

**PROFESSIONALISM, EVIDENCE AND POWER:  
KEY THEMES INFLUENCING THE MANAGEMENT OF  
A MENTAL HEALTH PROGRAMME IN THE NATIONAL  
HEALTH SERVICE IN ENGLAND**

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**Thesis submitted in partial fulfilment of the requirements of the  
University of Hertfordshire for the degree of Doctor of Management**

**OCTOBER 2011**

## **ABSTRACT**

**Key words:** Competences; Complex responsive processes of relating; Evidence-base; Expertise; Mental Health; Research Method; Improving Access to Psychological Therapies (IAPT); Managerialism; New Ways of Working (NWW); Power; Professionalism.

**Key Authors:** Abbott; Clegg; Dreyfus and Dreyfus; Elias; Flyvbjerg; Foucault, Mead, Roth and Fonagy; Seddon; Stacey.

This thesis critically examines a national programme in mental health which has been driven by the implementation of National Institute of Health and Clinical Excellence (NICE) guidance. Assumptions which underpin research method, drawn from the natural sciences, are critiqued in terms of their adequacy in accounting for human relating and expert therapeutic practice. The work of Dreyfus and Dreyfus (1986) is problematized in how they account for proficiency and expertise as intuition and the leap that they make from calculative to deliberative rationality. An alternative source of understanding, based on non-linear causality and complex responsive processes, is developed, building on the work of Stacey (2001, 2005, 2007). The ineffability of expert practice (or clinical judgement) is contrasted with competence based, rule governed practice, which necessarily underpins the early stages of learning. It is argued that because research practices undertaken in randomised controlled trials (RCTs) must be describable, measurable and focussed on predictable outcomes, then these cannot account for expert practice, therefore the assertion that the Improving Access to Psychological Therapies programme (IAPT) is wholly based on research based, evidence based therapies, cannot be substantiated.

The work explores professionalism and specifically considers the role of psychiatrists, psychologists and psychological therapists in mental health and in increasing access to psychological therapies. The role of managers and managerialism are explored, specifically how the NHS has sought to manage

professional staff and multi-disciplinary teams in adopting corporate and new ways of working (NWW). This includes the importance of and difficulty in countering professional identity using competence based approaches. The performance management processes in the NHS are recognised as an equally relevant source of evidence (to that of NICE), despite there being a poor (traditional) evidence base for it (Stacey, 2010; Seddon, 2008).

Power relating in human relationships is identified as immanent, using the context of a management group, and it is argued that Foucault's concept of disciplinary power (1994) can account for what is considered to be knowledge and truth, drawing on specialist expertise based on science and research, with a forceful potential for rendering others silent as well as pervasively self-silencing, in processes of inclusion and exclusion (Elias, 1978). It is argued that these on-going processes of relating influence policy decisions at national and local levels and how these policies are implemented in practice. The inevitability of unpredictable outcomes is highlighted, despite strong centralised programme management along with the provision of an explicit blueprint for implementation.

## **ACKNOWLEDGEMENTS**

I would like to thank, firstly, Dr. Gordon Stewart for encouraging me from the outset to undertake the DMan and for supporting me through the process by reading my work and helping me find my voice.

Secondly, I would like to acknowledge the encouragement and rigorous challenge I received from my supervisor Professor Doug Griffin, my second supervisor Professor Ralph Stacey and the DMan course director, Professor Chris Mowles.

My experience of the DMan research process was greatly enhanced by my fellow students, particularly by my learning set colleague and friend, Mathilde Visser.

Finally, I would like to express my gratitude to my colleague Professor Graham Turpin for reading my work and ensuring that my reflections on my day to day work are fair and have resonance for others.

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## **SUMMARY OF ABBREVIATIONS**

BDT: Brief Dynamic Therapy

CBT: Cognitive Behavioural Therapy

CCTA: Creating Capable Teams

CEO: Chief Executive Officer

CPR: Cardio Pulmonary Resuscitation

DMan: Doctorate in Management

DSM: Diagnostic and Statistical Manual of Mental Disorders

GMC: General Medical Council

IAPT: Improving access to psychological therapies

IPT: Interpersonal Psychotherapy

LI: Low Intensity

NA: National Advisor

NHS: National Health Service in the UK

NICE: National Institute of Health and Clinical Excellence

NIMHE: National Institute for Mental Health in England

NOS: National Occupational Standards

NWW: New ways of working

PASS: Programme Analysis of Service Systems

PCTs: Primary Care Trusts

PMG: Programme Management Group

PSA: Public Sector Agreements

PWP: Psychological Wellbeing Practitioners

RCT: Randomised Controlled Trials

RTB: Realising the Benefits

TPS: Toyota Production Systems

UKCP: United Kingdom Council for Psychotherapy

## **INTRODUCTION**

The material in this thesis has been drawn from my experience as a participant in the development and implementation of a flagship programme of mental health policy on improving access to psychological therapies (IAPT). During part of this time, I led a separate but related national programme on the mental health workforce. The ways of thinking that have emerged from IAPT, as I have researched them in this thesis, are, I would argue, equally applicable to that workforce programme, and to many similar policy implementation processes in the NHS, and indeed in a great number of public and private organisations.

### **The reader's journey**

The method of this thesis has been to take up my direct experience of working as part of a management group on a national programme, to explore themes that have arisen for me as I reflect on my experience and to consider and compare authors to help me gain a greater understanding of what may have been going on. The reader will be taken through four projects: the first is retrospective, looking at my career to date and what has led me to undertake this research, leading to my question of enquiry. This question is how far professionalism, evidence and power influence change management in the NHS. Projects two, three and four explore each in detail. My argument as it has emerged from this work is summarised below. The final section is a synopsis and critical review, where I reconsider what I have come to think as I reach the end of the DMan research. In this, four themes have required greater analysis: the role of management as a profession; the theme of expertise and its problematisation in considering the nature of evidence; power; and finally method, because of the different assumptions underpinning research method in IAPT and the DMan. I finish my thesis with what I consider to be my contribution to knowledge and practice. This includes: that it is expertise that is a critical factor, for me, rather than professionalism, expertise based on evidence drawn from scientific research trials has high status and can influence policy development and evidence



from performance management is taken as seriously as evidence based medicine or practice in the NHS. Evidence, however, as it is currently promulgated cannot account logically for expert therapeutic practice and all are inextricably bound by disciplinary power in what can and cannot be questioned. Finally, irrespective of the specificity of a blueprint, it will always be interpreted differently in local situations, based on complex responsive processes of relating, building on the work of Stacey et al (2001) resulting in unpredictable outcomes.

### **The context**

To situate the subject of my enquiry, the national IAPT programme and my role within it, it is important for the reader to be aware that the National Health Service (NHS) consists of two key elements: generalist healthcare provided by general medical practitioners and nurses working in local communities (described as primary care); and specialist services provided largely in hospitals, through consultant medical practitioners and multi-disciplinary teams (secondary care). I came to the IAPT programme, which is located in primary care, having spent my career in secondary specialist mental health care. I have continued to work in a (specialist) Trust, throughout my involvement with IAPT. The issues which have challenged me most in secondary care have been the dominance of the psychiatrist, the ways multi-disciplinary teams operate and how far the needs of the person using those services are properly understood and met.

At the time of embarking on the DMan, there were two options available to me. Firstly, working as a management consultant to support the implementation of New Ways of Working (NWW) in the Trust, which would have drawn me to focus on professionalism and power. Secondly, working in IAPT, which had evidence based practice as its *raison d'être*. I would have preferred to do the former, but as luck would have it, my new role in the Trust took some time to bed in so I took IAPT as the main focus of my research. This has proved both interesting and challenging as it has opened up a number of questions, which have tested my taken for granted assumptions

in ways that may not have emerged had I relied solely on my work with psychiatrists and multi-disciplinary teams.

### **My argument**

I outline how I have (inadvertently) adopted a managerialist approach to managing clinicians. I now take this to be a naïve foundationalist stance, believing that a better understanding of the needs and views of people, who use services, embedded in policy, would transform professional practice. This approach has met with only partial success. I examine the role of the doctor as it has emerged historically and conclude, in psychiatry at least, that it has been equally, if not more importantly, influenced by its social status as by its clinical expertise. I argue that the status of psychology has grown because of its adoption of a scientist practitioner role and its promotion of a research evidence base. In contrast, I posit that the status of counsellors and psychotherapists has suffered by their fragmented organisation, their perceived historical lack of commitment to research and their perceived resistance to regulation. I discuss how I have supported the use of competences as a means of workforce planning, to challenge a professionally dominated process, but have come to recognise the limitations of such an approach, given the strength and importance of professional identity. I consider the assumptions underpinning the evidence base for NICE recommended psychological therapies and problematize the application of positivistic approaches to human relating. I argue that the target culture of the NHS, critiqued by Seddon (2008), although having a very limited evidence base, is taken as seriously as NICE guidelines by commissioners and policy makers. I critique the concept of expertise, as defined by Dreyfus and Dreyfus (1986), and contest the leap they make from rule governed to intuitive practice. I argue that evidence can only logically be based on measurable behaviour. As expert behaviour cannot be so described, then the scope of evidence based practice must be limited to rule governed behaviour. Finally, I identify the importance of power-relating in influencing what gets addressed in policy development and implementation and how we are all

subject to disciplinary power as described by Foucault (1994). I highlight how this is inevitable and the risks where silencing of conflict is a key factor.

### **Organisations and the context of complex responsive processes of relating**

Generally speaking, it is common to think of organisations as systems, operating at different levels, such as executive, middle management and team level, where the board sets the strategic direction for the organisation and staff are expected to implement the service, often requiring change, efficiency savings and improved quality. Performance is managed through activity, costs and adherence to standards, inspected and regulated by outside bodies. This process assumes that the chief executive is similar to the captain of a ship and that (s)he will guide and control the ship through stormy and calm waters and the crew will undertake their roles as required to run a tight ship; all is consciously planned and predictable. In the NHS, the complexity of the organisation(s) and the huge costs have come to be managed through performance targets, although there has been a constant struggle between top down and bottom up planning. Furthermore, the importance of managing organisational culture and winning hearts and minds is recognised as of key importance. Clinical staff working in the NHS, usually characterised as doctors and nurses, are clearly not corporate crew members and promoting their involvement in leadership and management is seen as vital.

From a complex responsive processes perspective (Stacey, 2001, 2007) there is no discrete organisation existing as a whole ‘thing’, rather, there are groups of people working and interacting together in different ways to implement policy targets, although they may take up the idea of the organisation as an idealisation. Of key importance is that whatever may be intended, no matter how clear, the meaning will be interpreted differently locally, because of the different professionals involved and the variable nature of services, including funding and local priorities, all of which are influenced by power relating. This local interpretation cannot be controlled nor fully predicted and the process of change is likely to be iterative. This analysis is based on the

complexity sciences of uncertainty, which I will discuss more fully later. At first, this perspective paints a rather alarming picture of potential chaos, because it contradicts a taken for granted view that we are all part of a managed system, which leaders can stand apart from and guide. On closer examination, most people will recognise how plans rarely get implemented in the way intended by policy or senior staff. The theory of complex responsive processes of relating is inspired by writers such as Elias (1978) and Mead (1934), by Stacey, Griffin and Shaw (2000), and by Foucault (1972, 1994). It is a way of thinking that is constantly changing and emerging and I will be taking up these authors to see what insights they offer in my thesis.

## **Method**

The research method that I have adopted is one of reflexive narrative. The DMan requires that narratives are reflexively contextualised to current working practice as this develops over a three year period. There is no initial hypothesis that is to be tested nor variables that are to be controlled and measured. As the process develops, the issues that emerge cannot be predicted in advance and therefore the issue of *internal validity*, whereby causal relationships and replicability are sought, has little meaning in traditional methodological terms; nevertheless validity is sought through plausibility with peers. *External validity or generalisability* has specific relevance however, as I am seeking to describe how what happens in a specific context can have relevance or resonance with my peers.

In my critical appraisal I conclude that this thesis has allowed me to look in depth at what I have understood to be taking place in managing a national programme. I present a critique of my assumptions based on reading and comparing authors who have contributed to the relevant discourses, and I have come to a better understanding of the social processes that have been taking place. Precisely because it is reflexively unique to my specific context, I argue that my research has direct relevance to others, offering insights into how people work together in organisations, often in unpredictable ways.

*I will now turn to my first project, which seeks to understand the influences and assumptions in my career to reach my research question.*

## **PROJECT ONE (2008/9)**

### **PROFESSIONALISM, EVIDENCE AND POWER: INFLUENCING CHANGE PROCESSES IN MENTAL HEALTH SERVICES IN THE NHS**

#### **INTRODUCTION**

I have reached a point in my career, where I have been reflecting on what I have achieved. My early experience as a clinical psychologist made me realise that trying to help an individual with learning difficulties on a one to one basis without regard to their social environment was not effective. Exploring what the social environment meant, in this case the institution, and realising this was its staff, its physical space and its routines, led me to think that it was ideally placed to promote deviant behaviour, not only in its residents, but in everyone involved. I wondered how I could change the system to develop alternatives to institutional care and practice; in doing so, I began to make a transition from being a clinician to a manager.

My experience has been that changing buildings/ physical settings is limited in its impact on the experience of the service user; the most important element is the interactions that they have with staff and with each other. This is much more difficult to influence, so a key area of interest and engagement for me has been the nature and behaviour of professionals - primarily, but not exclusively, psychiatrists. The work I have just completed has taken six years –New Ways of Working (NWW) in mental health - can be summarised as how to enable staff to work more flexibly in multi-disciplinary teams, to overcome their professional barriers and to shift some of their usual ways of working to meet the needs of service users and carers more effectively.

Although people in the NHS now commonly use the term ‘NWW’, I am doubtful that it has changed the way staff and multi-disciplinary teams work in any significant way and in this project and thesis I would like to explore why this is so. People who use mental health services still complain of the

same things they did ten years ago. So, I have thought, with growing frustration, commonly after having been in meetings with professional staff, what does it take to change things? I have made some things happen in organisations at a local level and have produced publications nationally, but my power, in the way I currently think about it, seems less effective than that wielded by clinicians as they go about their work and chat to their colleagues. The Royal College of Psychiatrists now wants 'evidence' that NWW is working, but this seems a thinly veiled attempt at securing complaints from psychiatrists in the field to discredit my work; exploring this will be a key theme of my research.

I am also involved with and will become more so, in the national programme on 'Improving Access to Psychological Therapies' (IAPT). This is a major change process to train 3600 new therapists by 2011. A key issue emerging is the power of evidence, that is scientifically based, and the implications for therapists already in the workforce who are not competent in what the evidence suggests. Some of this relates to professional practice and identity, some about the limitations of the concept of evidence and some to the imposition of a service and staff model on local services, which does not fit.

I am attracted to the idea that change is not predictable, that people who manage and practise clinically are not acting rationally and appear to muddle through. Some of the best experiences I have had have been working with teams who come up with their own solutions, not ones that I thought of earlier. The idea therefore that local interactions might be the key to things changing in ways, which service users and carers say would help them, is important to me. I am becoming more conscious that some of my assumptions as a manager, that modernisation is a good thing per se, that if it is right for the service user then it must be right in a taken for granted way, is probably open to challenge and that I need to reframe this. In this regard, the work of Ralph Stacey (2007) has drawn me to this research. I want to use the DMan research to help me think and do things differently, perhaps to experiment in my work, based also on other authors I have begun to read.

## **TRAINING AS A PSYCHOLOGIST**

### **The importance of a scientific approach and the development of evidence**

My entry into the world of applied psychology came when I trained as a clinical psychologist in England in the 1970's. Psychology places great store on being a science, with the scientist practitioner role at its centre and audit and research as key functions. At that time, in that place, the dominant discourse was that of Skinner's Operant Conditioning and Radical Behaviourism. It sought to provide a science of human behaviour that would enhance predictiveness and ultimately control. Skinner stated:

Social sciences are sometimes said to be fundamentally different from the natural sciences and not concerned with the same lawfulness. Prediction and control may be forsworn in favour of interpretation. (Skinner, 1953: 8)

He emphasised the benefits of taking a scientific approach, including focussing on facts, avoiding premature conclusions and searching for lawful relationships in nature. Behaviour was acknowledged as a complex subject as "it is a process, rather than a thing" (ibid.: 14), but statements about behaviour had commonly been about single events. Skinner argued that this was fine as a starting point, but the move should be towards discovering 'uniformity' or rules. He argued that, although behaviourism was often criticised as being reductionist, that starting from the simple did not negate its relevance to the complex:

In our present state of knowledge, certain events...appear to be unpredictable. It does not follow that these events are free or capricious. (Ibid.: 17)

This approach appealed to me as there was a lot of material about the use of operant conditioning to change behaviour in clinical and educational settings which had practical relevance.



