincing government that this is an important area of health care.

What now? The New Savoy Partnership has a life of its own now, and as well as steering the conference on an annual basis, will also develop projects (and its own website), related to expanding the availability and improving the quality of psychological therapy services across the NHS. Having been midwife to this very creative and exciting prospect, I hope APP will continue to nurture its growth.

There is loss as well as gain in development and change. Without becoming maudlin, we need to remember Phil Richardson’s contribution this year, as we continue the
work, very much missing his unique combination of serious research expertise, offered always with sparkle and wit. I count myself fortunate to have worked closely with him. What has the APP lost? If it is right that this conference marks a watershed in the somewhat fragmented functioning of our profession, it is inevitable that APP itself must change. We have occupied a position of pretended splendid isolation, which is simply untenable. Phil was more involved with APP’s R&D work before my time and, whilst I never asked him directly what he thought he had achieved, I think the challenge, which faces APP, is that much harder without him. Phil’s approach to evidence-based practice was not restricted to any one modality, or methodology, he was equally at ease in thinking about quantitative or qualitative research. If he had a vision for APP, though, I had a sense it would have encompassed a practice-based evidence paradigm as a complement to evidence-based practice. This vision would have linked across NHS services via outcomes benchmarks. I hope the conference enables us to pursue that vision.

YOU SHALL NOT CRUCIFY US ON A CROSS OF CBT

I imagine myself standing on the stage, arms outstretched, as if nailed to the cross, head thrown back in agony, a crown of thorns (which spells NICEIAPT NICE...) causing a trickle of blood to flow from my brow. The Secretary of State, Alan Johnson, is doing his best to keep smiling benignly at the audience. The Minister for Care Services, Ivan Lewis, stands at a podium to the right of his boss, having just delivered a speech launching the plan to roll out IAPT services nationally. “You shall not crucify us on a cross of CBT”, I proclaim defiantly to the audience, as the security men close in, and the cameras click and flash.

£33M is being spent in 2008 to train new staff in CBT, some to deliver ‘low-intensity’ interventions, such as guided self-help, most to deliver face-to-face therapy for
up to 20 sessions, targeting the symptoms of depression and anxiety. Next year, another £70M will be spent; the year after, the same. And then there will be another round of negotiations with the Treasury to decide whether psychological therapies are worth continuing to spend money on. So how much out of this unprecedented level of investment is earmarked for psychoanalytic psychotherapy? Nothing. Psychoanalytic psychotherapy is not amongst the range of treatments recommended by NICE.

There are those amongst us, I know, who would have us respond to this reality, martyr-like, but knowing we have not betrayed the cause of psychoanalysis by keeping the true flame until the end. You know who you are! Sadly, I suspect, you are so wedded to this view that no amount of argument will be able to persuade you how wrong you are. So when I took my place at the podium to reply to the Minister, (faint cries of ‘Judas!’ to be heard, off-stage) on behalf of our profession, I welcomed their investment wholeheartedly for the genuine, transformative opportunity it represents for all NHS psychotherapies.

The responsibility for whether psychoanalytic therapies feature in future policy plans or service commissioning by Primary Care Trusts and Foundation Trusts rests with us. Who else is looking after these interests? No one. Our Away Day, back in November, was tasked with thinking about such improvement, and concluded we are not. What changes do we need to make to become more effective?

First, we must be able to represent everyone across the NHS (I would go wider and say the public sector) who is working and using psychoanalytic ideas, applying them in whatever settings as effectively as they can, and to do this we need to value all of this work equally for the overall contribution it makes. Our journal has always reflected this aspiration, but our membership profile, our organisational structures, and our name, does not. Specifically, we must make a major effort to revive M alan’s pioneering work at a research, training and service delivery level. We need to locate a suitable hub for this, probably the Tavi, and then to build a network of cost-effective services across the UK, all linked up.

Secondly, we must establish close and formal links with partner organisations, which share our values and aims. APP on its own has neither the resources nor strength as a professional lobby to be able to exert an independent influence. The Department of Health has invited me to reply to the Minister for Care Services on behalf of our whole profession is testimony to this approach.

Thirdly, my usual refrain, we must build our evidence base. At our conference at Savoy Place we heard from several eminent researchers about what the building blocks for this evidence base could be. For anxiety, Barbara Barber and Frank Marston each conceded during the conference debates, is not so much that psychoanalytic psychotherapy, and its variants, have yet to prove they are equal to or superior to CBT in treating depression. Rather, whilst basic science research and randomised trials proliferate for CBT, leading to a constantly evolving and growing evidence base, for psychoanalytic psychotherapy very little research is even being undertaken. In the UK, we have the Tavistock Adult Depression Study, comparing an 18-month (60 sessions) treatment with once-weekly psychoanalytic psychotherapy to treatment as usual, using a randomised design. To my knowledge, however, we have no trials underway for STDP (Short-term Dynamic Psychotherapy), and nothing, which has been published since NICE reviewed the evidence in 2004, and didn’t judge us worth recommending back then*. What do we expect in 2009? When are we going to wake up? *(“Psychoanalytic psychotherapy may be considered for the treatment of the complex comorbidities that may be present along with depression” 6.11.1.20 NICE Depression)

At present, then, we are at risk of being caught between the Scylla of a powerful and well-funded government programme, IAPT, which will be delivering a varied menu of different types of CBT, and the Charybdis of an equally powerful and well-funded soon-to-be independent body, NICE, whose recommendations thus far have depended upon efficacy findings from randomised controlled trials.

There are 3 sets of questions concerning research methodology we need to consider to find a way forward:

1. Are there specific difficulties, which make it especially difficult to establish the efficacy of psychodynamic therapies? What are these? How do we design solutions to them?

2. Do we believe outcomes across different modalities will always be broadly equivalent, because change comes about through common factors, or do we believe dynamic techniques can produce better outcomes? Can we show how and why we bring about such improvement?

