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The political climate the UK appears to be increasingly positive towards mental health professions. The Government have recently developed a new national mental health strategy "No Health Without Mental Health" that explicitly talks of parity of esteem for mental health with physical health. In June last year we even had an unprecedented debate in Parliament with Members openly talking about their own experiences with depression. Mental health, after years of being largely neglected, suddenly seems to have arrived on the political map.

Indeed, one of the most senior politicians in contemporary British political life, Jack Straw, (who in his career held a number of the main offices of State) explained in his autobiography that his childhood had been traumatic with a complex relationship with his largely absent father. He went on to bravely disclose that this led to episodes of depression in his adult life, and yes he had had psychoanalytic psychotherapy, and it had helped him enormously.

If that wasn't enough, we have also seen leading figures from British media, cultural and sporting life also 'coming out' and talking about their own battles with depression, emotional and mental health problems;

- Alastair Campbell, the former press secretary to the Prime Minister
- the comedian and actor, Stephen Fry
- and legendary England rugby player, Jonny Wilkinson

are just some of the very high profile cases.

So it's becoming ok to openly talk about seeing a psychotherapist; and this in Britain with our reputation of being unable to express our feelings. Despite our British reserve and coyness about discussing such things, stigma around mental health seem to be shifting, and so one might presume that the profession would be in rude health, growing and developing. But it's not quite working out like that - it's actually not looking so good for our profession.

Indeed if psychoanalysis were thought of as a brand it's a brand that is looking just a little tarnished; once even described, by a very high profile Registrant of the BPC, as a brand that had become 'toxic'!

The leading British economist and academic, Lord Richard Layard, in his influential book "Happiness: Lessons from a New Science", published in 2005 managed to dismiss psychoanalysis as backward looking in the first few pages! Lord Layard went on to significantly influence UK government policy on psychological therapies, resulting in a huge increase in public sector funding; but funding focused almost exclusively on CBT and a highly manualised stepped care model.

The current unprecedented pressures on Government spending, combined with an increasingly reductionist approach to mental health, with a focus on a high-volume short-term 'cure seeking' model, has resulted in psychoanalytically informed services coming under serious threat in the UK public sector.

The BPC recently conducted a joint survey with our colleagues at the UKCP. The survey received over 800 responses from psychotherapists working in the public sector:

- almost every respondent (97%) reported issues such as the downgrading of clinical posts, the freezing of posts, redundancies; temporary contracts, and pay decreases
- over two thirds (68%) reported increasingly complex case loads, longer waiting lists, premature ending of treatment and reduced choices of therapy for patients

So how have we arrived at this juncture?

How is it that psychoanalytic psychotherapy in Britain is feeling marginalised and under threat?

How, in the space of some 30 years or so, has the profession moved from being an exciting developing discipline, fashionable even, to something that is seen by some as isolated and out of touch and increasingly under pressure in the public sector ?

I'd like to offer up some suggestions from my perspective as the CEO of the British Psychoanalytic Council, and from my experience of working in healthcare for the last 20 years.

I apologise that my observations are rooted in a British perspective, but that is where my experience lies, but I don't apologise for seeming critical of the profession. I offer my observations as a friend and someone who passionately believes in the ability of psychoanalytic psychotherapy to provide real and lasting changes to people's lives.

For six years I ran a charity that, every year, provided 13,000 sessions of long term, weekly, psychodynamic psychotherapy. That experience showed me how profoundly life changing psychotherapy can be and I would like to see it universally available to those who could benefit.

At the famous 1918 Budapest conference, the early pioneers laid out their vision for the profession, seeing it as having three key components:

- research
- training
- and subsidised clinics

My contention is that the profession, certainly in Britain, has succeeded in just one of those activities, training, and even then only partially. Whilst the trainings are intellectually robust and underpinned by impressive academic credentials, they have developed in a fragmented and hierarchical manner and are not particularly economically or socially accessible.

Many training courses place intensive individual work in a complex hierarchical structure, with the training analyst and the apex. This has resulted in less intensive work, group

and couple work, being viewed as not quite real psychotherapy, and I'd like to pose the question: if the profession is not seen to rate this work then why should we expect others to do so?

In Britain, in the early years, these trainings developed in an ad-hoc manner, driven by passionate clinicians, often financed by wealthy benefactors and the fees paid by the trainees - public sector funding has only ever been realised in Britain for training child psychotherapists.

But we are now faced with the reality of this history with a high concentration of relatively small competing training institutions, often geographically concentrated in fashionable suburbs of north London, with an implicit orientation towards training to work in private practice.

Why does this matter? Well it matters because it makes the profession inaccessible for many people: financially, geographically and frankly socially and culturally, resulting in a professional demographic that does not reflect wider society. In this slightly rarefied climate, innovation has often been driven from an intellectual locus without regard to the changing external environment.

I'm certainly not going to argue that we lose our intellectual robustness, but I am arguing that training institutions need to become less hierarchical and more accessible.

Yes, continue training four-times- a-week analysts but also train less intensive modalities and, crucially, see these trainings as different, not inferior.