Two points strike me on reflection. Firstly, the role of the observer in that “(i)t is now accepted as a general principle in scientific method that it is necessary to interfere in some degree with the phenomenon in the act of observing it” (ibid.: 21); this will be relevant in thinking about the interpretation of a scientific approach and the status of evidence in the NHS. Secondly, how behaviourism can be seen as denying internal processes of self, mind and consciousness.

(T)he objection to inner states is not that they do not exist, but that they are not relevant to a functional analysis. We cannot account for the behaviour of any system while staying wholly inside it; eventually, we must turn to forces operating upon the organism from without. (Ibid.: 35)

Natural scientists had assumed that the mind required a different mode of enquiry and Skinner criticised this, commenting “(t)he contribution which a science of behaviour can make in suggesting an alternative point of view is perhaps one of its important achievements” (ibid.: 258). This resonates with Mead (1934), who stated:

Behaviourism in this wider sense is simply an approach to the study of experience of the individual from the point of view of his conduct, particularly but not exclusively, the conduct as it is observable by others. (Mead, 1934: 2)

This in turn led to his transforming the behaviourist argument and developing more fully the social nature of human beings and their interaction in terms of the “generalised other”. I plan to return to Mead’s work and the relation of his thinking to behaviourism in the course of my research.

In my practice, over time, I found the application of the principles of operant conditioning to more complex interactions, social situations and

organisations, although a stimulating intellectual exercise, was less helpful in getting to grips with how to make changes in those areas.

### **The relevance of evidence**

Many of the approaches and interventions used in mental health are not evidence based. The National Institute for Health and Clinical Excellence (NICE) was established in the NHS to provide clinical guidelines for practice and commissioning based on “best available evidence and expert consensus” (NICE 2009). This is a collaborative process, but starts with considering studies that are based on randomised controlled trials (RCTs). Those interventions in mental health that lend themselves most easily to RCTs are largely around medication and types of cognitive behavioural therapy (CBT). Many psychological practitioners take exception to RCTs being the gold standard of excellence in demonstrating evidence of effectiveness. This is a major issue currently in the national IAPT programme.

A question here is: is psychology a natural science, like physics, or a social science, like sociology? It is usually classified as the latter. In this case, Flyvbjerg’s (2001) analysis of why social science or inquiry has failed - because it seeks to emulate both the theory or ‘know why’ (episteme) and the ‘know how’ (techne) of the natural sciences - and should be more focussed on context and values (phronesis), is relevant. Nevertheless, in seeking to test out psychological interventions through RCTs, psychology, as a profession, is clearly wishing to model itself on natural sciences and to be on a par with medicine.

### **My first encounters with the question of professionalism**

During my clinical training, my perceptions of professionals working in the NHS began to form. On one occasion, during a medical training session, a person with schizophrenia was brought in and his symptoms were discussed at some length in front of him but without his involvement; eventually a diagnosis was given and medication agreed upon. No thought was given to

his feelings or to his broader needs. Although I was a novice, I felt that this illustrated a narrow, pseudoscientific and inhumane approach. The doctors were seeing the brain as the object and its functioning modified through medication as the primary explanation and treatment of the condition, without reference to the person as a whole.

About this time an 'anti psychiatry' movement developed, led by people like R D Laing (Boyers, 1972). This challenged the view that doctor knows best and acknowledged that physical and medical interventions could be actively harmful. The effects of long term psychotropic medication were beginning to be understood, causing, for example, Parkinson's Disease in long term users. I remember being asked to do some work with a woman with Obsessive Compulsive Disorder; on my second visit I found she had been moved and on enquiry, was informed that she had had psycho-surgery (lobotomy). *One Flew Over the Cuckoo's Nest* (Kesey, 1962) was made into a film about this time and its theme resonated with me and my fellow students very forcibly. The hero in the story, Murphy, has elected to plead insanity to a crime in the belief that a spell in an asylum will be easier than going to prison; he gets away with it and is pleased that his ploy has paid off. As he becomes a patient, he hides his medication as he can see the effects it has on other patients and he goes on to radicalise them to take back control over their own lives. Although this produces positive responses in the patients, it is seen by the professional staff as a challenge to their authority. Too late, he realises that his duration in hospital will depend on his perceived response to treatment and that he has fewer rights than he would have had in prison. He is ultimately given a lobotomy which results in him being powerless. For me, in reality, psychiatrists seemed hugely powerful. I did not see any expert psychology role models in mental health settings, and so I did not feel I had sufficient means of explaining or interpreting people's verbal behaviour (therapy), nor sufficient skills to be effective in counteracting what I perceived to be unquestioned medical primacy.

## **THE IMPORTANCE OF MY FIRST NHS JOB**

In contrast with mental health, I felt that I could make a contribution by joining a department of radical behavioural psychologists working in a hospital for people with learning disabilities, where I had had a successful placement. We worked as a team and were able to modify behaviour under controlled settings, e.g. enabling people to eat by themselves, dress and speak a few words, as well as reducing inappropriate behaviours. But these behaviours disappeared when the individual returned to their ward. Very clearly, the hospital ward, and the staff within it, had shaped and maintained dependent and inappropriate (sometimes life-threatening) behaviour.

Many of hospital residents had been rejected when young (often on medical advice) and been put into care. There were still children there, but contact with an adult was only a few minutes per day. There were no “ordinary” rhythms of development and routine, the large numbers of residents (about 30 on a ward) meant that they were treated as a group rather than as individuals. Staff were trained to look after rather than to enable them to do things for themselves. There were long periods of time when individuals were not engaged in any social interaction, they would become apathetic but also violent to themselves and others: head banging, eye gouging and other behaviours were common. Their lives were being wasted. From a behavioural perspective, they had a very limited repertoire of ‘appropriate behaviours’, resulting from an absence of opportunities to learn new skills and ways of interacting. Instead, staff tended to spend time doing things for them or in intervening to stop them doing things, both of which served to promote dependence and increase levels of challenging behaviour.

The hospital was powerful in maintaining the status quo. Staff, originally enthusiastic, were changed by working in these settings. It also seemed their training contributed to their formulation of the needs of the people with learning difficulties as having a pathological or medical origin. We trained staff in changing behaviour: principles, analysis, techniques and monitoring, but there were frequent occasions when observation charts were not

completed and programmes of intervention not followed. As a result, I found my view of nurses was developing in a negative way. I blamed them for not collaborating with us to improve the experiences of their patients. As a psychology team, we perceived ourselves as innovators. But on reflection, although we were well intentioned and ahead of the technological game, we were arrogant about our superior psychological formulation and practice and no doubt came across to others like that. We were not working in a ward 24 hours a day and thus not gaining that knowledge of being with the person on a continuing basis, which Benner (2001) identifies as one of the significant contributions of the nurse. All in all, despite our self-perceived superiority, we as psychologists were powerless to influence the institutional practice, except at the margins.

### **The importance of values**

Skinner might help us understand what was going wrong, but I concluded, from my position of being based in an institution, that there needed to be a better way of understanding, planning, delivering and evaluating good services, which he did not provide. So, in 1980, with the encouragement of Chris Gathercole, an eminent psychologist at the time who was proselytising about a new approach in learning difficulties, I attended a five day residential course on 'Normalisation' and the 'Programme Analysis of Service Systems' (PASS) Implementation of Normalisation Goals (Wolfensberger, later published in 1983). This was what I had been wanting – a clear articulation of values and of how individuals identified by society as 'deviant' (different from social norms in a negatively valued sense) not only suffer from that primary impairment (e.g. learning disability), but they then are handicapped by our response to them: segregation, labels, loss of relationships and of a hopeful future. As a result of this analysis, services could be identified which could re-dress the process and break into the vicious circle of devaluation and non-achievement. These included ordinary housing, mainstream education, jobs, good health care and so on (all with support appropriate to individual needs). What staff were called, how they dressed, how they addressed their clients, all became highly relevant and influential.

These five days changed my professional life dramatically. The nature of the training had been exacting and persuasive in that it drew on real life examples, was delivered by an inspirational leader and had us applying a process of assessment in real life settings. I came away with a means of understanding and articulating why we did things, the importance of values, philosophy and culture and how these had long term and often unconscious effects. But just as important, I had a way of envisaging what future services could look like for people with disabilities. I could describe it and it was simple – they needed the same opportunities as everyone else. ‘An Ordinary Life’ (1981) was subsequently published by the King’s Fund and had a key impact on thinking about disability in England.

Interestingly, the term ‘normalisation’ used here is different from that of Foucault. Wolfensberger talked about normalising everyday experiences and opportunities to improve access to valued roles in society by people with disabilities. Foucault (1976) meant it rather, as a way of classifying people around a norm, whereby anomalies or deviance from the norm were identified for corrective purposes.

Back at work, I started immediately to apply the standards I had learned to current projects. Needless to say, I found myself unpopular: changing the planning of buildings, once underway, is well nigh impossible; but the psychological readjustment, an admission that we had all been wrong, was not acceptable to people who had not been through my “conversion experience”. This was the beginning of my career in change management.

## **INITIAL REFLECTIONS**

The origin and nature of the psychiatric institution has been described by Foucault (1994). He chose this area of inquiry as the foundation of an analysis of power because

...if, concerning a science like theoretical physics...one poses the problem of its relations with the political and economic structures of

society, isn't one posing an excessively complicated question? Doesn't this set the threshold of possible explanations impossibly high? But on the other hand, if one takes a form of knowledge...like psychiatry, won't the question be much easier to resolve, since the epistemological profile of psychiatry is a low one and psychiatric practice is linked with a whole range of institutions, economic requirements, and political issues of social regulation? Couldn't the interweaving of effects of power and knowledge be grasped with greater certainty in the case of a science as 'dubious' as psychiatry? (Foucault, 1994: 111)

Clearly the scientific credentials that most psychiatrists would emulate are not rated highly by Foucault, and this is echoed by other branches of medicine. He is also alluding to the fact that the evidence base for psychiatric practice at that time was not convincing. The early development of the institution, in his view, together with the growth in the importance of the doctor resulted more from a 'being there' way of interaction between the doctor and the patient rather than any interventions that could be shown to be scientifically effective.

In thinking about the development of psychiatry, Foucault in *Madness and Civilisation* (1961) described his schema of three ways by which the person (the subject) is objectified. Firstly, through 'dividing practices', such as the establishment of the Hôpital Générale in Paris in 1656, where the poor, the insane and vagabonds were confined together, moving through to classification of diseases and the rise of modern psychiatry in the 19<sup>th</sup> and 20<sup>th</sup> centuries; secondly, through 'scientific classification'; and thirdly, through 'subjectification'. In this case this was about the establishment of the doctor-patient relationship and the willingness of the patient to subject himself to the practice i.e. become an object.

Scott describes the development of a theory of state since the 16<sup>th</sup> century, through, for example, "maps of legibility" (1998: 3) to enable states to classify and control its subjects. Foucault uses the concept of

‘normalisation’ or scientific classification (Rabinow, 1984: 8) whereby people were differentiated with the purpose of control, which influenced the direction of law and medicine in the 19<sup>th</sup> century. Classification could take place through isolation of ‘anomalies’ and corrective or therapeutic procedures could be instituted. All were intended to collect detailed knowledge about and exercise strict control over the population in the name of its welfare. The legacy of these processes could be seen in the long stay hospitals that were still thriving in the middle of the 20<sup>th</sup> century.

## **MOVING INTO MENTAL HEALTH SERVICES**

### **Beginning to question power relations**

I had been successful in developing some innovative community services and moving people with learning disabilities from long stay institutions into them, with positive results. On reflection, I believe I was able to do this because I had moved to a new area, where there had been no institution, no established hierarchies and traditional ways of doing things. I was leading the process of service development, supported by an operational manager, who was forward thinking. My vision was completely based on a belief in normalisation and I had had little opposition to this perspective. It was only when my organisation merged with another and the new chief executive asked me, in 1989, to move into mental health services that power and conflict became a core issue for me. My task was to set up a resettlement team to help move people out of the long stay psychiatric hospital. Although the hospital had been planned for closure for several years, no action had been taken by managers or clinicians to do this. My boss was determined to close the hospital at last, and I would be instrumental in the process.

It had been fourteen years since my last exposure to mental health services and it proved to be a complete shock for me. I was struck by the attitudes of staff and of nurses in particular, who seemed to see mental illness symptoms and not the person, echoing my earlier experience. For a period of time I was seriously worried that I was being naïve. After all, I had never worked in



mental health services, I was not an expert therapist, and perhaps things really were different in the mental health world. This reflected my lack of experience in this area of work and unfamiliarity with the dominant medical discourse, which in any case I was resistant to. Benner's (2001) view of the caring role of the nurse differs from my experience of them; describing the role of nursing as including caring for as well as enabling the person to regain their independence.

In 1991, I was given the role of Director of Planning and was charged with closing the psychiatric hospital and designing and implementing a community based service, by 1995. I set about developing a service user group to help advise me and organised an important event that helped shape strategy, called a 'Search Conference', where external facilitators worked with a multidisciplinary stakeholder group, including service users and carers. People were asked to consider what their ideal future would look like, what their current experiences were, what the gaps were and what needed to be addressed to redesign services. What emerged was in sharp contrast to current services and to the plans of the professionals. This was essentially a 'modernising' agenda, arrived at democratically by gaining consensus from the group of stakeholders. I used this as a mandate to move forward to plan on this basis in a rational manner.

I established a set of multidisciplinary project groups with service users and carers as members, to develop proposals on how all of those elements could be developed. On the face of it, this was a strongly managed, inclusive, process, but behind closed professional doors, forces were gathering to protect power bases. Specifically, from the psychiatrists' perspective, this was to re-provide the same number of acute admissions beds as they had already (as this was generally seen to be their power base). Audits of admission were carried out, however, to identify where admissions could have been avoided and what services could have made this possible. It showed that there were real alternatives with fewer beds; but none of this was fully embraced by the consultant body, which mistrusted the data as evidence.

## **Interpreting evidence from professional perspectives**

Let us consider a concrete example, in older people's mental health services. I was persuaded by a psychologist to use a model of demand and capacity, which suggested that a huge change in services was feasible: reducing from 62 beds to 12 because most people could be supported at home, and changing the staff skill mix to a ratio of two support workers to one qualified professional, resulting in a radically different service model. It was piloted for a year and found to be successful and was implemented fully from 1995. Success was measured by quick access to the service, satisfaction from service users, their families and GPs, as well as managing within the reduced number of beds. The effectiveness data were there.

It seemed that this was successful because there was a robust methodology, based on need. Unusual in mental health services, there was a clinical champion, the psychologist, a rigorous researcher, who collected data on the use and quality of services, thus creating an evidence base. There was a management champion, me. But there was a weak psychiatrist base – there was one consultant for an older population of 30,000. This was contrary to the Royal College of Psychiatrists norms which recommended three full time consultant psychiatrists for this population size. The consultant in question was specifically recruited to work to the new model.

But, within a year problems emerged. The consultant decided he wanted his own outpatient clinics, rather than just working with the team (a traditional approach leading to potential duplication of effort). Some social workers were unwilling to carry out a 'core' assessment (one done by everyone irrespective of discipline) because some of the questions were psychological in nature. Some nurses felt more comfortable with more qualified nurses rather than support workers. It was, therefore, hard work to keep the process on the rails and meant me having regular meetings with all concerned to trouble shoot.

Subsequently, the hospital was closed and a modern, dispersed, community based service was implemented. Staff were transferred to their new community posts and although the buildings had changed and some training was provided, they continued to talk and behave in ways they always had. Indeed, the manager of our service user network, with whom I had worked closely to develop plans for the new service, said to me one day ‘it is all very well you involving service users in planning, but when they see a psychiatrist in an outpatient clinic, they do not feel that they are being listened to and you can’t do anything about that, can you?’ Although by that time I had been made an executive director for the Trust with strategic responsibility for mental health services, he was absolutely right. I had not been able to influence the clinical practice of psychiatrists and other professionals. This has led me to reflect on the power of professionals, why they did not want to be challenged nor change and how I could address this more effectively.