3. Where should we invest our research efforts: in understanding the therapeutic relationship, and what makes an effective therapist? Or in understanding psychopathology, and developing treatments which target reduction in symptoms, and identification of maintaining factors? Can we do both - if so, who is needed in the Research Consortium to make it happen?
We need to bring together the best brains amongst us to see if we can formulate a sufficient consensus around these questions, and then to put together research teams, working to address the gaps in the evidence base. These teams will probably need to draw on expertise from outside our discipline, health economists, for example, to advise on technical issues from their own specialty. Measurement techniques, using the existing methodology based on patient self-report questionnaires, are being refined with new psychometric instruments all the time. It is an area psychoanalysts have begun to explore, but yet to claim. For me, there are very clear parameters within which APP’s R&D strategy must operate. What I would like to see is an ‘Open Door’ review of outcome studies in short-term dynamic psychotherapies. We must be geared towards establishing cost-effective treatments, relevant to public sector settings. These need to be made available, free at the point of delivery, to the whole population. This is what we must aim for. Nothing less.

JEREMY CLARKE

‘STEPPED CARE IS COMING: HOW WILL IT IMPACT ON PRIMARY CARE COUNSELLING?’

Report on a Saturday morning APP primary care section event held on 8 March 2008 in a GP practice in the Paddington Green Health Centre.

At this event Rosie Rizq, who is specialist lead for research and development in Ealing primary care mental health and wellbeing service, gave a talk introducing the way stepped care is being implemented in Ealing. She commented on both gains and losses of the new structures and approach as well as some of the difficulties involved in implementing substantial change. A response was given by Anna Bravesmith who is a primary care therapist in Kensington, where similar changes are beginning to be implemented. Dr Tony Burch then gave a second response from his perspective as a GP in Brent, where, as yet, there are no published plans for stepped care. The event was chaired by Dr Andrew Elder, co-chair of APP’s primary care section and GP at the practice where the event was held. Twenty people attended including counselling psychologists, psychodynamic and integrative psychotherapists and counsellors working in primary care, managers and supervisors of primary care counselling. Some of these were new to APP events.

The audience had a range of perspectives on stepped care. There were some who had barely heard about it at all and others, particularly managers, who were attending training on the implementation of IAPT and had much information on the subject. There was lively discussion after Rosie’s talk and the two responses and it is clear that this kind of small scale event is much valued at ‘grass roots’ level as a contained space in which to gain information, share ideas and feelings and meet other primary care practitioners. The twenty four people gathered were able to function as one discussion group enabling dialogues that cannot take place in a large scale conference. An informal atmosphere was intentionally cultivated by the organisers - Anna Bravesmith and Andrew Elder- and the venue carefully chosen to provide a setting for the event which was the very same as the setting in which primary care therapies are conducted, namely a GP practice. At a cost of only £5 it was easily affordable for any NHS employee. We feel that such small scale events are very important to APP and that they complement the large conferences now being planned and successfully initiated last November with the ‘Psychological Therapies in NHS’ conference resulting in the Savoy declaration.

Rosie Rizq described stepped care in Ealing, which is being implemented in accordance with the IAPT model which is by now well known. I will briefly summarise the Ealing version: Step 1 consists of recognition of a mental health problem in the patient by GP, nurse or health visitor and the application of screening tools followed by CCBT or books on prescription. Step 2 concerns mild to moderate depression and may sometimes involve the primary care counsellor/psychotherapist but more often will involve GP, vocational advisor or primary care mental health worker delivering CBT under supervision. At step 2 guided self help, computerised CBT, community groups, or other brief psychological interventions of 6-8 sessions may be used or simply ‘watchful waiting’. At Step 3 moderate to severe depression is treated by some or all of the following: gateway workers, GP, CBT therapists or primary care counsellors/psychotherapists. Brief psychological interventions of 8-12 sessions are offered at this stage and assessment, there may be liaison with CMHT/secondary services, onward referral or signposting, advice and support. Unusually, Ealing are also offering very limited places for longer term therapy of 30 sessions at Step 3. Step 4 is for treatment resistant, recurrent, atypical and psychotic depression and those at significant risk. At this stage mental health specialists, home treatment teams, early intervention services and assertive outreach may be used and provision of medication, complex psychological interventions and combined treatments are all likely. Step 5 is inpatient care for those at risk with combined treatments, medication, and ECT.

Rosie commented on the large task of data collection which IAPT requires and how standardised data must be submitted on every session of psychological intervention, not, as at present, merely at the beginning and end of
Rosie explored these tensions by talking about some particular points critiquing the stepped care model, and the culture surrounding it. The continuing adherence to a medical model of practice and climate of managerialism and tick-box bureaucracy was described as problematic. The position of NICE on psychodynamic therapy with a narrow view of what constitutes evidence-based practice with RCTs of CBT cited as ‘gold standard’ is leading to widespread devaluing of other approaches. She felt unhappy about well trained analytic psychotherapists being required to undertake CBT training and the ever briefer interventions adopted in primary care at the expense of more discretion about longer treatment which has hitherto been possible for individual practitioners. She had serious doubts about the introduction of inexperienced untrained mental health workers, mainly at step 2 and Ealing had needed to put in place very substantial supervision for these workers as an expense not yet costed. Her conclusion included some thoughts on the unconscious significance of change and the anxiety for psychodynamic practitioners within organisations often responding with increasing authoritarianism and bureaucracy. She spoke about how this promotes a primitive psychology which can lead to splitting, projection, destructiveness and difficulties in communication. She ended however with a note of moderate optimism saying that her own view is that the future contains hope, as there will be advantages resulting from stepped care and the additional funding being invested in primary care mental health services.

During Rosie’s delivery there were several comments and questions and subsequently we heard Anna Bravensmith’s response some of which is reproduced below:

Response from an analytic psychotherapist in primary care
Practitioners who criticise the new structures being introduced are sometimes regarded as ‘anxious’ or ‘resistant to change’. In my view it is not change itself that we are concerned about, but the nature of the changes. At the centre of the stepped care model is the idea that one can prescribe the correct treatment, and level of treatment, for an individual human being’s mental anguish as if prescribing a medicine, on the basis of a superficial listing of symptoms. There is no room to consider that each individual invests different meanings in their symptoms and that, even if the symptoms do not appear to score as ‘severe’, it may need a highly sophisticated mind to unravel this meaning, explore it collaboratively with the patient with reference to the unconscious, and generate new meanings. The novelist Hanif Kureishi wrote recently in the New Statesman: ‘it is a tempting simplification for the medical profession to believe that the mind is treatable in the same way as the body... far from advancing in our knowledge of our mental states we are reversing into ignorance.