We also need to think and talk more about the core competencies required to work in a contemporary setting. I suspect that in doing so we might re-engage with professions such as social work and teaching: professions I'm told we were closely aligned to up until the 1970's but somehow have drifted away from.

A degree of rationalisation of training institutions seems inevitable, probably desirable, and indeed is already happening; and as this continues to happen, we need to consider how we rationalise the trainings themselves, gain economies of scale, ensure we make them more accessible to people from different ethnic and economic backgrounds, and crucially train people for the work that is likely to be available on graduation.

So what of the other two activities identified at the Budapest Conference in 1918: research and subsidised clinics?

Let's take a look at research first.

Otto Kernberg, in a paper with the provocative title "Suicide Prevention for Psychoanalytic Institutes and Societies", covers great swathes of issues facing the profession. His paper, published last year, resonated with many discussions we were having at the BPC and I'm sure many of you will have seen it.

In the paper, Kernberg clearly links success of the profession to engaging with the scientific community and the world of evidence, arguing that institutions must inject a research orientation into their organisational life, and establish an evidence base of effectiveness of the work.

I know from personal experience the extraordinary anxieties that this research can raise in the profession. When the CEO of a psychotherapy agency I announced we were going to commission Professor Peter Fonagy, of the Anna Freud Centre, to conduct an independent review of the effectiveness of the clinical work. The clinical team promptly presented me with a list of reasons why this was not a good idea, how it would be difficult; and, there was even a small group who seemed to think I should be removed from my post for making such a suggestion!

Well, we overcame the anxieties, did the research and, exactly as I suspected, it showed the clinical work was of good quality and was making a difference to people's lives.

Yes, we had to modify the methodology to get it right, yes I recognise that the instruments used to measure the outcomes can be debated, and yes I accept that such measures are subjective and the lived experience of the individual patient is what really matters; but the point was we had some statistics gathered and interpreted by a respected academic that suggested the psychotherapy was worth funding.

It is no coincidence that CBT has enjoyed real growth in the UK; our colleagues in the cognitive world have very effectively developed and publicised a body of evidence for the efficacy of their work. It was this evidence that Lord Layard took up and successfully convinced the Government to inject millions of pounds into developing CBT orientated services.

The Budapest Conference's third and final component of their vision was for subsidised clinics. This has (except on a small scale) proved to be the most tricky to deliver. But in 1918 the health systems that we now enjoy across Europe had not been created, certainly not in Britain, and I wonder if we should reinterpret this idea into more contemporary language and think of it as psychotherapy being available as part of each nation's public services .

Hansjeorg's paper illustrates how across Europe there is a divergence in the availability of psychotherapy: countries with an insurance based model tending to offer more intensive psychological therapies than those (like the UK) that have a centrally controlled system funded from general taxation: Hansjeorg arguing that it's the element of patient choice inherent in insurance based models that is driving this divergence. I would agree, and suggest that we all have to face the market and harness patient choice.

In the UK, psychoanalytically informed work is under very real pressure. The new CBT orientated services, as helpful as they are for many people, don't serve the needs of everyone. Indeed the UK Government admit that this service will only help half the people that need psychological and emotional support:

Using the Government's definition of 'recovery' official Department of Health figures appear to suggest that

- 40% of patients who complete treatment 'recover'
- 25% of patients who enter treatment 'recover'
- And only 15% of patients referred to the service can be shown to have 'recovered!

Perhaps these figures are inevitable, as it is a short term, symptom-focused, 'cure'-seeking modality. Of the 85% of patients who have not demonstrated 'recovery' I

wonder how many have had their anxieties made even worse by this highly manualised, reductionist approach. What is going to happen when those in serious difficulties, those chronic and disturbed patients, the personality disordered and the perverse, fail to be 'cured'?

Given an informed choice I suspect many would chose to access longer-term more-intensive psychoanalytically informed modalities.

It's this emphasis on a short-term cure that underlies the challenge that faces psychoanalytic psychotherapy in Britain. I'd argue that we need to find ways to properly engage and involve patients to help them articulate this need for choice. But patient involvement has not been something the psychoanalytic profession has been good at; often doesn't see the need for it or argues that it interferes with the therapy. I think we need to seriously think how we can involve patients and users as they will be our greatest allies.

So to conclude: my apologies again for drawing on my experiences in Britain. It is the experience that I have, but I look forward to hearing about your experiences today

In Britain it seems it is the 'social project' of organisations and training institutes that is missing, we have lost ability to respond and develop to the external world because it would compete with the centrality of intensive work.

We have arrived at a highly hierarchical profession with only one speciality. Imagine if medicine was only defined by neurosurgeons! We seem to be at best ticking over as a profession and not engaging in development.

Like or not, there is an external world that we need to engage with, and that world contains a market place with competing products.

We might get away by continuing to offer a "niche product" but it seems a risky strategy; the market is not a sentimental place. We are highly treatment led, often present ourselves as offering just one product, and could be accused of being very self serving - we do what we do because we like it and believe in it. What we don't do is project ourselves as providing a service which can, where it needs to, collaborate, modify its practices, and respond to contemporary concerns and social preoccupations.

Let's not forget the vision laid out almost 100 years ago in Budapest.

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