## **FURTHER REFLECTIONS ON THE INTERWEAVING OF POWER AND EVIDENCE**

In thinking about a rational approach to change and accumulating evidence to support decision making, the issue of what constitutes evidence and who defines it through this process is a classic example of one of Flyvbjerg’s propositions:

Power determines what counts as knowledge, what kind of interpretation attains authority as the dominant interpretation. Power procures the knowledge which supports its purposes, while it ignores or suppresses that knowledge which does not serve it. (Flyvbjerg, 1991: 226)

Much of what I was trying to do was logical, planned and had been agreed through consensus, but it did not seem to work that way in practice: services emerged that were similar to, but definitely not the same as, what had been agreed. Stacey (2007) recognises this, in articulating a different way of conceptualising organisations as *complex responsive processes of interacting*:

From a complexity perspective, stability, harmony and consensus cannot be equated with success and unpredictability is fundamentally unavoidable, making it impossible to talk about being ‘in control’. The ‘whole’ is not designed or chosen in advance because it emerges in local interaction. Such emergence is in no way a matter of chance because what emerges does so precisely because of what all the agents are doing or not doing. (Stacey, 2007: 237)

Among Flyvbjerg’s propositions arguing the relationship between rationality and power, he states that rationality is context dependant, “...whenever powerful participants require rationalisation and not rationality, such rationalisation is produced” (Flyvbjerg, 1991: 228). He cites Machiavelli from *The Prince*.

We must distinguish between (t)hose who to achieve their purpose who can force the issue and those who must use persuasion. In the second case, they always come to grief. (Machiavelli, 1984 [1591]: 51-52)

In relation to the struggle to maintain the new service, this resonates with Flyvbjerg’s proposition six: “(p)ower relations are constantly changing (and) demand constant maintenance, cultivation and reproduction” (1991: 231).

## **THE BROADER QUESTION OF PROFESSIONALISM**

### **TAKING UP A NATIONAL ROLE TO ENABLE NEW WAYS OF WORKING (NWW)**

In 2003, I took up the post of Director of the National Workforce Programme for the National Institute for Mental Health in England (NIMHE), which was established to support the practical implementation of Department of Health policy. I was very aware of the dangers, in working at a national level, of becoming remote from services. I had often felt that the further away managers get from what happens at grass roots, the more likely they are to get it wrong. But I knew the limitations of facilitating and sustaining local change, particularly where there were national barriers, and felt this was an opportunity to see if I could make a difference by working at a national level.

My opportunity arrived quickly. The then President of the Royal College of Psychiatrists had approached Ministers to see if anything could be done to address the crisis of recruitment and retention of consultant psychiatrists. Since psychiatrists were a key group in the workforce, it fell to me to work on the project. Their stories were similar: large caseloads, a feeling that the buck stopped with them, a resentment at the high usage of locum psychiatrists (who were paid twice as much as them, did less work and were often of poor quality (SCMH/NIMHE 2005)). They expressed their discontent, were heard and were presented with some challenges: how to make the best use of their time and how they might work with others to take on some of their work and responsibilities.

#### **Beginning the process of challenging professional boundaries**

NWW was born. We focussed on how to use the expertise of the consultant most effectively, how to extend the role of other professions to take on some of their work and how to develop different roles to bring new people into the workforce: all to improve the experience of the service user, their carers and

supporters. We published extensively (2005, 2007, 2009). Below, I highlight some specific aspects of the work.

*Defining the limits of clinical responsibility:* The General Medical Council (GMC) ruled that consultant psychiatrists were NOT responsible for all patients seen by the team nor for the work of other team members, but they were responsible for those patients they saw directly and for the quality of their advice to others. This confirmed that other professional bodies expected their members to be accountable for what they did within their professional scope of practice. They could not assume the doctor would take clinical responsibility for their work.

We reviewed and amended College *Guidance on the employment of consultant psychiatrists* and replaced it with new joint guidance in 2005, sponsored by Trust Employers and the College, without norms but with ‘indicative numbers’, which was a compromise. Since then, the interpretation of the guidance has proved conservative, so a more radical revision, which removed all reference to numbers, was published in May 2009. The College has signed up but its commitment remains to be seen. As Flyvbjerg comments “...constitution writing and institutional reform may often be essential to democratic development, (but) the idea that such reform alters practice is a hypothesis, not an axiom” (Flyvbjerg, 1991: 234).

*Changing practice through pilot sites:* Some key changes in psychiatric practice emerged through funded pilots. One, in Bromley, reviewed the use of outpatient clinics where consultant caseloads were commonly 350 to 500; it found that 46 doctors could reduce their workload by 60%. Additional freed up doctors could then see people quickly in a crisis, thus being much more accessible: a win-win for all.

Describing the *Distinct Contribution of the Psychiatrist:* It was felt important by psychiatrists to clarify this as part of the process in case there was a move to ‘de-medicalise’ the workforce. Subsequently, all professions produced their own “distinct contribution” paper. Although I was not personally in

favour of this, as I felt this would serve to emphasise difference as opposed to working more collaboratively to meet the needs of service users and carers, I recognised this was important to their professional identity.

*Developing a methodology for analysing cross professional working:* We looked at what only one profession could do, what they could give up if others were able to take on those aspects and what they would like to do if they had the capacity. The emerging matrix showed clearly that there were very few tasks that only one profession could do. But, everyone was dissatisfied with it as they felt it was a reductionist view of multidisciplinary working. What was much more important was how each professional approached the formulation of peoples' needs. Dreyfus and Dreyfus found that expert practitioners often find it difficult to articulate what it is that they do in clearly differentiated terms as "the performer is no longer aware of features or rules and his/her performance becomes fluid, flexible and highly proficient" (1977: 12). Eventually, the group came to the view that we were approaching it from the wrong direction and needed to shift from a professional to a service user focus. To help teams apply the process, we developed the *Creating Capable Teams Approach* (2007): a way of addressing NWW in a systematic way within teams. Interestingly, I always insisted that it was described as an 'approach', but others were keen to label it a toolkit.

The final major publication, *New Ways of Working for Everyone* (2007), describing what NWW meant for every profession, was widely welcomed. Employers were struggling, however, to implement NWW comprehensively across their organisations. It was still largely dependent on enthusiasts working at an individual level, changing their own practice and providing leadership in teams and services. So, to assist managers in organisations in a strategic process, we produced an *Implementation Guide* (2007) and ran a series of learning sets for directors and senior clinicians in 38 trusts in England. Results confirmed that Trusts had a long way to go with workforce reform and modernisation.

## **An emerging backlash**

A telling confrontation occurred in summer 2007, in the final stages in the preparation of the Mental Health Bill. The role of the doctor as *Responsible Medical Officer* was proposed to be replaced by that of a *Responsible Clinician*, which could be undertaken not only by a doctor but also by other professions. The British Medical Association (BMA - the medical 'trades union') and the College asked for an eleventh hour change to restrict that role to doctors. They were unsuccessful and from November 2008 that role has been open to all professions. This challenge was a flash point for psychiatrists and a significant backlash to NWW has ensued, articulated in an article by Craddock (2008) titled 'A wake up call for psychiatry', which suggests a loss of identity and authority for the profession. This has been a rallying call for the disaffected.

Since the Blair Labour government came to power, there has been huge investment in the NHS. Regular staff surveys however, suggest that doctors and nurses were not positive about the NHS. The Prime Minister in 2007 therefore commissioned Lord Darzi to produce his 'Next Stage Review' (2008). This highlighted the importance of clinical staff not only delivering clinical care but being team members and service leaders: described as "new professionalism". This is seen by some as an opportunity to reassert old hierarchies, whilst one of its key intentions is to draw practitioners into leadership roles. The current president of the College is re-writing his definition of the role of the doctor, which reasserts that the doctor is responsible for the work of the whole team - the position that we clarified was NOT the case in 2005. My programme finished in March 2009 and led to an outburst of triumphalism from those who dislike NWW. The outcome remains to be seen.

## **SUMMARY AND CONCLUSION**

My career as a psychologist and manager has been a set of transitions from seeking to understand people at an individual level to understanding how to



change systems for more radical and sustainable transformation. Skinner's radical behaviourism offered the most promising discourse to me in working with people with learning disabilities, where working with carers/their environment was of key importance. Understanding how we are shaped by our environment can seem to be, but is not necessarily, simplistic nor reductionist. There is a tendency to look either outside or inside the person for explanations as though these are alternatives, but Mead identified how the two could inform one another; this was to be echoed by Skinner.

Conceptually, this made sense but it did not offer me a way of thinking about institutionalisation and how or what alternative shape this should take. My influence in 1980 was Wolfensberger's notion of 'normalisation'. This clearly drew on Foucault's analysis of the rise of the asylum and the evolving role of the doctor, where he described how he produced a set of tools for local use, without a prescribed outcome. I suppose the PASS manual developed by Wolfensberger, was just such a tool or more importantly a way of thinking, based on a clearly articulated set of values, which proved invaluable to me in identifying what needed to change in services. I was able to facilitate changes in learning disability services. When it came to mental health, however, I found not only a different way of interpreting behaviour, based on a medical model, but also that this was firmly located in the role and hence the power of the psychiatrist. This was altogether a different discourse for me. It was what I had perceived and avoided many years earlier.

The developing importance of the role and power of the psychiatrist has its origins, according to Foucault, in wise and moral philanthropists in early institutions, such as Samuel Tuke, the first doctor appointed to the Retreat in York. Their influence was perceived as quasi-miraculous rather than scientific. Developments in the 19<sup>th</sup> century changed that role but not its importance, shifting to psycho-analytic and then to biological interpretations of mental illness in the 20<sup>th</sup> century. This almost unquestioned power of the doctor is still with us today - the expertise whilst it can be considerable, is not infallible, and can be harmful, particularly in the field of mental health.

The power of professionals has been a continuing theme throughout my career: how they interact with one another, on an intra and inter disciplinary basis, their perception of management (from the dark side) both locally and nationally, and the great variation. All have proved to be both fascinating and infuriating. The formal and the informal processes at work, the political and the realpolitik at the Department of Health and at the Trust Board, show how important it is to be aware of power and how it can be made to work. A rational approach to change, with explicit benefits for all, articulated in lucid documents, has proved to be necessary but not sufficient to effect change on a large scale.

A theme from NWW is about the importance of defining and using competences to describe what an individual and a team might need to demonstrate in order to deliver effective interventions. Competence underpins the analysis of the developing practitioner and this, of itself, has led to defensiveness in the workforce. I feel this approach has strengths and drawbacks: it helps flush out what people can mystify as their ‘clinical judgement’, but it can atomise behaviour into such small elements that become unwieldy and overly protocol driven. There has also been a time honoured approach in the NHS (and elsewhere) of people going on training courses, but not being able to use their learning and skills on return to the workplace. There can be an assumption, too, that an expert practitioner has transferable skills, that almost becomes a ‘trait’. Benner suggests that: “skilled performance is defined situationally rather than as a talent or trait that transcends all situations” (2001: 178). This could be highly relevant in understanding why some psychiatrists are reluctant to change their practice through NWW, such as by reducing outpatient clinics and specialising more, as they may not feel they have the expected expertise to work differently in new settings.

All of this has been happening in the context of an evolving scientific paradigm. Power and position are enhanced by evidence, usually drawn from the physical sciences. This is a developing area of importance in the NHS; and in mental health, where psychiatrists and psychologists are perceived to

have the greatest expertise. This does not change the fact, however, that much of what is done in mental health services does not have such an evidence base. This has resulted in two perspectives: firstly, that staff spend much of their time doing things that should be stopped (e.g. tea and sympathy); and conversely, that service users are helped by some interventions that are not NICE approved - these can be articulated by them and by practitioners. Both have led to people feeling aggrieved. Interestingly, the call for evidence of the efficacy of NWW is rarely juxtaposed with the need for more evidence for traditional ways of working. This reinforces the point that what constitutes evidence and how it is collected is politically as well as scientifically determined. This issue is gathering strength in relation to psychological therapies.

It is not clear to me, as I reflect on implementing NWW, if I could have done things differently that would have influenced this change in the views of the upper echelons of the College and of some psychiatrists in the field. I doubt it, as it is the result of a myriad of conversations and debates up and down the country. The sociologist Elias, reflecting on the rise of the social sciences, commented on new ideas that challenge the established order, observing “that the greater the anger and passion aroused by the conflict, the less chance of a changeover to more realistic, less fantasy-laden thinking” (1978: 22) there is likely to be. Scott (1998) reviewed how often well intentioned national schemes had at least unlooked for, and sometimes downright harmful, effects on the recipients, taking as examples political, economic, urban planning and environmental schemes. It is likely that some critics of the NWW programme would perceive it as just such a catastrophe: they thought it was worth trying just because there was a shortage of psychiatrists. For them, it had the unlooked for outcome of seeing other professions taking on work that traditionally only they did. The same is true for other professions, some psychologists are bemoaning ‘giving away’ (a frequently used term) their psychological skills, particularly in the light of the national IAPT programme.

At the beginning of the process of NWW, I had no real idea where it would lead; I knew we needed to clarify and get away from restrictive practices, but the form that new ways of doing things would take was not clear to me, nor anyone - there was no blueprint. The unpredictability of change is unsurprising therefore, as Scott says: “(v)irtually any complex task involving many variables... values and interactions cannot be accurately forecast” (1998: 327). The implementation of NWW was left to local people, there were no targets and the CCTA was developed to help individuals and teams come up with their own solutions. This might be described as using the ‘know how’ or the practical skills of local practitioners and teams to solve their problems based on their own knowledge. This is part of the current strategic direction of the Department of Health - local decision making at all costs. However, the frequent experience in mental health teams is of unhelpful power differentials, inefficient services and disrespect of staff and service users alike. The principles of NWW are quite general and so they require “...translation if they are to be locally successful” (ibid.: 318). It would be a mistake, however, to think things are not changing. As Oakeshott observes:

The big mistake of the rationalist...is to assume that ‘tradition’, or what is better called ‘practical knowledge’, is rigid, fixed and unchanging... No traditional way of behaviour...ever remains fixed... Its history is one of continual change. (Oakeshott, 1962: 31 )

But these changes are likely to be slow and incremental. So far in the NHS, this has led to very variable and therefore inequitable services and to what is referred to as a ‘post code lottery’.

So, I am interested in thinking more about how there can be more timely, effective shifts in practice and attitudes in mental health services. Flyvbjerg suggests that there needs to be a re-orientation towards what is actually done “(i)nstead of thinking of modernity and democracy as a rational means of dissolving power, we need to see them as practical attempts at regulating power and domination” (1991: 236). Foucault reminds us that power is often

negatively viewed as repressive, but the reason that power has such importance is “...simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse” (in Rabinow, 1984: 61).

In trying to bring about change, Scott (1998: 345) has some practical suggestions: take small steps; favour reversibility; plan on surprises; and plan on human inventiveness. I am therefore keen to explore what using power, in the context of a rational framework, can look like in local services and national policy implementation.

Having spent my career trying to straddle a top down and bottom up approach to service development, I would like to use the DMan research process to help me think how local interaction could help me address the issues of professionalism, evidence and power in mental health services in the NHS

*I will now move to my second project to focus on professionalism, which is based on my involvement with the national programme to increase access to psychological therapies.*

## **PROJECT TWO (2009)**

### **HOW ISSUES OF PROFESSIONALISM ARE SUSTAINING AND CHALLENGING THE POWER RELATIONS IN A NATIONAL NHS PROGRAMME**

#### **INTRODUCTION**

I have been working on an English national programme to improve access to psychological therapies (IAPT). The government announced, in 2008, that it would provide £173m to fund the programme to enable 900,000 more people with anxiety and depression to access evidence based psychological therapies by 2011. The national target is to train an additional 3,600 therapists to deliver therapies, recommended by NICE. The rationale for the investment, put forward by a member of the House of Lords (Gerald<sup>1</sup>), was that as a significant number of people on incapacity benefit were suffering from anxiety and depression, if they could be helped by therapy back into work, this would be a short term investment, that would save money in the longer term as well as promoting 'happiness' in the population. Project two is about how I have experienced the implementation process of this programme, primarily in the context of the Programme Management Group (PMG), both through the formal meetings and the informal communications outside the meeting.

The management structure of the IAPT programme has two components: a core group of relatively junior generalist staff, headed up by a general manager, and a number of National Advisors (NAs) to the programme. The latter have gradually joined the programme, some explicitly because of their clear expertise in this area, some have just appeared without a clear explanation and others have been inherited from other programmes - I am included in this last group. Some members of the core group, all the NAs and Gerald are members of the PMG.