It is significant that I am citing a novelist here since in psychotherapy, whether brief or long, and in whatever setting, the imagination of both patient and therapist needs to be actively engaged in a form of story-telling. This is the way to break out of the patient’s repetitive, or if you like, unimaginative, malfunctioning narrative. Adherence to the findings of research, as represented by NICE guidelines, in a rigid way, or to the new manualised therapies, constrains imagination and innovation by definition because practitioners are required to be the same as each other, and required not to deviate from a predefined pattern. Peter Fonagy pointed this out in his summing up at the recent Psychological Therapies in the NHS conference where he used the word ‘ossification’ as a likely result of too much standardisation. It’s worth pausing to think that ossification is not something psychotherapists want to be modelling and that we are attempting to counter rigid and defensive structures in our patients.

In the stepped care structure, though it may be implemented with variations, there is an implicit belief in standardisation based on some pieces of research lifted out of the context of the whole evolving and quickly changing area of research, itself revealing contradictions and the instability of yesterday’s findings. The predominance of CBT is being increasingly enshrined in NHS structures despite the findings of Michael Barkham presented at the Psychological Therapies conference that what is actually most significant is the individual psychotherapist. That is to say that it is not whether the method is CBT, integrative or psychodynamic that matters, it is the particularity of the therapist. This is now requiring further research into what those particularities may be. These are some of the findings using CORE data. It is supported by the research of Stiles (2007) showing that CBT, Person-centred therapy and psychodynamic therapy are essentially equal in effectiveness.

What is most important in truth, as Stiles found, and I think we all know from experience, is the relationship between patient and therapist. I think we also need to consider that the patient treated in his/her own GP practice...
in Primary care has many context-specific resources. There is potential in the therapist's collaboration with the patient's GP for an experience for the patient of being contained by a parental couple; there is the potential for feeling contained by a family in the form of the practice team, nurse, health visitor, receptionist etc. Bodily care and mental health care are not arbitrarily divorced from each other but rather provided for in the same place. All these factors activate transferences as part of powerful inner fantasies which can be used by the patient to play with constructively and to experience something different from the traumas and deprivations of the past. Importantly also a re-imagining of what was facilitative in the past, maybe getting back to what was good enough may happen. What I find especially disheartening in the stepped care model is that these potentials will be lost, seemingly without even being considered. This would be the outcome of mental health being more strictly separated from bodily care, therapists/counsellors working away from GPs and practice teams in specially designated centres, and GPs relegated to an involvement only at the preliminary referral stage. It would seem that in stepped care the GP's role will be to fax a referral form to someone who will assess the patient and decide what sort of treatment they need to receive. What a tremendous impoverishment will result from this segregation.

Stepped care will be implemented with some variations but there are many issues about assessment itself which are worrying to me. In some areas assessment by telephone is being practised, such as South West London and St Georges and others. This I think is inadequate and possibly dangerous, as serious pathology may be missed. In other areas graduate mental health workers with little training will be providing 'triage' postponing complex and a sophisticated assessment that offers containment till later, when it may be urgently needed. Lists of questions on a so-called 'tool' with tick boxes will replace informed assessment. Probably many of us know from experience how inadequate some of the screening tools really are. For example PHQ9 used to measure depression depends on the patient being able to take a balanced view of themselves and resist either an urge to exaggerate symptoms in order to get help, or to minimise them in order to comply with an internal prohibition on facing the extent of their misery.

Response from GP perspective

One issue concerned the interface between primary and secondary care services in mental health and how patients get 'lost in the system'. Despite the claims that stepped care will 'streamline' services and make transfer between levels smooth and efficient the two GPs at the event were sceptical. Another area of interest re-emphasised was the nature of involvement of GPs beyond making an initial referral into the system. In some practices GPs and therapists have worked together collaboratively over a long period and we intend to explore this with some clinical casework at a future APP event. Dr Tony Burch pointed out that such clinical collaboration, within the setting of the GP practice, has in some places been developed but has never been widespread. He went on to say how valuable that collaboration, as experienced by GP, counsellor and team can be, and how patients who would otherwise never be picked up by the current system have been held, and helped, by that team. Perhaps therefore it is important to keep alive a valuable way of working which is increasingly threatened by changes in the NHS through the rehousing of counsellors at central sites with no meaningful contact between GP and therapist. A variation is the housing of a counsellor in one practice but without particular ties to the patient community attached to that practice. Patients are being referred across practices.

These changes tend to break relational attachments between psychological therapists and GPs and between patients and their own practice. Nevertheless Dr Elder made the point that what is not acknowledged is that patients continue to have care from their GP both before and after mental health treatments of a specific kind and are helped by the GP to contain anxiety, often having an important attachment relationship and experience of the therapeutic aspect of continuity. This will increasingly be missing from treatment by a series of brief interventions in varied venues. He emphasised that Step 5 is not a final solution and the patient will return to the GP. Overall there is a lack of understanding of the important role of GPs in mental health.

General Discussion

Stepped care investment was thought by some participants to be further investment in gate keeping so that secondary services become even less accessible. However provision at step 1,2 and 3, is not going to be effective for severe mental disorders and there was anxiety about the continued provision of enough places for onward referral. More particularly Jonathan Smith voiced concern that the huge investment in step 2 is in the wrong place and that money made the point that what is not acknowledged is that collaboration, as experienced by GP, counsellor and team can be, and how patients who would otherwise never be picked up by the current system have been held, and helped, by that team. Perhaps therefore it is important to keep alive a valuable way of working which is increasingly threatened by changes in the NHS through the rehousing of counsellors at central sites with no meaningful contact between GP and therapist. A variation is the housing of a counsellor in one practice but without particular ties to the patient community attached to that practice. Patients are being referred across practices.
counsellors/psychotherapists would be under too much performance pressure if such ‘electronic supervision’ were introduced. Another issue raised was about duplication in the structures of teams in the evolving polyclinics and those of stepped care and how these would fit together. Participants also voiced concerns about lack of information, consultation and relationship building in the implementation of stepped care but there were also some who felt hopeful about the future and that adaptation to new ways of working would be central.