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<sup>1</sup> Names have been altered to protect identities

The PMG meetings take place monthly and are usually chaired by the senior civil servant in the mental health policy branch of the Department of Health. They are attended by John, the IAPT programme lead, a general manager by background, who usually sits next to the civil servant, whom he always pre-briefs. Gerald and the NA on Clinical Issues (Derek), who is a psychologist and world expert on the use of Cognitive Behavioural Therapy (CBT) in people with anxiety disorders, usually sit next to one another as they have collaborated from an early stage in the process and both are academics. The NA for Informatics (Ricky) is a nurse therapist, educator and researcher, brought in because he was led one of the early IAPT demonstration sites. Other NAs include Primary Care – Abe, a general medical practitioner; Education and Training – Brian, a psychologist, educator and academic; Counselling and Psychotherapy – Jack, a clinician with a non CBT power base; Service Users – Luke; Carers – Laura, and me, as Workforce lead.

## **BACKGROUND AND THE TENSIONS IN THE IAPT PROGRAMME**

The starting point for the IAPT programme was to implement NICE guidance on anxiety and depression. There was little doubt, at a national level, that this was the correct thing to do. The psychological therapy most strongly recommended by NICE was CBT. With its emphasis on behaviour, on structured processes and measurability, CBT had lent itself to rigorous scientific investigation, namely randomised controlled trials (RCTs). The research outcomes suggested that in the case of people with mild, moderate and severe anxiety and depression, it could have enduring benefits for around 50% of them. There was a key problem, however, as there were only small numbers of CBT therapists across the country. The picture was complicated, as well, by the fact that the service delivery model in which such therapists were expected to work was what was described as ‘stepped care’. This was based on the assumption that people should be offered the appropriate level of intensity of intervention, according to their needs. The rationale for this was twofold: firstly, that referring people to specialists too early could be stigmatising and overly interventionist and secondly, that it would not be cost effective. So CBT intervention needed to be differentiated into two steps –

step 2, *low intensity*, which largely consisted of assisted self-help and signposting and step 3, *high intensity*, which was face to face therapy. (step 1 being primary care – the generalist health process in the UK).

Two national demonstration sites were established to test out the recommended service model. As luck would have it, one staffed the service largely with CBT therapists (high intensity) with only one assistant (low intensity), the other employed mainly ‘case managers’ who delivered low intensity interventions, with back up from a small number of CBT therapists. The mix of staff in the two sites could not have been more different and they reflected the beliefs of the two clinical leads. The former was a psychiatrist psychotherapist, who firmly believed that face to face therapy was the most valuable; the latter was an academic with a nursing background, who had spent years training and developing graduates in new bespoke curricula (Ricky). Therein lay the rub: what was the right balance of staff and mix of skills and competences, to meet people’s needs in the shortest period of time? The evaluation of the two sites suggested that when looking at depression alone (excluding anxiety, specific related conditions, such as post traumatic stress disorder) there was little difference in the two. Both produced similar rates of recovery to that published in NICE, but the low intensity focussed site saw larger numbers of clients and was much cheaper.

As the IAPT programme gained momentum, based on these two demonstration sites, a business case was developed to deliver this model of service on a large scale. Workforce modelling was rapidly undertaken, but the emerging evidence for the utility of the low intensity workforce was overturned. This was decided by Gerald and Derek, (who saw the IAPT programme primarily as a training initiative), because of their decided preference was for highly qualified therapists who could replicate the work undertaken in research studies. They pronounced that the NICE evidence for stepped care was poorer and could not be relied upon, therefore a decision was made to produce more CBT therapists rather than Low Intensity (LI) Workers (subsequently named Psychological Wellbeing Practitioners [PWP]) and a 60:40 split was adopted. I was unhappy with this, but was



pragmatic in that if the business case was successful, it would bring in more resources that could be used flexibly if necessary. I also knew that my influence would not be powerful enough to change this view.

My role in this process, at the time, was as workforce director for the IAPT project; it was part of a broader role leading the national mental health workforce programme until March 2009. In this role, I had worked with various mental health professionals, including psychiatrists, psychologists, nurses, occupational therapists, pharmacists and social workers, both individually and through their professional bodies. During this programme and throughout my professional career, I have always been struck by the professional defensiveness of many practitioners, in that they have covertly or overtly viewed themselves as superior to their multi-disciplinary colleagues. They have also assumed that professionally qualified staff must be better at providing services to clients than those who are not professionally affiliated. In contrast, and perhaps counter-intuitively, feedback from service users has consistently been at odds with this professional view, with stories that people feel more listened to by support staff than they do by professional staff. I was directly involved in the development of a new role, the 'Support Time and Recovery (STR) Worker', recruiting people from local communities and with lived experience of mental ill health. Initial evaluation and ongoing feedback from service users has been very positive about the role. As a result, I came to IAPT with a propensity to challenge professional assumptions and to promote more diverse roles, so I was sympathetic to the case manager / low intensity role. The first battle lines were drawn therefore - the professionally qualified CBT therapist versus the non-professionally affiliated PWPs. At that time, many psychologists disassociated themselves from the CBT focus as they felt it was too narrow. Later, rancour developed amongst counsellors and psychotherapists, who felt they were being overlooked in what was acknowledged to be an unprecedented, well funded national programme for psychological therapies.

PMG is, therefore, a microcosm of these clinical tensions, which have developed since the programme's inception.

### **A typical meeting of the IAPT Programme Management Group (PMG)**

At the time of writing, PMG has only been meeting for about a year; before that, there was little in the way of governance structures for the programme and it was not at all clear how decisions were made. Now, PMG has taken on a critical role in the management of and influence on the programme.

The atmosphere is always tense and there is rarely a corporate feel to the discussion. There are usually some tête-a-têtes going on before the meeting between those with known alliances and there will be much non-verbal communication between those people throughout the meeting. The business of the meetings to date has been almost exclusively on the performance management of the implementation process, the political and policy agenda and the means of delivering quality standards for CBT.

The agenda is usually dominated by John, leading the performance management side of things and by Derek questioning in great detail and making authoritative statements about the programme. This is often in terms of impending catastrophes that are likely to befall the programme if there is any deviation from the key task of implementing CBT. The practical realities of implementing an IAPT service in 115 organisations simultaneously, all of which have different starting points and therefore the necessity, in my view, of accepting that there will be differences in configuration of services, is considered to be heretical and likely to lead to chaos. Jack, Abe, Brian and I seem to have become constrained by the joint voices of Gerald and Derek. John sometimes challenges us to make a contribution, but we seem uncharacteristically hesitant when we do. I always feel much more relaxed if Gerald or Derek is absent. In individual talks with others, they all dislike coming to PMG, but recognise that it is important to be there as things will get decided in our absence.

At a recent meeting to review the role of the NAs, significant preparation was made to elicit individual views in advance and to plan sharing of perspectives

that would give us equal weight. Although this was chaired by John, it was hatched by the excluded NAs in informal discussions. The meeting itself was amicable enough on the surface and views were straightforwardly expressed, which was a big change, but John explicitly acknowledged Derek over others at the end of the meeting, which left the rest of us feeling deflated.

Similarly, at a subsequent national conference for new IAPT services, chaired by Derek, where Gerald gave a keynote address, he attributed the success of the programme entirely to Derek and John, in the full knowledge that there were three other NAs in the audience.

So I am led to reflect on what is going on in this process, where a small number of people, within a group of others well regarded in their field, can dominate the discussion and the focus of the programme overall. I have been surprised at the intensity of the emotions I have felt during these meetings: anger at the dominance of such a small number of people who claim the intellectual and moral high-ground; frustration at the narrow focus that privileges an ideology of evidence, based on the natural sciences, to the exclusion of all other perspectives; annoyance that a major service redesign and change process can be portrayed only as a training initiative, ignoring the complexity of local differences and the implications for the sustainability of the workforce in the longer term; and humiliation that my role and contribution is constantly being minimised. I know I am not alone in having these feelings, but I suspect as the only woman involved at a senior level, perhaps overly concerned with a preference to collaborate, that I have been more overt in my concerns.

There is now, however the beginning of a fight back of the constrained group to have a more inclusive approach to other therapy modalities and practitioners, on which I will elaborate later.

## KEY THEMES EMERGING

There is unquestioning support of the NICE approved **evidence** based therapies. To suggest that there is anything of value in conducting therapy in any other way, which does not have an evidence base, anchored in scientific RCTs, is to risk personal and public humiliation. Evidence based practice, based on the natural sciences, is therefore an **ideology** of the programme and of the PMG. It is rooted in a cognitivist and positivistic view of the world, both in relation to clinical issues and in relation to management processes.

This value impacts on the constituencies of the NAs. What have primary care, counselling and psychotherapy, workforce, service users and carers got to offer here? Although they have their own evidence base and practical experience, they are on the whole ‘messier’ and less concrete. They cannot be so easily demonstrated through tables of outcome data, which is a key focus of the programme as a whole. This has led to me and these other NAs to feel silenced and to feel like outsiders. I am interested in what has led to this splitting in the group.

What makes Derek feel able to trump the views of all others in the group is, in my view, that he is recognised as the **expert** in this context. Although all the NAs have joined the programme because of the expertise they bring: knowledge, skills, know how, experience, prestige and political influence, there seems to be a clear hierarchy of expertise. This seems to be based, at least partly, on academic knowledge and on the ability to show evidence from one’s area of expertise that can be objectively measured.

This seems to be directly linked to the unspoken and unchallenged view of the value of **professionalism**. NAs are professional advisors but this is not a typical NHS inter-professional conflict commonly seen in multi-professional teams, particularly where there is challenge to the primacy of the doctor. Academic credentials are key to this and when combined with clinical practice expertise, they are perceived to be irresistibly superior to clinical practice on its own, without the research evidence base, and to management

expertise, including dealing with the practicalities of organisational change and service redesign.

There is clearly an imbalance of **power** in the group currently, directly related to political influence and professional identity. This results in anxiety about individual positions concerning potential and actual influence, not only in terms of the internal PMG, but also in terms of the knock-on effect on external constituencies and whether NAs will be able to meet the expectations of the diverse groups they seek to represent. The issue of personal identity and potential exposure raises the issue of shame on the part of the NAs.

A final theme is **control** in that there is an expectation within the national programme that it will provide the answers for local people in local services in what are new circumstances of developing psychological services. Gerald and Derek are extremely concerned at the loss of control that is inevitable in the coming year of the programme, as there has been a political decision to devolve the funding to local commissioners. Financial incentives are considered to be the main levers for local development, along with IAPT being featured in what is known as the “NHS Operating Framework”, which identifies ‘must dos’ for commissioners. IAPT is a tier three priority, which is more of a ‘may do’ and it has proved impossible to increase its priority nationally. This has caused Gerald and Derek, in particular, a great deal of concern, resulting in much political lobbying and catastrophising statements; but they have not been successful. In terms of working with uncertainty, even more so at this time, the ‘outsider’ or constrained NAs openly acknowledge the unknowability of what the impact of this policy may have. This is particularly in the light of the economic downturn and the expectation that savings will have to be made to fund these new developments. There is a keen feeling that PMG should be used to explore these issues, test out assumptions and come up with new ideas. But that it has not been safe to do so as this would be to expose the individuals who profess not to know. This is clearly unproductive and poor use of the people in the PMG and their potential to create new ways of understanding by debating and problem solving together.

There is a clear intention in the group to address this, as articulated by John, but it feels like the group is stuck in a groove of CBT and its service enactments.

I intend to consider how professionalism is important in this project and how this might inform my ways of understanding the processes of PMG and the way the NAs interact.

### **PROFESSIONALISM: KEY THEMES**

I take a professional to be a person in an occupation, who has specialist knowledge and skill, the exercise of which requires discretionary judgement and the possession of which enables the person to control their own work and to hold privileged economic, cultural and social status. Professionalism is the qualities or typical features of a profession. Professional bodies control entry to and expulsion from the profession, linked to codes of ethics and protection of professional and commercial interests (Stewart: 2008). Having spent most of my career bumping up against professionalism, I want to explore if professionalism is a major issue that is being played out in the PMG.

My starting position is that I am suspicious of professions. Although almost universally, they may have the best interests of their clients at heart, it has been my experience that they have frequently taken the view that they know best, by virtue of their knowledge and expertise, therefore downplaying the experience of their patients. They also tend, depending on the primacy of the profession, to consider themselves to be superior to other professions. There is nevertheless an idealisation of professions that has developed over centuries.

Larson (1977), in a Marxist analysis, begins by saying that in most cases sociologists perceive that

...professions are occupations with special power and prestige.  
Society grants these rewards because professions have special

competence in esoteric bodies of knowledge linked to central needs and values of the social system, and because professions are devoted to the service of the public, above and beyond material incentives. (1977: x)

Khurana (2007), in describing the development and fall of management as a profession, took a positive view of professionalism.

Professionalism and professionals are powerful ideas and institutions...They often occupy the highest status positions in an occupational hierarchy. In cultural terms, they are carriers of important societal norms and values concerning such matters as the relationship between knowledge and power and the maintenance of trust. (2007: 8)

## **THE IDEOLOGY OF CULT VALUES OF PROFESSIONS AND LINKS WITH ABSTRACT KNOWLEDGE**

Abbott (1988) viewed professions, not in isolation from each other, but in terms of inter-professional competition. 'Control of knowledge and its application means dominating outsiders who attack that control. Control without competition is trivial' (1988: 2). His concept of 'jurisdiction' and how this differentiates professions formally and academically is particularly interesting where he reflects how this changes in practice. Boundaries become blurred as people work together and develop skills and knowledge that can become interchangeable. The public would be shocked, for example, if they were to learn of the number of assumed medical roles, which are actually undertaken by non-medical staff. In IAPT, we see the role of the PWP taking on that of a more experienced therapist in terms of screening assessments.

Griffin describes how Mead's (1923: 237) concept of a 'cult value' of, for example, a hospital to 'provide each patient with the best possible care' (2002: 189) will emerge in different practices as it is implemented by

clinicians on different wards, thus becoming ‘functionalised values’. He argues that this process gives rise to conflict as differences will arise which may be contested. These practices in turn can impact on the cult value and how it may evolve.

Academic knowledge is interwoven with defining jurisdictions and is controlled by academics. In the mind of the public, there is a belief that abstract knowledge implies effective professional practice, but this is not necessarily true. It is the symbolic combination that is culturally powerful; so having a strong academic, abstract knowledge system is important for all professions. Khurana suggests, in thinking about the development of management as a profession, that there were deliberate links made by employers with universities to establish business schools as a means of legitimising the role of the manager (2007: 3). Here, there is a linking with science for respectability. Freidson (2001) describes how the level of abstraction informs the level of academic qualification and hence the status of the profession.

Professionalism itself can be considered to be a “cult value”. Stacey and Griffin state “cult values are precious aspects of collective identities, that are always aspects of personal identities” (2005: 16). The PMG is a process where cult values are functionalised in ordinary, everyday situations as people interact, which inevitably causes conflict. It is in this functionalisation, with its conflict, that cult values enact a sense of identity and evolve at the same time.

A vital issue that emerges from the discourse on professionalism is that of academic knowledge as an abstraction and how this sits with practice and competences, which I will return to later.



## **PROFESSIONALISM: THE ROLE OF THE DOCTOR**

I want to reflect on the historic development of professions and focus initially on medicine as it has come to influence the NHS and provided the dominant interpretation of the needs of people with mental health problems.

### **Gaining status through social position**

Foucault's work, *Madness and Civilisation* (1961), traces the development of institutions in the 17<sup>th</sup> century, from the opening of the Hôpital Générale in France in 1656, as I describe in project one. The institution provided 'great confinement' and herded together people, who had committed all types of transgressions and had a variety of difficulties, but was 'not a medical establishment' (1961: 37). It was more a means of social and economic control. The subsequent development of the asylums, through Pinel at Bicêtre in France and through Tuke at the Retreat in England, have now passed into legend. Tuke was portrayed as a Christian philanthropist, but Foucault argues that the truth was different and that a key principle was, quoting Tuke himself:

The principle of fear, which is rarely decreased in insanity, is considered as of great importance in the management of the patients. (Ibid: 232)

Pinel took a less religious, but still moral stance, towards patients. But both he and Tuke developed the role of the 'medical personage' as the 'essential figure in the asylum'. This position controlled entry and discharge and was one of significant power. It was not, however, based on medical skill. "It is not as a scientist that homo medicus has authority in the asylum, but as a wise man" (Rabinow, 1984.: 159). Any power to cure was borne from the "quasi-miraculous" (ibid.: 162) power of the doctor-patient relationship and the presumed efficacy of moral behaviour. Foucault posits that the development of the natural sciences in the 19<sup>th</sup> century and the role of medicine within this, obscured the views of psychiatrists from their roots as 'very soon the

meaning of this moral practice escaped the physician, to the very extent that he enclosed his knowledge in the norms of positivism' (ibid.: 162). This is not surprising and perhaps reflects Elias (1978) when writing about the development of sociology, who said that in the development of thought, natural forces were explained in terms of magical and metaphysical explanations until scientific theory, offering explanation and prediction, took hold. Scientists challenged conventionally accepted ideas and Elias described them as "destroyers of myths". Although this new scientific approach became the dominant discourse in how doctors thought about their work, there was (as yet) little reliable evidence on their efficacy.

So we have here an historic development of the role of the doctor, powerful for his gravitas rather than for his ability to cure. Abbott (1988) says something similar in his historical view of the rise of professions working with people's problems, in that institutions had been developing at a great rate to house the insane and thus remove them from society. It was here that the role of psychiatrists grew as they became directors of those institutions. Their treatments were focussed on moral therapy, which proved to be 'a clear failure' in his view, but incarceration had powerful cultural influence, both for society and for the profession. As Abbott comments wryly, although 'the failure of moral therapy put psychiatrists' jurisdiction in an embarrassing position, there were no real competitors, and psychiatrists retained control by default' (ibid.: 294).

Foucault's description of the local interactions of a small number of key people like Tuke and Pinel and the ensuing power the psychiatrist assumed in controlling institutions, despite the lack of efficacy of their treatments, suggests that other factors were involved. It seems that the physician, in working with the insane, who were feared by the public and who themselves were in awe in the doctor-patient relationship, took on the appearance of the supreme expert, the idealised professional.

Starr (1982), in his analysis of the *Social Transformation of American Medicine*, from the 19<sup>th</sup> century onwards, describes medicine as a sovereign

profession, which is “an elaborate system of specialised knowledge, technical procedures, and rules of behaviour... (but), by no means are these all purely rational.” (1982: 3) He talks about the ‘authority’ of professions, which is secured through the influence of two necessary elements, “legitimacy, (which) rests on the subordinates’ acceptance of the claim that they should obey, (and dependence) on their estimate of the foul consequences that will befall them if they do not” (ibid.: 9-10). Both of these clearly play out in Foucault’s analysis of role of the doctor and the acceptance of this by the patient.

Starr describes how medicine in the US was able to establish cultural authority through the nature of the doctor- patient relationship. The emergence of psychiatry and how it came to dominate not only the care of people with severe mental ill-health but also how this metamorphosed into what Abbott described as the ‘personal problem jurisdiction’ (1988: 280) directly influenced the rise of psychotherapy as a profession. It therefore has clear links to the context of IAPT, but in a more subtle way than is the day to day experience in specialist mental health services.

### **Individual and social perspectives**

According to Abbott, personal problems were largely dealt with in the family or by the clergy until the mid-19<sup>th</sup> century. The clergy would have been focussed on religious exhortation to change to receive redemption. As society changed, however, with the growth of industry, cities and worker movement, not only did this result in people finding it difficult to cope with these changes, but also family networks were disrupted along with their potential to provide support. The clergy, because of their number and place in society, continued to be the key source of help for people; but they began to see the causes of mental ill health as being socially determined. Abbott states:

Washington Gladden and other social gospellers attributed many of these personal problems directly to such social causes as poverty, unemployment, and rootlessness. At the same time, Gladden defined

the pastor-client relation as one of friendship, strongly opposing “unbending professionalism”... This new construction of everyday life problems appealed to legitimating values: to egalitarianism, to efficiency, to altruism. But it made little appeal to science. And its diagnoses more reflected general social criticism than skilled investigations, while its treatments required social changes that elites found unacceptable. (1988: 293)

At the same time, neurologists were developing as a respected academic group within medicine as they became skilled in the categorisation of often unexplained or untreatable illnesses. There was a huge demand for their services at this time as unhappiness in the population grew, but their numbers were too small to meet such demand and the efficacy of their treatments was very poor.

So, at the beginning of the 20<sup>th</sup> century, we see two professions: psychiatrists and neurologists, who were in much demand for dealing with people with mental health problems, but with little in the way of effective treatments to cure them. Both, however, were working to a medical model to explain and predict behaviour.

Psychiatrists began to move away from their institutional power base because the nature of the work was leading to a high turnover of doctors. They did this by shifting from focussing their work solely on the institutionalised severely mentally ill, to what they considered to be preventative work. Notice here how an historical perspective can reify groups, such as psychiatrists and can infer intention to a process, which would have emerged iteratively over a number of years. This interpretation will have shifted with the retelling, which is what Mead (1932) would argue as being in the living present, acting into the future, whilst re-inventing the past as we do so.

Abbott posits that psychiatrists were forced then to look at social conditions as the cause of problems for many and hence adopt a social stance. This was problematic however because those causal factors were difficult to change.

The academic group within the profession, supposedly, therefore, developed 'adjustment theory', a body of knowledge based on the adjustment of the individual to society. This meant looking at how the person could adapt to their circumstances rather than change them, the purpose of treatment becoming therefore social control. Abbott, quoting from the Commonwealth Fund, stated

(p)sychiatry may do much to adjust human beings, children or adults to tolerable conditions of life. The implicit assumptions of this theory were (1) that all social factors in nervous and mental disease were important only through their effect on the individual; (2) that any violation of social rules ("the mildest psychopathies, the faintest eccentricities") signified mental problems and (3) that the proper approach to such problems was individual and not social'. (1988: 298)

This individualistic perspective is based on a positivistic philosophical stance, on the assumption that there is the individual and the society and that the individual can stand outside of that society. Elias, as reported in Goudsblom and Mennell (1998), in a presentation that he gave to the Royal Medico-Psychological Society in 1965, drew attention to this:

All these groups (of professionals) are inclined to see their own province of the human universe as the most basic and the most central... In the psychiatrist's perception, as I see it, the single individual - the single patient - stands out sharply in the foreground. It is not unusual to speak of a patient's 'social background'... and 'environment factors'. The terminology itself implies the existence of a wall between the highly structured person in the foreground and the seemingly unstructured network of relations and communications in the background. (Gouldsblom and Mennell, 1998: 78-9)

Griffin on the same subject, states: "Just as scientists succeeded in splitting the atom, various disciplines began to 'split' the understanding of the

individual” (2002: 128). This can be seen clearly in multi-disciplinary teams in the NHS; each profession is bent on demonstrating their distinct contribution in relation to the biological, psychological and social determinants of behaviour. There is something more fundamental, however, which was being asserted by psychiatry in the early 20<sup>th</sup> century, and indeed, still today, and this is that there are standards, which are taken for granted in the western world, by which man can be judged, and that it is possible to manipulate the individual to conform to those standards. Mead (1908), in considering the philosophical basis of ethics suggested that:

Moral advance consists not in adapting individual natures to the fixed realities of a moral universe, but in constantly reconstructing and recreating the world as the individuals evolve. (1908: 194)

Abbott states that this psychiatric stance of moulding the individual to society was remarkably popular with the public as it appealed to their understanding of their conditions, to science, to individualism and to social orderliness. I take this to mean that, at that time, there was still a strong pioneering inheritance in the US, which was focussed on the individual and there was an equally strong belief, linked to Christianity, about accepting one’s lot. Whatever the complexity of these influences, it did place the profession of psychiatry in a quandary about its knowledge base. This has proved an enduring issue, in my view, and has caused difficulties for the profession in articulating its basis in natural sciences, whilst also clearly having intrinsic links with psychology and, more importantly, with sociology. There was also a clear differentiation, still prevalent today, between mental health problems which arose from *organic* or physical/neurological causes, such as dementia, and those which arise from *functional* causes, such as depression, relating to the psyche. Abbott suggests that this originates from the overlapping jurisdictions of psychiatrists and neurologists, where agreement was reached that neurologists would concentrate on organic problems and psychiatrists would concentrate on those with functional difficulties. This jurisdictional divide was, of course, simplistic and it reinforced the Cartesian mind/ body split, which is still prevalent in the delivery of healthcare today in the UK.

Reflecting on whether there is an individual versus a social perspective in IAPT, I find that it is very individually focussed. Therapy is seen as a way of helping people manage their problems more constructively, including supporting them in (to) employment. Its social impact is through the aggregated results from individual therapy on the economy and therefore on society as a whole.

### **The influence of Freud?**

Abbott suggests that Freud's psychoanalytic theory, which took into account basic drives, affect and intellect, offered a "more rigorous and consistent" (1988: 305) approach to understanding personal problems, emphasising the importance of professional inference. Elias ( Goudsblom & Mennell 1998: 77), who trained as a group analyst, was respectful of Freud, but he was critical of Freud in not considering the relationship of the id, ego and super-ego within the person and between individuals. He also criticised his 'ahistoric' perspective that ignored the long civilising process of mankind, during the course of which "the wall of forgetfulness, separating libidinal drives and consciousness or reflection has become harder and more impermeable" (1934: 64). Elias therefore felt that Freud's approach was an individualistic one that took insufficient account of the social development of sexual and social norms.

In his early years, according to Flyvbjerg (2001), Freud was optimistic that psychology would become a natural science, be measurable and "free from contradiction". In later years, he became more sceptical, commenting "mental events seem to be immeasurable and probably always will be so" (2001: 26-27).

Abbott observes that "Freud himself saw no reason why therapists had to be physicians, and only the violent opposition of American psychiatrists prevented the International Association from following Freud's policy" (1988: 307). Here we see an early suggestion that (psychodynamic) therapy

could be carried out by a wider group of professions or therapists. In contrast, it is clear that Starr felt that this was a threat to the power base of doctors, agreeing with Rabinow, who described the impact of Freud as follows

To the doctor, Freud transferred all the structures Pinel and Tuke had set up within confinement. He did deliver the patient from the existence of the asylum within which his “liberators” had alienated him; but he did not deliver him from what was essential to this existence; he regrouped its powers, extended them to the maximum by uniting them in the doctor’s hands; he created the psychoanalytical situation where, by an inspired short circuit, alienation becomes disalienating because, in the doctor, it becomes a subject. (1984: 165)

What accounts for this discrepancy of views? Was Freud more interested in the patient-therapist relationship and power differentials within that as an integral part of the transference process with the patient, rather than on the professional status of doctor? Starr touches on this when he suggests that the reasons that medicine gained such power over the public was because it sought to link its area of competence with science but more importantly, that the professional could diagnose and re-interpret for the individual the meaning of their needs.

By shaping the patient’s understanding of their own experience, physicians create the authority under which their advice seems appropriate. (1982: 14)

Until the 1960’s, psychiatrists in the US and the UK controlled the development of the profession of psychiatry, as well as that of nurses, social workers and psychologists. Although other professions were keen to develop as psychotherapists, as Abbott observes:

If Freudianism was the only legitimate psychotherapy and only doctors could be Freudian analysts, and personal psychotherapy was necessary for work with personal problems, then psychiatrists had



absolute control both of jurisdiction and knowledge system. (1988: 307-8)

This ensured that neither social workers nor psychologists could practise unless under medical supervision and were in subordinate positions. This has been changing, but it has left its mark on current power configurations of therapists nationally.

### **The importance of professional inference**

Abbott explores how professional jurisdictions get defined. Borrowing the metaphor from medicine and applying to all professions, he suggests that professions get linked to the tasks they undertake by the use of *diagnosis*, *inference* and *treatment*.

Diagnosis and treatment are mediating acts: diagnosis takes information into the professional knowledge system and treatment brings instruction back out of it. Inference, by contrast, is a purely professional act. (Ibid.: 40)

Inference is the mystery ingredient of professionalism.

Professional thinking resembles chess. The opening diagnosis is often clear, even formulaic. So also is the endgame of treatment. The middle game, however, relates professional knowledge, client characteristics, and chance in ways that are often obscure. (Ibid.: 48)

If there is too little inference required and hence a transparent link between diagnosis and treatment, he suggests this makes the profession vulnerable to others challenging its' jurisdiction, perceiving they could do it just as well. On the other hand, if most of the work is idiosyncratic and based on inference, it will not be persuasive to the public. Psychologists prefer to describe inference or the interpretative process as formulation. All professions have a tendency to assess the patient according to their own

classification system and conceptual framework, as Elias pointed out above (1998: 78). Abbott's view is that the strongest reason for Freud's success was that his approach to professional inference was more complex and internally coherent.

The issue of assessment is a much debated one in mental health, including IAPT. Screening by PWP's (the least qualified practitioners) is part of the stepped care model to manage demand through protocols. Many services have not set up this system and use experienced staff instead. Although intuitively this seems to make sense, the results do not bear out the superiority of an expert assessment. Most professionals assess using their own frame of reference and do not necessarily accept the views of colleagues. In relation to doctors, Craddock (2008), in a gesture from disaffected psychiatrists, railing against the modernisation of professional working practice, wrote '(w)e should seek to minimise the unhelpful influences of political idealism' (2008: 7). He asserts that psychiatrists need to see everyone referred in order to carry out a 'thorough, broad based assessment'. This is highly impractical, but the article has been a rallying call to some psychiatrists and is framed very much as the insider/ established order versus the outsider groups of other professions, managers and policy makers.

### **Reflection: The Relevance of the Medical Profession to the Development of IAPT**

It would seem, then, that the ideology of the profession of medicine, in relation to mental ill health, has been developing for over 300 years. Its influence arose through its social position which conferred high status on the role and title. It is interesting that this statutory role has continued, although its rationale has now been overtaken by its links with science, even though evidence of efficacy remains variable.

In secondary mental health care, the role of the doctor, although being challenged by other professionals and managers, remains dominant as I still see on a regular basis. Mental health policy is clinically led by a psychiatrist,

which forms the context for IAPT. There is no psychiatrist, however, within PMG. Abe, the GP on the group, is a doctor but is also one of the outsider NAs, because, I suggest, he is a generalist rather than a specialist, without a specific evidence base. So, although psychiatry has had a profound influence on the development of psychotherapy, it has now bowed out of the field of common mental health problems in the UK. I want therefore to consider the rise of other professions and their importance in relation to IAPT.

### **PROFESSIONALISM: THE EMERGING INFLUENCE OF PSYCHOLOGY.**

The explosion of demand for therapy in the 1960's was due to political, educational and pragmatic factors. The social move to close mental institutions and the development of psychotropic medication led to a shift in service models and professional roles. In the US, psychologists and social workers gained independent status and psychiatrists lost their grip of this jurisdiction, shifting to more biological and psychopharmacological jurisdictions. This latter movement was reflected in the UK.

Psychologists developed their professional profile initially through developing and using intelligence tests in World War 1. They continued to build on this, and personality testing, by expanding their knowledge and evidence base through academic research. This work focussed on experimental psychology and appeared to have the unexpected effect of reducing the amount of research being carried out on clinical research including psychotherapy and pharmacology. Clinical and other applied psychology roles developed in the latter part of the 20<sup>th</sup> century. Experimental psychology, concentrating on research, has sought to measure, manipulate and predict behaviour, and has had a longer pedigree and more prestige than applied psychology until recently. By building their scientific credentials, although at that point it did not extend to the efficacy of therapeutic practice, psychologists began incorporating a “scientist practitioner” specialism into their jurisdiction. This subsequently played out in the development and evaluation of behavioural and then cognitive behavioural therapies.

I recall, training as a psychologist in the 1970's, being imbued with a strong sense of being superior to nurses, occupational therapists and social workers and being competitive with psychiatrists. At that time the qualification was a Masters level degree; but in the 1990's the training of clinical psychologists became a doctorate.

Clinical psychologists became part of a powerful elite 'us' group with the title of doctor... Doctoral status also helped to identify us as a group distinct from counsellors and psychotherapists. Counsellors and psychotherapists are considered 'other'. Our superior status has become an important aspect of our professional identity...Furthermore, achieving doctoral status has strengthened our power base vis-à-vis our other main rivals, psychiatrists... This has been a crowning achievement for the profession. (Hester O'Connor, 2005: 110)

So it is only fifteen years since psychologists could legitimately feel themselves equal to doctors based on their title and on their research expertise. Furthermore, they have led a shift away from psychoanalytic approaches to therapy and towards one that lends itself to systematic evaluation based on observable and measurable phenomena.