Future Plans of the primary care section for Saturday morning events:
The energy generated by the event ‘Stepped Care is coming…’ will be channelled into a further event on 21 June centreing on the collaboration between GP and counsellor/psychotherapist/psychologist as well as collaboration within primary care teams in the current culture. This is being planned at the present time and we are considering some of the points made by the participants in relation to the theme.

Report by Anna Bravesmith 16/03/08 comments would be welcomed email: anna@jar59.fsnet.co.uk

Research & Development Update: Spring 2008
We are working on a number of important projects, mostly in an advisory capacity to NHS committees of one kind or another.

1. NICE is currently reviewing its guidelines for Adult Depression – both the original guideline of 2004, and a new guideline linking depression to chronic physical health conditions. These are due for publication in 2009. My role is as a member of the Guideline Development Group for the revision of the original 2004 version. There are 5 CBT specialists represented on the group.

2. Skills for Health are producing a set of Competence Frameworks for psychological therapies, and have published the first of these for CBT (see www.ucl.ac.uk/CORE/). These frameworks will be used to inform the training and skills requirements for IAPT services. Dr. Alessandra Lemma has been seconded to review the evidence base and produce a draft set of competencies based mainly on manualised treatment approaches, which have proven efficacy. My role is as a member of the Expert Reference Group, alongside other dynamic clinicians and researchers, under the chairmanship of Professor Anthony Bateman.

3. New Ways of Working is a Department of Health initiative aimed at reviewing the traditional roles and working practices in mental health. It is a cross-cutting programme with a focus on improving productivity, efficient staff deployment, building and sustaining new teams, and ongoing organisational development in the delivery of mental health care. My role is to co-Chair a working group, which looks afresh at the roles of all Psychological Therapists.

4. The Psychoanalytic Strategic Alliance (PSA) currently consists of the APP, BPC, and Tavistock & Portman NHS Trust. The Executives of these organisations will meet on a regular basis, produce a joint strategic plan, and agree a work schedule. We are looking to make this a wider group over the coming months. Setting up a Research Consortium will be one part of our overall planning. My role is to provide advice to APP’s Executive, and to the PSA. One consequence of this for APP, for example, is our current Sections will benefit from opportunities to link up with the equivalent sub-sections in the PSA.

5. The New Savoy Partnership and the IAPT programme are now inextricably linked at a number of levels, including collaborating on the annual conference. My role includes being on the National Programme Board, chaired by Minister for Care Services, Ivan Lewis.

6. I would like to welcome Linda Stephenson, who has taken on the role of Research Assistant in R&D.

OLD PEOPLE ABUSE - COUNCIL REPORT CR84

INTRODUCTION
This is an update of Council Report CR84 published in 2000. Since then much has happened involving older people but little has changed. Primarily there have been many publications and some court rulings. The NSF for older people dealt inadequately and by comparison with the NSF for mental health, discriminatorily with the mental health of older people and it did not mention abuse. The report of the Rowan enquiry into alleged abuse in a ward in Manchester identified factors, which are well known, having been identified in many previous enquiries. NICE has been seen to deprive those with early dementia of the only currently available medication and was supported in that at judicial review. Older people in privately run care homes were ruled by the court in 2002 to lose the protection of the Human Rights Act 1998. The Audit Commission 2007 reported on poor diagnostic facilities and inconsistent services for those with dementia. The first report 2006 of the Age Concern enquiry into mental health and well being in later life identified ageism and discrimination as potent factors in diminishing well-
being. The second report 2007 details the high level of unmet mental health needs amongst older people, with age discrimination remaining the fundamental problem.

Reports, enquiries, court rulings are merely words, but behind these publications and pronouncements are real people. The Audit Commission 2007 looked at cost effectiveness and found failings, but within that are individual patients and their families struggling to cope. Attitudes and suppositions from ruling or influential bodies are passed down the line to the care relationship. Abuse is person driven and therefore preventable. The role of the doctor is in not only identifying abuse but thinking about and endeavouring to change those factors, which lead to abusive practices in themselves and in others.

The parliamentary health select committee published its report on Elder Abuse in April 2004, they recognised that the protection of older people comes a very poor second to the efforts to tackle child abuse. Unfortunately the most trumpeted recommendation was for the registration of care workers. This failed to appreciate that the subtleties and complexities of potential abuse needs to be understood and are unlikely to be resolved by regulation alone. Abuse occurs within human relationships.

The NHS’s retreat to the market could be seen as a betrayal of the whole population but it particularly disadvantages those already physically and mentally disadvantaged. The Gift Economy created by Bevan in 1948 aimed to identify needs and meet them rather than to make money. The NHS was set up as a socially funded cash-free gift economy independent of business. Now the boundaries between the NHS and business are being destroyed and contrived competition is being introduced (Hart 2007). Commerce in this setting promotes mistrust but there is little discussion about whether we want to have a market economy or a gift economy, whether we have economics-based or ethics-based values. Payment by results turns the patient into a financial unit and thereby introduces the concept of the profitable and the unprofitable patient. Patient choice has little meaning for the physically disabled older patient with dementia and perhaps co-morbid depression. The state is shamefully evading its responsibility for the care of older chronically sick patients in its system of not funding the long term care of the majority of patients with Alzheimer’s disease.

From many aspects, abuse is a subject which is difficult to consider. This paper will not examine abuse in families but concentrate on abuse in the institutions where older people should have the expectation of being cared for well. There are major evidentiary problems, not least because of conflicts of interest and that publicly to reflect negatively on where one works risks one’s own reputation. There is a lack of awareness of what constitutes abuse, particularly in so called “less severe” types. In all institutions there is more focus on penalties rather than on prevention.

This document is unlikely to say anything not “known” already but will consider why with this knowledge there has been no change over many years and many inquiries. Protocols, policies and regulations seem so far to have failed to address structural and systemic inequalities as well as ignoring the psychosocial aspects of care work. There is clear evidence (Gran et al 1995) that the quality of the relationship with staff members is the most important aspect of quality of care for residents in a home and patients on a ward. The drive to make care situations more domestic (Help the Aged 2006) has proved too difficult and has been essentially unsuccessfully - nowhere will be like ‘home’. Maybe homes and wards should be more of a community with reciprocity in relationships creating a positive culture with care centred on the individual and opportunities for meaningful activities. Increasing staffing levels will give better outcomes but ‘levels of staffing expressed as bodies per resident’ (Kane 2004) may not tell the whole story. Staff and more particularly their managers and supervisors need the understanding for staff not to be merely custodians (Menzies 1977) but to work therapeutically in demanding and complex jobs with space for reflection and clarity about the goal of care. They need to feel appreciated and recognised with a sense of achievement. Doctors too, whatever their seniority, have these needs in their work.

DEFINITION, RECOGNITION, PREVALENCE AND CONSEQUENCE

Institutional abuse of older people is a common insidious and serious indictment of the caring professions and their managers. It is a difficult subject and easy to be complacent, thinking that it is not a problem in the places where we work although it may happen in others. All of us need to think carefully about and discuss our own practice as well as that of our teams and departments. Abuse is maltreatment as a single or repeated act or neglect; it may be intentional or due to ignorance or thoughtlessness by a person or persons in a position of power. It covers a number of domains: physical, sexual, social, psychological and financial. The circumstances may range from minutely subtle interactions or tone of voice to acts that constitute a violation of human and civil rights. Elder abuse takes many forms (appendix I). It is both, under recognised and under reported. Rarely it occurs as an isolated event and may persist over extended periods, several types of mistreatment may occur simultaneously, the word “abuse” may be a euphemism for some acts that are criminal. What links the range of behaviours is that they occur in situations in which the victim is dehumanised and seen as an extension of and solution to the abuser’s needs. The abuser relates through power in the absence of clear thinking.

Abuse is a problem in NHS and social services facilities...
and also in the private sector. It is not possible to put figures on the incidents of abuse although it would seem that elderly people living in care are more likely to be at risk than those living in the community. Unless there are witnesses, the perpetrator will have reasons to keep it secret and many victims will either not wish or not be able to complain. It is rarely an isolated event, much abuse is unthinking and the perpetrators may not realise that what they are doing constitutes mistreatment. It is not merely increasing age that makes people vulnerable, there are dangers in seeing older people only as potential victims, however, health services for those over the age of 65 years see many patients who may be mentally incapacitated and others who are vulnerable through physical frailty and dependency. Those in institutional settings are the most vulnerable, even more so than children and the most likely to fall pray to dehumanising attitudes. Institutional abuse includes individual acts or omissions and managerial failings. Abuse does not only occur in rare dramatic and well-published incidents, it is a common part of institutional life. Telephone surveys, in which the respondent remains anonymous has revealed some information about abuse to which staff have admitted, and acts, which they have witnessed (Pillemer and Moore 1989, Goergen 2001). These studies are from America and Germany but we have no reason to think the situation is better in the UK, where abuse allegations made to the UKCC average about 1000 annually. Half of these relate to physical, verbal or sexual assault, more offences occur in nursing homes than anywhere else. However, abuse is not only a problem for nurses and their managers, it is an organisational problem with causes and solutions to be found at all levels and with all disciplines in the organisation.

The grossest of abuse is obvious to both perpetrator and observer but many times people are not aware that their actions are abusive. We have all had the experience of going into units where things did not feel right but it is difficult to specify the problem. The quality of life in long term care is not usually measured in terms of comfort, relationships, emotional atmosphere, but room size, and although that may be important, other aspects are more so. Common practices become accepted and acceptable, merely by years of enactment. Physical restraint is still used in some units. Patients with the most cognitive impairment and most impaired mobility are more likely to be restrained (Gallinagh et al 2001, Breithauser et al 2005). The therapeutic use of restraints has not been adequately explained, perhaps there is the belief that falls will be prevented and behavioural disturbances controlled, but the evidence does not support this. Anti-psychotic medication is overused in the treatment of patients with Alzheimer's disease, particularly in those whose behavioural symptoms are mild (Ballard et al 2007). For people with more severe behavioural symptoms, balancing the potential benefits of medication against decreasing verbal fluency and cognitive function and increased mortality is more difficult.

Some pointers to the recognition of abuse are given in appendix II. They are taken from studies and experience of the effect on the individual patient or resident and from inquiry reports into alleged abuse in institutions. However, there is no major contemporary research agenda looking at institutional care of older people and the consequences of its failure. However, the consequences may be startling, Lachs et al (1998) found that older victims of mistreatment were three times more likely to die earlier than those older people who were not ill-treated. Help the Aged (August 2007) have recently tried to push the research agenda forward, in their recent report they found nurses reluctant to report problems, 58% saying they would not do so. The reasons they gave were not wanting to be mistaken, overwork, fear of meeting with the alleged abuser and ignorance. Staff in an oppressive situation may develop a passive acceptance and hopelessness while what is needed is critical awareness and responsiveness. We cannot ignore the widespread belief that the needs of older people are less important than those of the young. Older people too may echo this view – "I've had my innings". It is incumbent on care providers as organisations and as individual staff to treat everyone with respect whatever their gender, race, sexual orientation, disability or age.

AETIOLOGY

The causes of elderly abuse are complex and varied and involve a combination of factors. Ongoing abuse in an institution is unlikely to be due only to individuals with malevolent intent, many factors come together within the organisation, which is ostensibly there to do good but something goes wrong, "care is corrupted" (Wardhaugh and Wilding 1993) and normal moral concerns are neutralised. Understanding the multiple factors which play a part in the aetiology of abuse is necessary to devise principles of good practice, training, supervision and other solutions to prevent it. Some of the causes will be to do with socio-cultural attitudes and social policy, at the next level it will be to do with organisational factors. At the individual level there are some people who do not have the personal qualities needed to be involved in this type of caring work and there are some older people who are more likely to be abused than others.