### **CBT and its challenge for the profession of psychology**

CBT was developed in the late 1970's through merging behaviour therapy and cognitive therapy (Gilbert, 2009) and was taken up because

...it had two key strengths. In part because of opposition from psychodynamic and other approaches that were contemptuous of its apparent simplicity and "conscious mind focus", it needed to prove its value with outcome research, and so strove to do so. Second, it was adopted by many clinical psychologists who brought their "science" to the study of psychological processes in psychopathology, and over the years welded psychological science into CBT. However, clinical

psychology commitment to CBT has been both a strength and a problem - a problem because...CBT is a model for therapy, not a science of mind or a service model. (2009: 400)

The latter is a real dilemma for psychologists now, in relation to IAPT. From a professional perspective, they are exploiting the opportunity provided by a national programme to enable them to lead service developments and hence enhance their professional status. On the other hand, this involvement in IAPT can imply that they are solely defined by a therapist role and by a CBT perspective within that. This caused a split in the profession from the outset, which still persists.

In articles in *The Psychologist* (2009), Gilbert, Marzillier and Hall criticise IAPT for focussing on CBT. They seek to emphasise the complexity and the messy nature of clinical practice and express their concern that an overly simplistic message of IAPT will be received by commissioners and the public, which might promote a reductionist view of causal factors and ensuing interventions. They are also concerned that there is now too heavy an emphasis on one to one individual therapy with a tendency to locate the problem within the individual and effectively reinvent the medical model. This ignores the fact that there is good evidence that poor mental health is linked to poverty and that interventions may be more appropriate with communities rather than with individuals. White (2009), for example, working in the most deprived areas of Glasgow, has identified that large proportions of people in that community, when asked, do not rate themselves as depressed (even though they may be unemployed, in poor housing and in bad health), as this is what they have always known. Explicitly he says

...the assumption that mental health problems are exclusively attributes of the person ('symptoms' in the language of medicine) and that individuals can overcome their problems ('get better') needs to be challenged. (2009: 406)

This has echoes of the emergence of psychiatry 100 years ago and the comments of Washington Gladden (1988: 293). Here, we need to consider the breadth of the knowledge base and scope of clinical psychology practice as being 'bio-psycho-social'. Psychologists have made a great deal of the importance of social influences on behaviour and have compared themselves favourably with psychiatrists, whom they often caricature as operating on a medical model, looking within the person for the source of the problem, often for a biological cause which will respond to medication.

Nevertheless, psychologists are themselves positivists; consider this definition.

Clinical psychologists tend to define their profession in terms of (a) the basic science of psychology and (b) its application to the understanding and resolution of human problems. The clinical psychologist is first and foremost an 'applied scientist' or 'scientist-practitioner' who seeks to use scientific knowledge to a beneficial end. (Marzillier & Hall, 1999: 9)

The cognitivist paradigm relies on an assumption that in order for evidence to have value it must be hypothesis-driven and empirically testable. Gilbert expresses his view that the profession of clinical psychology has

...springboarded from CBT and (is) developing sophisticated models of the mind, combining various aspects of psychodynamic theory with a better understanding of non-conscious processing. We are some way from an integrated science of mind, psychopathology and psychotherapy, but clinical psychology will be fundamental to moving us in that direction-provided we stay evidence based. (2009: 401)

Psychologists clearly see themselves as leading the way in developing evidence based psychological therapies. This is the position that Derek takes up in PMG and IAPT.

## **COUNSELLORS AND PSYCHOTHERAPISTS – A DIVERSE PROFESSION?**

Abbott (1988) says very little about the general development of counsellors and psychotherapists. He implies that counsellors grew from the clergy as they developed their pastoral role and that psychotherapists were drawn from the traditional professions, including social work and psychology.

In England currently, there are more than 30,000 counsellors and psychotherapists. They mainly fund their own training, have varied qualifications and rates of pay, their conceptual frameworks are very diverse and they have a number of professional bodies which offer voluntary registration. There is a lot of infighting between the different groups, evidenced by the debate in 2008 on the subject of professional regulation (Sunday Telegraph: 2008: 3-4), the boundaries between counselling and psychotherapy, their protected titles and standards of proficiency. Counsellors are mostly employed in primary care and are valued by GPs because of their ready accessibility. Psychotherapists work more in specialist mental health trusts. To a large degree, both groups work in private practice.

This diversity and lack of cohesion has caused both groups to struggle for a professional profile in the NHS. The lack of research into the efficacy of their modalities has resulted in a paucity of evidence, which in turn has led to NICE, largely, not recommending their therapies. All in all, with the introduction of IAPT, with its national profile and CBT focus, counsellors and psychotherapists have felt disaffected and excluded from dialogue and development. This is the constituency that Jack represents. I find myself wondering: are these groups of people members of a single profession? It does not seem like it. The way that Derek and Ricky describe them is often pejorative. Out there, in practice, counsellors have been asked to undertake CBT training, which some have done, but not always willingly. In other areas, counselling services have been decommissioned, resulting in unemployment and a feeling of being devalued. Their professional identity is not highly valued, I would suggest, because of the lack of evidence of

efficacy of their treatment and the lack of social status that they have had historically.

## **PROFESSIONALISM AND ITS MEANING FOR MANAGERS**

So far, I have focussed on clinical professions: doctors, psychologists and therapists, but managers as professionals are important in IAPT and PMG. Professionals claim a body of knowledge and skills, but also usually a set of ethics and values to underpin their practice. This is the basis of the argument put forward by Khurana (2007) in his analysis of the rise of managers as a profession.

By the end of the 19<sup>th</sup> century, with the growth of larger organisations, a new management role emerged, requiring different sets of skills to lead and coordinate processes. However, “managers were controversial or, at the very least, members of a new and unfamiliar economic and social group whose role required explanation” (ibid.: 3). In order to enhance the skills of managers and the prestige of business, employers made alliances with universities and established business schools for the first time. The subsequent professionalization of managers ensued for sixty years until the 1950s. Khurana suggests that this began to be eroded as the role of the manager as a professional, looking after the interests of the business and its employees, was replaced by the entrepreneur, who could maximise profits for shareholders, irrespective of what implications this may have for employees’ lives, such as through mergers. The charismatic CEO began to be seen as only able to be recruited and retained if high personal rewards were offered. No assumptions were made that such people would have loyalty to their organisation nor have an interest in its long term future. In Khurana’s view this constituted managers moving “from higher aims to hired hands”. In his view of the world, he appears to assume that being a professional is a good thing in its own right, specifically having motivation beyond self-interest, in having a “calling” for an organisation.

Starr describes the tensions between professionalism and rule of the market:



The ideal of the market presumes the “sovereignty” of consumer choices; the ideal of a profession calls for the sovereignty of its members’ independent, authoritative judgement. A professional who yields too much to the demands of the client violates an essential article of the professional code: Quacks, as Everett Hughes once defined them, are practitioners who continue to please their customers but not their colleagues. (1982: 23).

I find this a surprising assertion. Perhaps it relates to the slightly confused notion in the NHS, that patients are also customers. The use of market principles in the NHS in encouraging competition between providers has been a means of modernisation over the last 20 years. In the NHS, though, people are not customers because their treatment is free. Although I would argue this is a good thing, it means they have no purchasing power, which is what drives market and provider behaviour change. Professionals almost universally are now direct employees of the NHS and are therefore subject to organisational constraints. This is different from the US, where health-care is funded through private insurance and where the patient may be more of a customer; however the vast majority of doctors are self-employed and exert more professional influence. The different cultures of the two countries appear to result in the differing status of doctors in those societies. Doctors and pharmaceutical organisations have more power and authority in the US, which has resulted in strong control of non-medical interventions such as CBT.

Management as a profession is clearly taken for granted in the NHS. There are organisations for managers, bespoke training that recruits high flyers, and a weekly national magazine covering policy, politics, job adverts and gossip. But until 1989, there were no such roles as general managers, only administrators, who worked to support matrons and medical superintendants. The change to adopt general management was driven by the government at the time, which wanted to make better use of resources and to challenge the traditional power of the medical profession. Many professionals saw this

initiative as wresting power from them and so it is hardly surprising that this was seen as an overt challenge by them. There has been, since that time, a clear split between what is characteristically described as management versus clinician perspectives.

### **Clinicians as managers**

There has been a recent policy imperative to attract senior professionals, doctors in particular, into clinical leadership roles, through the Darzi “Next Stage Review”, which I mention in project one. Corrigan (2009), a former advisor to Number 10, wrote that some doctors were arguing against this

... based on the belief that practising medicine revolves around the autonomy of the doctor. The core of this model is that doctors take decisions and stand by them. Therefore any doctor seeking to lead another doctor essentially undermines that autonomy and needs to be resisted....Good leadership needs good followership...But following does give up something to the leader who is carrying out leadership at that time....And if medical school teaches doctors that they are or should be in charge of their practice, this is a poor start for the development of followership. (2009: 22)

This statement is interesting as it highlights one of the difficulties with how Kant’s (1790) thinking has been interpreted. As Griffin (2002) states

Kant resolved and “eliminated” the paradox of determinism and autonomy by creating the “both...and” way of thinking which is at the very core of systems thinking. (2002: 91)

In other words, it is paradoxical that individuals can be construed as having the freedom or autonomy to make their decisions whilst also being determined by the system in which they operate. Kant suggested that we think of nature ‘as if’ it were a system about which we could hypothesise. Unfortunately this has been taken up in systems theory as though the model is

reality itself and can be applied to human interaction. This is the basis of the critique of systems thinking in Stacey's (2005) work on complex responsive processes. If one person is taking a leadership role, others should follow; but we know that does not necessarily happen and hence the dilemma faced by the government on the professional resistance of doctors. There is a clear intention in the NHS, which I have shared, to seek consensus and thus achieve an ideal service; a feeling that if only some professionals would embrace the vision (and therefore tow the line) that services for patients would be improved. Leaders are intended to challenge practice, so conflict is inevitable, but with the intention of achieving harmony. Mead (1923: 238) described this as fooling ourselves with 'hopelessly ideal' illusions of being in the right. Identity is a powerful characteristic of being a professional, which is at the crux of the protectionism of professional boundaries or jurisdictions. The struggle between and within professions can be seen clearly in the development of professions delivering mental health care generally and in delivering psychological therapies more specifically. Although IAPT is a newcomer to the scene, it is entering a variety of practices and beliefs at a local level, where professional identities are being challenged. We are seeing emerge, unsurprisingly, a variety configurations of professionals and practices, not all of which are judged, centrally, to be appropriate.

The development of new and enhanced roles in IAPT (the PWP and High Intensity therapist) has been a significant gesture to the existing professional workforce. It has caused positive reactions (investment in psychological interventions) and negative reactions (only CBT). A way through the professional rivalries has been sought through the use of competences to underpin practice.

### **THE IMPORTANCE OF COMPETENCE OVER PROFESSION**

I should say, at this point, that I have always found it sensible, intellectually, to consider competences as a building block for practice. It seems obvious that people should be clear about what they need to do, based on specific knowledge, with a means of assessing whether they are able to practise

according to these standards; this is the essence of the Sector Skills Council's National Occupational Standards (NOS). In practice, however, I have usually found them too detailed and overly complicated to engage with. Skills for Health, which produces competences in the UK health sector, is keen to develop web based tools to assist people to use NOS to develop job descriptions, education and training and career frameworks for psychological therapists. In my previous role, I tried to devise an approach to working with multidisciplinary teams to help them review their practice, based on the needs of the people using their service (CCTA) and I had initially tried to use NOS tools to help teams to review their competences. It proved too difficult a task and I decided instead to look at capabilities which were broader and easier for teams to engage with. There is no consensus on these distinctions; however, Fraser and Greenhalgh (2001) distinguish the two as

Competence - what individuals know or are able to do in terms of knowledge, skills and attitude.

Capability - extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance. (2001: 799)

The World Health Organisation (1988) described competence as something that

...requires knowledge, appropriate attitudes and observable mechanical or intellectual skills which, together, account for the ability to deliver a specified professional service. (1988:2)

Assumptions behind competences are that learning is the activity of separate individuals, there are measurable outcomes of learning, and there are minimum standards which define what all practitioners should achieve. They belong to a technical rationalist approach to teaching and learning.

Distinctions between competences and capabilities have their roots in the development of specialisms: the mechanistic and the discretionary. The first can be reduced to a set of steps that need little training or knowledge, the

second requires not only a body of knowledge but also judgement to change practice, informed by that knowledge in the face of uncertainties.

In IAPT, competences have been used to develop national curricula for both high and low intensity CBT training, where there is a heavy emphasis on skills in practice that are enacted and evaluated on video by raters. Some people with previous professional backgrounds are considered less easy to teach than others without a professional background. It is postulated that this is because of the differing conceptual frameworks or mental models that they bring to the learning process. Video ratings have shown less experienced students doing better than experienced practitioners.

This raises an important issue about human learning. Dreyfus and Dreyfus (1986) developed their five step learning model from novice to expert. Flyvbjerg (2001) discussing this, quoted a fascinating example of six people administering Cardio Pulmonary Resuscitation (CPR) to victims, where five out of the six were inexperienced trainees, and only one an experienced practitioner. Videos were shown to three groups of subjects: experienced practitioners, students and teachers of life saving techniques. The subjects were asked who they would prefer to resuscitate them; 90% of the experienced subjects chose the experienced paramedic in the film, 50% of the students and only 30% of trainers picked correctly. The trainers' concept was that good CPR was about following the rules, which they could more easily observe in the trainees. The expert had gone beyond rule based behaviour and made, in what Dreyfus argues, a qualitative jump from the first three to the fourth and fifth levels of practice. Unfortunately, this proficient and expert practice is not easily measurable, indeed Dreyfus argues that '(e)xisting research provides no evidence that intuition and judgement can be externalised into rules and explanations, which, if followed, lead to the same result as intuitive behaviour' (1986: 21). I take this to mean that competences cannot assist training beyond the level three 'competent practitioner' category; all first three levels being based on calculative rationality. Experts and proficient performers act without thinking and hence work intuitively with a level of virtuosity. This is perhaps a way of thinking about what

defines an expert professional; someone who can act into the unknown, modify their practice depending on the context and exercise 'clinical judgement'. The latter is always acknowledged as important, but it is uncomfortable as it is less easy to identify and categorise into competences. This has been taken up as 'metacompetences,' in the production of competences for CBT (Roth & Pilling, 2007).

I now feel I am calling into question this predisposition to value competences. My view has been that they offer a different way of describing the workforce, being based on what professionals do rather than what they are called. I have, however, found myself becoming concerned that there seems to be an increasing reliance on them in workforce terms. Having said that, I do not think we would have achieved what we have so far in IAPT without clear guidance on training and practice, based on competences.

## **REFLECTION ON TAKING UP PROFESSIONALISM IN MY CAREER**

In thinking about professionalism through my career, I have tended to focus on the professions of clinicians and not of managers. I have not considered myself to be a professional manager nor have I sought training or read much management literature. This lack of building a knowledge base to support my practice in management positions for twenty five years suggests to me that I tacitly favour experience and knowledge in practice rather than academic credentials. I also wonder whether, having openly eschewed being defined as a clinical psychologist, I have, nevertheless, used the scientist practitioner framework of my psychology training as my way of viewing organisational change. Khurana describes the content of MBAs as drawing on a wide range of other professions and disciplines, which of itself weakens its jurisdiction. I am coming to the view that this has been influencing my views of different professions and of PMG now. Having moved from an executive role in 2001 to a workforce role, for which I have no management qualifications, I have gained experience and good outcomes. It seems to me that the systemic approach that I have absorbed in working in NHS management, together with

my affiliation with a scientific perspective as a clinical psychologist, has led to my difficulty in critiquing the IAPT programme in PMG: professional clinical and academic expertise is what is clearly valued by key players. I agree with having clarity of purpose, outcome measurement, and of defining the workforce in terms of competences instead of professional labels.

## **REFLECTIONS ON THE IMPLICATIONS FOR PMG**

The scientific basis of psychology as a profession has profoundly influenced how the IAPT programme has been constructed and implemented, even though there are intra professional concerns about the interpretation and use of evidence. Having trained in clinical psychology, in common with many of my IAPT colleagues, I have been acculturated to the value of being a scientist practitioner. Although I worked in a radical behavioural tradition that disavowed cognitive considerations at that time, it nevertheless was drawn from the same positivistic perspective. This, together with the highly focussed managerial perspective which is target driven and imbued in systems thinking, makes it hardly surprising that the dominant discourse is one which results in treating organisations, groups and therapeutic relationships as if they were biological phenomena.