SOCIETAL/PSYCHOSOCIAL FACTORS

Elder abuse is a societal problem. Wards and homes are a microcosm of society, staff (also relatives and patients) bring with them conscious and unconscious attitudes and prejudices onto the ward. The ward easily reflects the widespread belief that the needs of older people are less important than those of the young. Older people too may echo this view – "I've had my innings". It is incumbent on care providers as organisations and as individual staff to treat everyone with respect whatever their gender, race, sexual orientation, disability or age.
organisational factors

The sociologist, Ervin Hoffman, wrote of the “total institution” in which inmates are separated from the outside world and daily life is carried out by timetable; there is a basic distinction between the managers and the managed; the aims of the institution are more important than the aims of the individual within; reminders of personal identity are stripped by stripping personal possessions, privacy and individual responsibility; mobility is restricted. This sounds grim but aspects of the above description may be recognised in all long stay wards and homes in which we work. Where do we adequately care for someone physically, how often do we consider the emotional life of the patient? People with dementia often function at a worse level than that determined by the illness alone, because the attitude of the surrounding “carers” (Kitwood 1990). As staff we may service patients with a regimen of tasks but with limited social and emotional engagement between us and the patients (Terry 1997).

Caring for older dependent people is difficult, demanding, stressful and undervalued work; undervalued, reflecting the position the patient is holding in society. By a domino effect demoralised staff may find it easier to take out their frustrations on the patients rather than to take them up with their managers. Quality of life for patients is inextricably linked with the quality of life for staff (Menzies-Lyth).

It may be the case that staff who are critical of the way the unit operates, may be intimidated, ostracised or victimised themselves. Group norms are powerful and it is easier to go along with institutional expectations than to speak out.

Leadership is vital in setting a culture; are staff praised for finishing the tasks as quickly as possible or for spending time talking to patients/residents? Is the manager in the office with the “all important paperwork” or helping and supervising in the direct care of patients? Neglect is a form of passive abuse, this may be multi-factorial, of course it may be intentional but it may be cutting corners to be quick or not wanting to deal with a difficult patient or resident and needing help and supervision in that. Stannard 1973 showed how the everyday conditions of work in a nursing home kept the nurses from seeing or hearing about patient abuse. The conditions also provided the nurses with routine ways to deny its occurrence, when such a claim was made. These conditions can impede the development of trust and communications along groups who work and reside there. Distrust, hostility and cynicism also prevents the nurses hearing about abuse. If staff have a low level of involvement in their role, it is easy to look the other way. The lofty goals of health and service learned during professional training, then give way to goals of custody and maintenance of order. Those who stay in these circumstances have socialised the culture, those who cannot accept it leave and therefore there is no change unless senior staff takes the lead and model the caring role. Wards for older patients may be isolated geographically but also organisationally - staff and patients, both neglected. There needs to be a culture where it is acceptable and expected that senior clinical staff, managers from all levels, including the Trust or Home Board, will visit the wards frequently, so that the wards feel themselves to be a part of an ongoing interesting and interested whole. Staffing recruitment, retention, skills mix and training are crucial and an understaffed, undertrained unit will not be able to do imaginative work with the residents. Staff burnout characterised by physical, psychological and spiritual exhaustion has been implicated by a number of authors as a feature of environments where abuse occurs and needs to be recognised and prevented by senior staff. Payne and Fletcher (2005) found organisational causes to be burnout, level of conflict, isolation, poor training, low morale, low salaries and staff shortages. (Need to put in something about Alzheimer’s Society. Report home from home Nov 07)

The poor manager may be weak and ineffective or strong and efficient with efficiency masking rigidity and an inability to listen. Senior staff may have an ad hoc reactive style resulting in crisis management and an inability to see the whole picture. Management may fail to see a pattern of events that are treated as individual instances, in isolation. Much abuse is subtle. Managers and workers need at one and the same time to think broadly across the
institution and about the minutiae of their individual
interactions with patients and other staff.

Investigations into allegations of abuse eg. in Camden
Beech House, North Lakeland, Gosport and Manchester
Rowan ward have identified similar and known risk factors:
- An impoverished and institutionalised culture and
  environment.
- Low staffing levels.
- High use of bank and agency staff.
- Little staff development.
- Lack of clinical supervision.
- Poor clinical leadership.
- Inadequate monitoring of prescriptions.
- Outdated practices.
- A lack of knowledge of incident reporting.
- A parochial inward-looking culture.
- Weak management with confused accountability.
- Geographical isolation, particularly at times of
  transition.

It would appear that neither the NHS nor other supposedly
caring institutions have been able to learn the lessons of
previous inquiries.

PATIENT CHARACTERISTICS

Older people with physical or mental impairment seem
to be the most at risk of abuse (Aitken and Griffin 1996).
Perhaps for them the power imbalance is the greatest
(Kumar S 2000) and they may be seen to offer staff few
rewards in terms of therapeutic achievement. Some surveys
have revealed a high level of patient violence towards staff,
and risk factor for abuse, as aggressive patients are more likely
to have aggression shown to them. Newberry (1987) found
that aggressive residents were four times as likely to be
abused than more passive residents. In Stannard’s (1973)
participant observation in an American nursing home,
most workers regarded abuse as wrong or evil but there
was a notion that the patient who violated institutionalised
expectations of proper behaviour should be punished,
particularly so if the staff member was assaulted. Goodridge
(1996) found a correlation between staff/patient conflict
and abuse, particularly over issues of personal hygiene and
the wish of the patients to go outside.

Few victims complain, there may be anxiety about the
consequences and fear of having to testify. For the older
generation there may be an element of pride in survival –
they have been through the war and will get through this.
There is the passivity of the repeat victim who may have
learned compliance as a coping style, although this may
reinforce instances when aggression may occur (Quinn
and Tomita 1997). Societal attitudes cast older adults in
the role of non persons, through ageism, sexism and
destructive attitudes towards the disabled perceived as
unattractive. The more vulnerable and impaired an

INSTITUTIONAL ABUSE OF
OLDER PATIENTS

Elder abuse has been in the recent news with the Action
on Elder Abuse Survey detailing its frequency by family
members. This emphasis on problems in the domestic
setting should not blind professionals to the continuing
problem in the institutions in which we work. Institutional
abuse of older people is common, insidious and a serious
indictment of the caring professions and their managers.

Elder abuse takes many forms. It is both under-recognised
and under-reported. There have been major investigations
into allegations of abuse e.g. Camden Beech House, North
Lakeland, Gosport, Manchester Rowan Ward and each
have identified similar and know risk factors. It would
appear we have not been able to learn the lessons from
inquiries.

Aetiological factors are multiple, complex and deep rooted
but individuals’ responsibilities are clear. It is a difficult
subject and easy to be complacent, thinking that it is not
a problem in the places where we work although it may
Each member of staff is responsible for his or her own actions. However staff have line managers and professional and training leads. Support, supervision and training is vital if the task of caring for disabled, dependent patients is to be done well. Senior staff are responsible for setting a tone which should be respectable and empathic with patients and for setting an example of good, open communication within the team in which they work. Leadership is vital in setting a culture. The management style needs to be open and reflective promoting a positive and supportive atmosphere on the ward. Training should be a priority not only for clinical staff but also for non-clinical managers. Open and transparent reporting of problems needs to be encouraged but with a response that does not discourage further reporting and learning. Good management is dependent on the quality of thoughtfulness, communications and relationships rather than bureaucratic prowess - forms to be completed or information collected without a direct bearing on the work of caring for patients.

From previous inquiries and some thought about incidents some of the means of detecting and preventing abuse are known. Perhaps the causes of abuse are so deeply rooted personally and socially that apparently simple measures are not implemented. Understanding the multiple factors which play a part in the aetiology of abuse is necessary to devise solutions to prevent it. Different disciplines need to work with patients in different ways and will be able to identify areas of potential abuse - the over medicating or patronising doctor, the social worker "emptying a bed" as soon as possible, the OT who overreacts to "risks", the nurse who restrains in an enthusiastic manner, the manager who sees speed and "efficiency" as the mark of a good member of staff etc etc. Every discipline will have different requirements for their profession but each will need training not only for their particular job but also to acknowledge a common humanity, understanding what it may be like to be the one who is cared for, recognising how personality and personal history may impact on their values and work and to learn self-criticism. Training will also include managing particular situations for example the patient who is "demanding", the aggressive one, the one no-one likes, the one who will not get better etc. Clinical leaders need to consider priorities for wards while having individualised and flexible care regimes. Sensitive supervision is the sine qua non of this work and also includes listening to things that are not sad directly. Work groups discussions are an opportunity to recognise and discuss mixed feelings about patients. Case reviews can be used to model self criticism and to voice counter-transference issues. Organisations need to examine inherent ageism in their services and consider each person as an individual quite apart from their demographic features. Senior staff need to create an atmosphere where it is possible for anything be said – even measured criticism of themselves.

The abuse of older people has its roots in the way we as a
A REVIEW OF CONTINUING CARE

The true virtue of human beings is fitness to live together as equals
John Stuart Mill 1869

Society makes much of independence, entrepreneurship, rationality, efficiency and also celebrity. Cultural icons tend to be young, fit and fashionable. This is a difficult world if you are old and ill, particularly with a dementing illness and increasing dependence. It is easy to dismiss someone with a dementia, to reach superficial conclusions, to behave without moral respect. The word respect derives from sources meaning to “look out”, “look back” or “again”. The continuing care review is an in-depth look again, a consideration of long stay patients with dementia, the staff and families around them. The review began as a proactive initiative to examine our continuing care service rather than waiting for others to tell us what they thought – the good and the not so good.

Dementia of any cause is a neuro-psychiatric disease but its expression can be mediated by previous experience and personality and by the current psychosocial environment. A bio-psycho-socio-spiritual approach provides staff with the basis for addressing all aspects of the person’s life, rather than restricting the focus to brain disease. It is increasingly accepted that people with dementia can express views, needs and concerns, even in the later stages and the challenge is to find effective ways of communicating. A person centred approach rather than assuming a loss of self implies an ongoing evolving relationship and acknowledges the continuing complexity of life. The review endeavours to be an affirmation of a common humanity without differentiation of “them and us”, although within the health care hierarchy the patient, doctor, nurse, relative etc are positioned differently – this is only a problem if the patient is seen only as the patient and the doctor behaves only as a doctor.

The working group and contributors comprise a wide range of disciplines. Due to the nature and the degree of the disability of the patients on continuing care wards no patient was directly involved although their experiences were included. Representatives of the Alzheimer’s Society and the Companions of The Oaks (a relatives group and charity) were active participants.

The remit of the group was threefold:
- to improve the lives of patients on continuing care wards, most of whom will be there until the end of their life.
- to improve the working lives of staff on the wards, recognising they have a difficult job, which is frequently undervalued.
- to improve the experience of relatives and friends of patients on the ward who may have problems coming to terms with the apparent differences over time in the person with dementia.

The review group has been working for a few years, having discussions, considering papers members have written between meetings, having low key visits to wards, involving staff in discussing ideas and improving practice and referring to existing guidelines, policy, legislation and literature. The review focussed on Enfield continuing care dementia wards but it is anticipated that the results will be applicable to the Barnet and Haringey areas of the trust and perhaps wider.

The group aimed to produce a proficient piece of work while endeavouring to raise awareness of a human dimension to professional lives. The topics covered are an attempt to examine each and every aspect of life on the ward. The work began with thinking about the roles and responsibilities of the different disciplines on the ward, the experience of the patient, the experience of the relative – what they would like and what they could contribute and what the staff would like working on the ward. We considered confidentiality, the non pharmacological management of “problem behaviour”; the use of medication and aromatherapy; food in all its aspects; managing incontinence; privacy and dignity; maintaining personal identity; communication with patients, between staff and with relatives; sexuality; palliative care; death and dying and the spiritual care of patients. Inevitably things will be missing. Future readers identifying major omissions are invited to contact a member of the group. The review should be read in association with "Understanding Institutional Abuse Of Older Patients: Some Reflections" and "Thinking About Our Patients", both documents published by the Trust.
If any general conclusions can be drawn from the work, they would be that the essential identity of the person persists throughout the dementing illness to death; there is a need for empathetic and understanding relationships with the inner world of the patients, with family and with staff; caring for patients with a dementia and meeting their family is traditionally not seen as skilled work but to do it well requires skill, patience, imagination and understanding.