From a complex responsive processes perspective, attention is paid to experience (Stacey & Griffin, 2005: 22). Research begins with a process of starting to notice experience in an exploratory manner to address meaning and is therefore not hypothesis driven. This perspective does not seek to predict behaviour but accepts that the future arises as continuity with potential transformation. I find this a persuasive perspective and I am convinced that the IAPT model is too rigid to survive the coming changes in funding and organisation. The forces at work in local organisations and professional practice will cause mutations. Furthermore, the limitations of NICE recommended treatments and the assumptions about science, the evidence base and its transference to human interactions is where I feel least comfortable and will explore further in project three.

## **Will the balance of power in PMG change?**

I can see now that IAPT has been developed in a rational manner to remove as much uncertainty as possible about how to train the workforce. It has, therefore, focused on the need for clear curricula, competences, learning materials, qualifications and now course accreditation to maximise replicability. It has not been possible to be as prescriptive about services as they partially existed before and it is this area where there has been the most diversity. Performance management, in the form of rates of people seen and outcomes of numbers recovering, together with data on costs, has been the way that the programme has been monitored. When I joined the programme at its inception I was curious at the ‘bubble’ nature of it, in that the model was conceived of and implemented as though arriving on virgin ground. I have learned that implementing change is a challenging, not to say thankless, task. I have viewed this programme as a process of service redesign, supported by training. Gerald and Derek have always chosen to portray IAPT as a training initiative and as a result I have been drawn into the remorseless prescription of education and training. The production of new workers without a clear understanding of how they will fit into existing service configurations and be sustained in the long term is a huge risk. Nevertheless, letting a thousand flowers bloom, which has hitherto been the process, has led to hugely inequitable services in England. Adding rigour to the process makes sense to me and as part of PMG, I am inevitably drawn into its influence. Elias and Scotson (1994 [1965]) commented about the compromises that are made in joining a particular group.

The satisfaction of belonging to and representing a powerful and, according to one’s emotional equation, uniquely valuable and humanly superior group is functionally bound up with its members’ willingness to submit to the obligations imposed upon them by membership of that group. (1994: xxiii)

Griffin comments: ‘It is astounding that we continue to hold fantasies that single persons or small cliques of persons can steer such complexity to



achieve targets that they have set in advance' (2002: 200). Nevertheless, in IAPT, there have been successes so although services have not been fully replicated, I am left wondering how I would have done things differently.

Ironically, at this time, other evidence based therapies, recommended by NICE, are now being taken up, partly in reaction to professional and lay dissatisfaction with the single focus on CBT. These are being addressed in the same systemic way by defining the underpinning competences to distinguish those practitioners from their colleagues, as NICE compliant. In entering the middle year of the programme, we are looking to describe what IAPT will look like in a "steady state" in 2011, meaning with the full implementation of all NICE recommended therapies in a single local service.

But a shift in the balance of power is emerging. The very fact that other therapies are being announced and worked on, that are less tightly defined than CBT, has led to a strengthening of Jack's and my voices. More energy is being expended by John on formalising processes to make this a focus for PMG. Derek has begun to make approving noises although this is still framed entirely on the basis of what NICE says rather than on the importance of enhancing relationships with a wider range of professions. Perhaps I also need to review how I see conflict, to see that it can produce creativity and to see how opportunities can be taken to make things happen more constructively. Is it possible, as Elias says, that

(p)eople need to distance themselves from the configuration in which they stand as opponents to each other, if they are to see it as it were from the outside. But they are scarcely in a position to do this sufficiently while the dangers and threats they represent to each other in their interdependence are relatively great, and while they consequently still perceive and think about their mutual entanglement very emotionally. (1978: 166)

Emotions still run high, so there is not yet an obvious time to embark on a process that seeks to explore this way of working in PMG. In thinking about

the NAs who continue to be constrained, Elias and Scotson's observation, based on the community of Winston Parva, "outsider groups, as long as the power differential is great and submission inescapable, emotionally experience their *power* inferiority as a sign of their *human* inferiority." (1994 [1965]: xxvi). Power and the taken for granted views of evidence will continue to be major issues facing the group over the coming year I am sure. However, if 'they begin to bite it is a sign that the balance of power is changing' (ibid.: xxv).

## **CONCLUSIONS AND NEXT STEPS**

Professionals as I have viewed them, in more traditional mental health specialist services in the NHS, have not had a direct influence on IAPT. It is more subtle than that. The long development of the status and power of the doctor and of the psychiatrist in particular, has more to do with their social position than their evidence based interventions. This perception has been altered by scientism in the 19<sup>th</sup> century and the great strides in physical medicine, but this is not been clearly demonstrated in psychological medicine. Other professions were constrained by psychiatrists but social change in the 1970's loosened that grip and they stepped forward to provide psychological and social approaches; in therapy terms, this jurisdiction came to be dominated by psychologists.

The growing importance of scientific evidence, the knowledge and research base of professions are increasingly important in the NHS and in IAPT. How this evidence is enacted in practice is fundamental to what happens next.

*I want to explore evidence more fully in my next project, to consider how this relates to practice.*

## **PROJECT THREE (2010)**

### **HOW THE DISCOURSE AROUND EVIDENCE BASED PRACTICE AND IMPLEMENTATION HAS COME TO DOMINATE A NATIONAL PROGRAMME FOR CHANGE IN THE UK NHS**

#### **INTRODUCTION**

When the IAPT programme began, it was intended to be a process that would be developed co-operatively between national experts and locally informed partners. Inevitably, however, it was centrally driven, because of the culture of the NHS and because it was explicitly based on the implementation of evidence based practice.

NICE was established in 2000 as the mechanism by which the NHS would try to ensure that treatments were based on what was proven, through research, to work effectively, rather than on what was the custom and practice of professional staff. This has since been a key bone of contention: does the evidence based on randomised controlled research trials trump that of what professionals feel works in practice for them, or indeed, what people using services think works for them? A major issue has been that, although NICE has published many clinical guidelines of what the evidence says works, these have not been taken up by professionals and by doctors in particular, in everyday practice. Although these issues apply across the NHS, the implications for psychological therapies were not really addressed until Gerald, a senior political figure, attempted to link economic policy to that of health investment and outcomes. This proved a convincing argument for government so IAPT has become one of the first evidence based programmes of change in England, with a heavy emphasis on targets, consistent standards, measurement and performance monitoring, to provide evidence to justify further investment.

## **THE IAPT PROGRAMME MANAGEMENT GROUP IN 2010**

### **The move to a broader range of NICE recommended therapies in the context of increasing local decision making and long term sustainability**

The key focus of the IAPT programme in early 2010 is to demonstrate that it is achieving the results that it predicted in order to make the argument for the continuation of the implementation process. Governance arrangements are changing, with funding being devolved to Primary Care Trusts (PCTs), local commissioning organisations, at the same time as they are preparing to address the effects of the economic downturn by making deep cuts in expenditure. The Secretary of State announced in December 2009 that IAPT should remain an important area which PCTs should invest in to achieve equitable access across the country. He also said that there should be an increase in the choice of evidence based therapies, beyond CBT, which has been the key focus to date in IAPT services.

Derek, an NA, is an international expert in CBT, both as a therapist and as a researcher. It is his influence that has impacted on Gerald, who persuaded the government to invest in IAPT. He is therefore in a very powerful position. The training programme that underpins IAPT has already delivered 1000 new CBT practitioners, which means that we are on target to achieve the 3600 extra therapists if there is no deviation from current investment. As there is a risk that there will be such a deviation, with PCTs seeking to find ways of reducing expenditure, Derek wants to keep this focus on CBT clear so as not to give PCTs an opportunity to evade their commitment and find different ways to hit the target. Many of us have sympathy with this and see that there is a real risk of what is called in the NHS 'rebadging' i.e. calling something you have got already something else in order to achieve a government target, which can be thought of as 'gaming' (Seddon, 2008).

To address these risks, a new policy document had been published (Realising the Benefits [RTB]), in which quality standards are outlined to guide commissioning in the coming years, including standards for non CBT

therapies and the numbers of staff required. I want to summarise some of the realities this raises for me and for the programme.

### **The relative strengths of the non-CBT evidence based therapies**

I have taken the lead in addressing how the programme will offer the wider range of therapies that should be made available, in collaboration with Brian and Jack. *Appendix two* summarises the therapies for depression, recommended by NICE, published in RTB. These were drawn up after a great deal of discussion and not a little conflict in the NICE development groups (although I was not present and only heard this from Jack, the NA on Counselling and Psychotherapy); and discussed in PMG and related IAPT meetings.

These additional therapies and the issues they raise for me are as follows:

- *Interpersonal Psychotherapy (IPT)* is accorded the same level of effectiveness as CBT for treatment of depression. The evidence is drawn largely from studies carried out in the USA, so there are very few practitioners in the UK. IPT therapists are drawn from existing counsellors and practitioners. Interestingly, there is little dissent amongst PMG about the appropriateness of this therapy, because of the strength of the evidence.
- *Behavioural Couple Therapy* is recommended where one partner has depression, associated with the partner, who is willing to participate in therapy. Jack and I met with senior people from two professional organisations that provide couple therapy across the country to explore how we could work together. Imagine my surprise to learn that the type of couple therapy that they train people for and deliver with clients is *not* that recommended by NICE, which is specific *behavioural* couple therapy. This therapy is based on work in the USA on approaches that were popular in the UK in the 1970's. This is a dilemma then: there are hundreds of therapists working across England in ways that the evidence does not (yet) support.

Does this mean that they have no effect? Why do they not do what is apparently effective? This is the most contentious therapy in PMG.

- The two remaining therapies are *Counselling* and *Brief Dynamic Psychotherapy (BDT)*. They are recommended, however, only if the client has declined CBT, IPT or Behavioural Couple Therapy. Indeed, NICE recommends that when discussing options with the client, the therapist should point out that Counselling and BDT are less effective, in the interest of informed choice. I wonder how this can be conveyed positively to clients?

So the last few months have seen the drawing up of specifications for these modalities using the same quality assurance approaches as for CBT: competence frameworks; national curricula and training manuals. After a tendering process, this work was taken on by the relevant professional bodies and experts, who are due to report back in spring 2010. Whilst this work is being developed, there are emerging late night emails expressing concern from Derek and Ricky about the potential nature of a national curriculum for each, stating that they expect the non-CBT therapies to be subject to the same rigorous procedures as the high intensity CBT training programme. The CBT curriculum was written by people who had experience in training therapists for the trials that figured in NICE guidance, which they consider an empirically aligned approach. A key concern, then, is that the people developing the work will not be appropriate experts in their field, or at least not by Derek's standards. Jack, on the other hand, is involved in the development of one of these alternative therapies and is feeling more confident and powerful in his role at this time. So, specifying in detail what needs to be taught, directly drawn from the research trials, is at the heart of what is considered to be evidence based *quality* standards.

### **The relative size of the non-CBT workforce**

A second issue that has been a topic of debate is the number of non-CBT therapists there should be in the broader IAPT service. There is a fear that because there are many counsellors already working in local communities that this broadening will give licence to 'rebadge' them as 'IAPT compliant'

counsellors. Derek has calculated that only between 8 - 16% of the therapists should be non-CBT therapists to cover the additional 4 modalities. This range has been derived from an algorithm based on aggregate findings from research trials. In defence of this approach, people, who have to negotiate with PCT commissioners, are generally very keen to have simple messages and clear outcome data as, increasingly, this is all that commissioners will be convinced by. This reflects the target culture of the NHS and the drive for commissioners to buy only services that are recommended to work.

### **Articulating the arguments for sustainability**

As PMG struggles with these new therapies, it is also focussed on how the services and workforce will be sustained after 2011, when the national programme will be wound up. Much of this will depend on whether the predicted outcomes will have been achieved and therefore provide evidence that will support future investment. The key outcomes required are:

1. *900,000 additional people will access therapy than would otherwise have done so:* this figure is based on a set of assumptions that a maximum of 25% of the population in need will require services at any one time. In order to contextualise this, the funding for IAPT was expected to cover about 8% of the population. There is therefore a large gap between prevalence (therefore potential need) and funded services, but I am left wondering about the legitimacy of these assumptions.

2. *Improved equity of access:* currently there is a post code lottery and gaps for groups in terms of economic status, culture, ethnicity, age and so on. There are variable waiting times, although these are rarely more than two months, much shorter than other psychological therapy waiting times in the NHS, which can be more than a year. The RTB recommends the use of locally agreed waiting time quality standards (notice here the language is changing from 'target'). NAs are ambivalent about this and wary that this could lead to 'gaming'.

3. *50% of those receiving therapy should recover*: this figure has been set, based on what Derek and Ricky say should be expected from the research trials. Key performance data are presented to PMG regularly; at a recent meeting, the recovery figures were reported as anything from -6% to 52%. How can this be so? The collection of data is through the use of rating scales at every session in order to capture those people who drop out before the agreed/anticipated number of contacts. A minimum number of two contacts are therefore required to feed the Key Performance Indicator for change/recovery. The data quality is undoubtedly an issue; there may also be an issue that the measures are not meaningful to some therapists and therefore not completed with care. So, how data converts into evidence to feed back to commissioners is crucial for IAPT.

4. *An independent evaluation* of the two demonstration sites is due to be completed in 2010. An early issue identified, which interests me, is that the changes in symptoms (or recovery) as measured by rating scales, which are the key guide for the therapist, are not always reflective of the views of the client. So, a drop of several points on the PHQ9 (the rating scale for depression) would not necessarily reflect that a person had not achieved one of their personal objectives, which was contributing to their mental distress. The issue then arises, whose evidence is important?

Finally, at a recent meeting of PMG, Abe (NA for Primary Care) raised the issue of NICE guidance on *Collaborative Care*, which needs to be addressed. Ricky is unhappy with the NICE recommendation as it pre-empts his research on the concept in the UK, which is as yet two years away from publication. It was commented that it was politically necessary to address this and after all, science is iterative. This struck me as the only comment at PMG that opened up a potential conversation about uncertainty and the prevailing dogmatism about science.



## **REFLECTION ON THE THEMES OF EVIDENCE**

My initial focus for this project is on the nature of the evidence for CBT as the privileged therapy over others and the assumptions underpinning research on outcomes. To assist me in this, I am drawing on the work of Roth and Fonagy (2005), *What Works for Whom?*, which considers the issues of research methodology as well as the specifics of what is recommended in the literature for different groups. I will be considering the first aspect of their work and seeking to critique assumptions they make that are taken for granted in the scientific and clinical psychology communities.

I have now more fully realised that evidence in IAPT is not solely concerned with academic research, but is also about data and measurement in the NHS management culture. I will therefore consider this issue initially through the work of Seddon (2008), *Systems Thinking in the Public Sector*, where he criticises government targets and appears to be suggesting that the solution is to be found in systems thinking. Although this may have much to offer and resonates with some aspects of complex responsive processes, I want to comment on his manifesto from this latter perspective.

It is important for me to consider the fundamental assumptions behind both elements of evidence; concerning science and what it can tell us through research. Alvesson and Sköldbberg state that

(t)raditionally research has been conceived as the creation of true, objective knowledge, following a scientific method. From what appears or is presented as data, facts, the unequivocal imprints of 'reality', it is possible to acquire a reasonably adequate basis for empirically grounded conclusions and, as a next step, for generalisations and theory building. (2009: 1)

It is a feature of being human to try to understand and explain what goes on around us, to seek to gain some certainty or predict what may happen in the

future. Elias (1978) posits that theological and metaphysical modes of thought, which predated scientific interpretations, were taken as self-evident in their time, for instance a belief that the Earth rested motionless at the centre of the universe. We are now in a time where people take for granted assumptions about natural science in their everyday and professional lives. He summarises this as follows

...scientific, 'rational' modes of thought prove themselves valid again and again in empirical research and in practical applications to the technicalities of everyday life. They seem so unmistakably the 'right' modes of thought that it must seem to the individual that they were a gift from nature, in the form of 'commonsense' or 'reason'. (1978: 44)

He describes Comte as the originator not only of the term 'sociology' but also of the term 'positivism'; 'positive' in his terms was a synonym for 'scientific'. Positivism is the philosophy underpinning psychological therapy research as outlined next, which seems to be taken for granted in PMG.

## **THE EVIDENCE BASE FOR PSYCHOLOGICAL THERAPIES**

Psychologists have been largely responsible for research into psychological therapies. Two leading academic applied psychologists, Roth and Fonagy, were commissioned by the Department of Health to provide a critical review of psychotherapy research, published in 1996 and revised in 2005 as *What Works for Whom?* Interestingly, Roth takes a non-partisan perspective, whilst Fonagy is psycho-dynamically rooted as Freud Memorial Professor of Psychoanalysis. This balance of backgrounds is reflected in the stance they take in their review. I want to address issues raised by their review as they relate to assumptions in IAPT.