JANE GARNER

Further Reading
Continuing Care Review Group 2007, Continuing Care Review. Barnet, Enfield and Haringey Mental Health NHS Trust available via 02083751147

APP AGM
Friday May 23rd
Venue tbc
Guest lecturer: Mary Target

Will all members please ensure that Joyce Piper has their up-to-date email address
Contact: joycepiper@compuserve.com

If you would like to comment on any of the contents of the Newsletter, please e-mail: Dr Kate Lockwood, Editor at kate.lockwood@eastlondon.nhs.uk
Please address queries or information for Forthcoming Events & Series Events to: Patricia Mchugh - patricia.mchugh@eastlondon.nhs.uk
For further information on APP events please contact Mrs Annabel Thomas, APP Conference Administrator
PO Box 707, Gerrards Cross, Bucks SL9 0XS Telephone or Fax: 01494 581539 E-mail: app@athomas99.freeserve.co.uk
APP website: www.app-nhs.org.uk

SERIES EVENTS

Series
IPA: Screening Conditions
IGA: Screen Memories
IPA: Adolescent Psychoanalysis/psychotherapy
IPA: Psychoanalysis and religion
Lincoln: Mind at Work

For further information on the above events please go to the relevant website

IPA/BPAS: Institute of Psychoanalysis/British Psychoanalytic Society
BAP: British Association of Psychotherapists
IGA: Institute of Group Analysis
SAP: Society of Analytical Psychologists
Tavistock and Portman NHS Trust
Melanie Klein Trust: granadanpriory@waitrose.com

For more details on the above events go to the relevant websites

APP: www.app-nhs.org
BAP: www.bap-psychotherapy.org
BPAS: www.psychoanalysis.org.uk
IGA: www.igalondon.org.uk
Lincoln: www.lincoln-psychotherapy.org.uk
London Centre for Psychotherapy: www.lcp-psychotherapy.org.uk
Melanie Klein Trust: www.melanie-klein-trust.org
SAP: www.jungian-analysis.org
Tavistock Clinic: www.tavi-port.org

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JOYCE PIPER

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JOYCE PIPER
# List of Forthcoming Events

## April 2008 - September 2008

### April
- **12th**: Art and psychotherapy supervision, Caroline Case, SAP
- **18th**: Developing systemic approaches to working with violence, Tavistock & Portman NHS Trust.
- **19th**: Psychosomatics, The uses of Psychotherapy, Peter Schoenberg, LCP.
- **19th**: Imagination, creativity and the joys of being ordinary, David Hewison, SAP.
- **26th**: The role of understanding in analytic practice, George Bright, SAP.
- **26th**: Lionel Monteith Public Lecture: Shame, debt and repetition: a psychoanalytic understanding of gang culture, Donald Campbell, Lincoln Clinic

### May
- **2nd-3rd**: The Self and the Sacred, BAP.
- **2-4th**: Psychotherapy and liberation, Anniversary Conference, IGA.
- **10th**: A Jungian understanding of perversion, Fiona Ross, SAP.
- **10th**: Resilience, suffering and creativity: the work of the Refugee Therapy Centre, Aida Alayarian, LCP.
- **10th**: Envy and the broad and flexible ego, Marcus West, SAP.
- **11th**: Three uses of dreams in groups, Robi Friedman, IGA.
- **17th**: Trauma in adulthood, Ronald Britton and Joanne Stubley, IPA.

### June
- **6th**: Annual Infancy Study Day: Working with Children under five, Tavistock & Portman NHS Trust.
- **6-8th**: Managerial and professional dilemmas, IGA.
- **7th**: Descartes’ dreams, Bob Withers, SAP.
- **7th**: Working with phantasy, The Melanie Klein Trust.
- **13th**: Developments in Systemic couple therapy, Tavistock & Portman NHS Trust.
- **13th**: Psychoanalysis and racism, Fakhry Davids, IPA.
- **13-14th**: Film Festival, IGA.
- **14th**: Working with narcissism and the narcissistic disorders, Marcus West, SAP.
- **14th**: Lectures on violence, perversion and delinquency, David Matthes and Stanley Ruzczynski, LCP.
- **14th**: I versus we: Goldsmiths Association of Group Psychotherapists. Contact nragiadakos@yahoo.co.uk
- **15th**: The inspiration of dreams, David Matthes & Margaret Rustin, Tavistock & Portman NHS Trust.
- **20th**: Supervision and consultation in mental health nursing: challenges and dilemmas, Tavistock & Portman NHS Trust.
- **20th**: Race, culture and psychotherapy, BAP.
- **21st**: Analyst as Artist: extending containment, aiding recovery from trauma and the discovery of the self, Penny de Haas Curnow, SAP.
- **27th**: Counselling children and young people in educational settings, Tavistock & Portman NHS Trust.
- **28th**: Music: an essential component of any analysis, Sandra Brown & Helen Odell-Miller, SAP.

### July
- **4th**: The Annual Trauma Seminar: Working with traumatised refugees, Tavistock & Portman NHS Trust.
- **11th**: Social work today: where does it fit? Tavistock & Portman NHS Trust.

### September
- **26-28th**: Rhythm and response: the dance of psychotherapy, BAP.
- **27th**: Trauma in age, culture and society, IPA.

For more details on these above events go to websites:

- **APP** [www.app-nhs.org](http://www.app-nhs.org); app@athomas99@freeserve.co.uk
- **BAP** [www.bap-psychotherapy.org](http://www.bap-psychotherapy.org) for further information, please contact Sandra Pereira, Training Co-ordinator (External Courses), BAP, Tel 020 8452 9823 or Email external@bap-psychotherapy.org
- **BPAS** [www.psychoanalysis.org.uk](http://www.psychoanalysis.org.uk)
- **IGA** [www.igalondon.org.uk](http://www.igalondon.org.uk)
- **Lincoln** [www.lincoln-psychotherapy.org.uk](http://www.lincoln-psychotherapy.org.uk)
- **London Centre for Psychotherapy** [www.lcp-psychotherapy.org.uk](http://www.lcp-psychotherapy.org.uk)
- **Melanie Klein Trust** [www.melanie-klein-trust.org](http://www.melanie-klein-trust.org)
- **SAP** [www.jungian-analysis.org](http://www.jungian-analysis.org)
- **Tavistock Clinic** [www.tavi-port.org](http://www.tavi-port.org)
- **Patricia McHugh**: patricia.mchugh@elcmht.nhs.uk

**Editor**: Kate Lockwood
**Events editor**: Patricia McHugh