## **The interface between research and clinical practice**

Efficacy as reported in research trials is not the same as clinical effectiveness in everyday practice. This is because, in order to demonstrate the impact of one intervention over another, research trials need to achieve a high level of *internal validity*. Roth & Fonagy state:

This can be defined as the extent to which a causal relationship can be inferred among variables, or where the absence of a relationship implies the absence of a cause. If internal validity is low, *statistical conclusional validity* is compromised, and the results of the study would be hard to interpret. However, achieving internal validity requires the use of techniques rarely seen in everyday practice, examples of which would be studying highly selected, diagnostically homogenous patient populations; randomising the entry of these patients into treatments; and employing extensive monitoring of both patients' progress and the types of therapy used by therapists. All of this poses a threat to *external validity* - the extent to which we can infer that the causal relationship can be generalised. (2005: 16-17)

Criteria for efficacy include:

- Replicated demonstration of superiority to a control condition or another treatment condition, or a single, high-quality randomised control trial
- The availability of a clear description of the therapeutic method (preferably but not necessarily in the form of a treatment manual) of sufficient clarity to be usable as the basis for training
- A clear description of the patient group to whom the treatment was applied. (Ibid.: 480)

So, immediately, there is a tension between demonstrating efficacy i.e. some certainty about the likely impact of a therapy, and its applicability to natural

settings. Here, patients are varied, the range of interventions and monitoring is variable, therapists vary in their qualifications, experience and practice, and services may impose constraints, for instance on treatment session numbers, access to supervision and so on. This is where I feel I need open up discussion with Derek and Ricky to explore how they can feel so convinced about the rightness of their adherence to NICE in the full knowledge, which they will undoubtedly have, of the limitations of the transferability of research findings to practice.

Roth and Fonagy also point out that, in seeking to identify homogeneous groups as subjects of study, the Diagnostic and Statistical Manual of Mental Disorders (DSM) is commonly used for classification purposes, as it has high reliability. This classifies people by diagnosis and, therefore, tests efficacy of treatment against these diagnoses. Where therapies do not identify people by diagnosis, such as in Counselling, or where research studies have not focussed on treatment for specific symptomatic conditions, the DSM diagnostic approach has proved highly problematic and has effectively excluded those perspectives from the evidence base. Critics therefore have described IAPT as ‘medicalising’ people. In the early days I was rather surprised by this accusation and was quick to refute it. On reflection, however, it is clear that this methodology, which has been drawn from medicine, and which has primacy in NICE, does indeed draw on assumptions about physical and biological causality and applies it to psychology. Furthermore, the utility of diagnosis must be questioned as it is now well established that people with the same initial diagnosis do not have the same patterns of outcomes, because the history of the condition and the current determinants are not addressed by that diagnosis. Equally, people who may not score on DSM, who have ‘sub-threshold’ presentations, are excluded even though they may be experiencing high levels of distress. The utility of diagnostic labelling for research purposes, therefore, is not reflected in its usefulness in clinical practice, where a broader assessment of need and impact would be appropriate. Interestingly, Roth & Fonagy commenting on the NICE Guideline on Depression (2004) write that:

(The diagnosis) ‘depression’ may be too heterogeneous in biological, psychological and social terms to enable clarity on which specific interventions, for which problem, for which person, and in what context, will be effective. (Ibid.: 487)

IAPT’s first year data review, of 140,000 cases, showed that more than 40% had missing data on diagnosis, particularly on anxiety related conditions. This has led to speculation on whether the measures are insufficiently sensitive to pick these up (and there are a number of more condition specific measures being recommended to services to ameliorate this problem), whether therapists do not feel confident to diagnose or whether the ‘right’ people are not being referred. The sample size of this audit is reported to be unprecedented in the NHS and therefore a great success, which illustrates the huge value attributed to quantitative data by the DH and NHS.

### **Evidence based practice and practice based evidence: when is evidence ‘real’ evidence?**

NICE draws on research trials on the basis of a hierarchy of evidence. RCTs, together with their aggregation in systematic reviews and meta-analyses are the gold standard; followed by controlled trials without randomisation and experimental single-case designs; cohort studies (in which groups of patients are allocated to treatment); case-control studies (where patients with similar outcomes are grouped retrospectively to assess outcome differences); then, finally, various descriptive studies, professional opinion and expert committee reports. However, it is really only RCTs and meta-analyses that are considered to be convincing evidence in the scientifically focussed psychological community, and it is these that are mainly reported in Roth and Fonagy’s review.

Where there is no such gold standard evidence, it is important to distinguish between therapies that have been shown to be ineffective and those where there is a relative absence of empirical data. The majority of therapies lie in the latter category and psychodynamic psychotherapy in particular is under-

researched according to Roth and Fonagy. They address directly the tension in the psychotherapy community.

Many of its practitioners continue to view psychoanalysis as incompatible with research, because its focus is on meaning, and narrative is not easily reduced to measures of symptoms or suffering (e.g. Whittle, 2000). It is easy to appreciate that this approach is less easy to manualise, or that adapting technique to conform to the rigor of a research trial represents a challenge. (Ibid.: 491)

They go on to say that there are, nevertheless, examples where it has been possible to do this, suggesting therefore that there is “no inherent discontinuity” between the approach and empirical investigation. They gently criticise colleagues who disengage from research by saying “while an absence of evidence does not preclude the possibility of efficacy, the credibility of a treatment is much reduced if an evidential vacuum reflects the reluctance of its practitioners to explore its impact” (ibid.: 491). This statement reflects divisions between the cognitivists, the humanists and psychoanalysts in their ways of understanding and approach to working with people. It also illustrates the taken for granted view that this type of evidence has credibility above all. Roth and Fonagy do recognise, however, that there are good reasons why RCTs can be impractical, giving an example of Personal Construct Therapy, where diagnosis is eschewed, numbers are small and the preferred evaluation process is single case studies, using measures that detect shifts in process and meaning rather than symptomatic functioning. They comment

(i)t follows that a demand that practice be based on evidence would be unhelpfully restrictive if that demand equates evidence only with randomised trials and neglects to note any specific issues that restrict the range of available methodologies. (Ibid.: 492)

This is what NICE has done, however, in taking RCTs as their benchmark, which has led to the domination of CBT in terms of efficacy in the world of psychotherapy.

### **Translating research into practice**

One is tempted to question what real bearing research efficacy can have to clinical effectiveness in everyday practice, if the search for clarity of causal relationships is itself removing the variables which are present in everyday practice. The approach taken in IAPT so far has been to draw on the training manuals used in research trials to develop national curricula, thus intending to replicate the practice of expert therapists in IAPT training and clinical application. This is effectively trying to protocolise practice. It is interesting to note that experienced clinicians have commented that, in reviewing their practice against these protocols, they find they have deviated from them. The question is whether this is a good or a bad thing. Derek is clear that this is a bad thing, highlighting a study which looked at therapist variables and outcomes of treatment, which concluded that CBT therapists were more likely to avoid requiring clients to carry out homework where they were hostile. This could be seen as appropriate or as collusion in avoiding conflict. Roth and Fonagy comment on this issue and conclude, given the conflicting evidence on the subject, that

(i)t needs to be remembered that most clinical practice is much more heterogeneous than any manual would credit, and that manuals themselves are essentially ideal prototypes that embody the principles of complex interventions that have taken many decades to evolve in the field. These facts are easily overlooked if the techniques embodied in a manual are reified as *the* way to practise a treatment, rather than *a* way in which it could be practised. Attempting to “legislate” the form in which a treatment is delivered runs the risk of ossification, and of stifling appropriate creativity. (Ibid.: 495)

The national curriculum for CBT has been reified in this way, in my view. It is a common complaint in IAPT services that people who present to services are not solely exhibiting anxiety and depression, but have other issues too, for example, the misuse of alcohol or drugs. This was excluded from eligibility criteria for IAPT because there was no research evidence to support therapeutic efficacy with people with that dual diagnosis. We therefore see the conflict arising again between what can be extracted from scientific research and how this appears rarefied from the complexities of people's lives. This is where it is important that local solutions are developed and evaluated to develop knowledge and evidence from practice.

Practitioners complain that IAPT's evidence base is too rigid. Although there are obvious grounds for their complaints, this is often an echo of a yearning for the past where things were perceived to have been better. But is this so? What 'evidence' is there of this? Assertions of truths cannot be supported without evidence of some sort and it is not credible in my view to suggest otherwise. On the whole, the psychotherapy community has been poor at recording outcomes and therefore the judgement about what has worked for whom has been very subjective and often therapist driven. Clinicians, who are experts in their field have a tendency only to read research pertaining to their field and to "selectively disregard findings that would require of them substantial modification of their mode of work" (ibid.: 496).

IAPT training is based on competences for specific application to anxiety and depression. This has the potential disadvantage of not preparing the practitioner for people presenting with more complex needs. Roth and Fonagy favour an approach that addresses a broader set of metacompetences, enabling the practitioner to understand the principles, learn new skills more quickly and to adapt techniques to match client need. This is not generally favoured by Derek and Ricky and has not translated overtly into IAPT practice. This same dilemma presented itself to me when I attended a meeting of university course directors who are delivering IAPT trainings. A new course lead asked whether she should expose her group of trainee CBT therapists to other modalities and to differing protocols or whether she should



simply stick to the most accepted CBT protocol. My response was that we were not seeking technicians that only know one trick, but they should be able to critique the evidence. Another, more experienced course lead, advised that it was wiser to stick to one approach so that the trainees become more competent and confident and can see positive results more quickly. We all found this a very powerful argument and I was left wondering if my criticism of the limitations of the evidence base in this project is in danger of throwing the practical baby out with the intellectual bathwater!

In concluding this section on what the evidence says works for whom, in terms of demonstrated efficacy, it is clear that there are significant methodological issues that throw doubt on the replicability of behaviours from research trials into everyday clinical practice. Positivism has had many critics since the early 19<sup>th</sup> century and has gone through various formulations including logical positivism and later logical empiricism. Its assumptions of linear, 'if-then' causality, the quantitative approach to establishing observable and statistically significant relationships and hence predictiveness are clearly exhibited in Roth and Fonagy's review. In a comparison with qualitative methods, Ann Chih Lin comments "Positivists believe that generalisation is both the measure and the goal of causal research", whilst "Interpretativist work draws upon notions of credibility and accuracy of description to establish validity." (1998: 169). She argues that both are important: a positivist approach which can demonstrate probabilities of outcomes (the 'what') and an interpretative approach that offers a mechanism for testing out assumptions about the 'how'.

The evidence base for psychological therapies is therefore based on assumptions drawn from physics and the natural sciences. This has been effectively disowned by many sociologists seeking to understand and interpret how groups of people in society interact together. Even Comte sought to distinguish the applicability of models for social processes from those for biology or psychology, and here is the key tension for me: is psychology a physical science or a social science? The research evidence treats it as the former, but the interaction between two or more people in

therapy, for me, means that it is essentially a social process. I will therefore turn to Mead for insights.

## **A DIFFERENT WAY OF THINKING ABOUT THERAPY AS SOCIAL INTERACTION**

George Herbert Mead offered a different way of thinking about psychology and social interaction. “Philosophically, Mead was a pragmatist; scientifically, he was a social psychologist”, says Charles Morris in his introduction to *Mind, Self & Society* (1934: ix). He goes on “(t)he terms ‘social’ and ‘psychologist’ have not long appeared together, nor in company with biological categories. Tradition has identified psychology with the study of the individual self and mind” (ibid.: xii). Mead himself said “(n)o very sharp line can be drawn between social psychology and individual psychology”. He went on to herald the important view of how the self emerges in the social context.

If we abandon the conception of a substantive soul endowed with the self of the individual at birth, then we may regard the development of the individual’s self, and of his self-consciousness within the field of his experience, as the social psychologist’s special interest. (Ibid.: 1)

This was a long time ago, but the issues that he discussed, continue to be relevant. Mead built on areas of agreement with J. B. Watson, who established the school of behaviourism, about the importance of behaviour or ‘conduct’, and addressed areas which he saw as severe limitations in behavioural theory. Specifically, he considered that Watson “abstracted the individual’s segment of the act from the complete or ‘social’ act” (ibid.: xvi). Mead addressed language as a social phenomenon; he considered the private world of the individual; he described the ongoing interaction in the stimulus-response of behaviours; and he asserted that the individual experience is crucial and cannot be reduced to physical phenomena.

What Mead articulated was the role of the *gesture*, and the vocal gesture in particular. It is the capacity of the human being to take the role of the “other” that enables the mind and the self to develop. “Mind...is the internalisation within the individual of the social process of communication in which meaning emerges” (ibid.: xxii). Moving away from a traditional perspective where the individual has primacy, and where mind and sense of self develop internally and then impact on others, Mead took the opposite view, which

(s)tarts with an objective social process and works inwards through the importation of the social process of communication into the individual by the medium of the vocal gesture. (Ibid.: xxii)

Man is therefore essentially a social being, born into ongoing relationships with others. His physical and neurological characteristics (the biological ‘I’) play into these interactions and enable him to use language symbolically and enable him “to be an object to (him) self” (ibid.: xxiii) and hence demonstrate consciousness (the ‘me’). This develops as the individual matures into the capacity to take what Mead described as the ‘role of the generalised other’ (ibid.: xxiv). The person influences and is influenced by his interactions.

Indeed, every action of the individual at either the non-linguistic or linguistic levels of communication changes the social structure to some degree, slightly for the most part, greatly in the case of the genius and the leader. (Ibid.: xxv)

We can see here the process of change and of socialisation of the individual so that he is able to reflect and direct his actions in anticipation of responses of others. This common activity, Mead described as ‘social universality’ (ibid.: xxviii), a synonym for objectivity.

It is for the positivist the most important type of objectivity - some would say the only possible type. The individual transcends what is given to him alone when through communication he finds that his

experience is shared by others, that is, that his experience and the experiences of others fall under the same universal. (Ibid.: xxix)

What is sought in positivistic science is ‘invariance’; a formula; a recipe or a rule. This is at the core of what is being sought in the extracted descriptions of behaviour from research trials, in IAPT. Charles Taylor (1995), in exploring rules, argues that “(w)hat on paper is a set of dictated exchanges under certainty, on the ground is lived in suspense and uncertainty” (1995: 177). Rules, in the IAPT context, can be seen as knowledge translated into protocols and competences, which dictate practice in therapy. CBT involves the use of schemas to help the person reframe their problems and decide on goals. The success or otherwise of the therapy is seen as being mainly to do with the competence of the therapist. This could be described as technical ability (*techne*) as distinct from knowledge (*episteme*) as defined by Aristotle. The emphasis, in IAPT training, on competence acquisition is important in ensuring that people are clear about what is expected of their practice, until they can consolidate their skills and grow in confidence as a result. In therapy, however, judgement becomes important as well as technique; Taylor takes up Aristotle’s third category, the concept of *phronesis*.

The person of real practical wisdom is less marked by the ability to formulate rules than by knowing how to act in each particular situation. There is a crucial ‘phronetic gap’ between the formula and its enactment, and this too is neglected by explanations that give primacy to the rule-as-represented. (Ibid.: 177)

Taylor is recognising that rules have their place in helping to describe and understand what happens in everyday life, but that these abstractions from time and space cannot be seen as the sole causal factors. He appears to share Mead’s view that social interaction is circular or ‘asymmetrical’, i.e. that we engage with intention with another, but that there is no certainty that responses conform to this intention and therefore ongoing adjustment occurs, as in therapy. He argues that ‘rules are transformed through practice’ (ibid.: 178), but states that ‘this reciprocity is what the intellectualist theory leaves

out' (ibid.) and which in his view therefore distorts the whole process of understanding. Taylor argues that this has to be 'embodied' in our day to day practice, drawing on the work of Bourdieu, and concludes "rules can only function in our lives along with an inarticulate sense encoded in the body. It is this *habitus* (my italics) that "activates" the rules" (1995: 180).

I take this to mean that knowledge or facts that natural sciences have sought to establish and which have been taken to explain social phenomena, have been shown to be inadequate in accounting for the way people go about their lives in practice. These social interactions are influenced by culture that gives meaning to these interactions; this could also be described as the 'generalised other' in Mead's terms. What this means for me, in relation to evidence that underpins therapy in IAPT, is that currently this is based on an intellectualised and abstracted model of human behaviour, which relies on therapist behaviour that is protocolised and which could be described as rule governed. Deviation from this protocol is seen as poor practice rather than as what would be expected in the symbolic interactions that take place in therapy, which could lead to new and emerging behaviour. Mead was a scientist as well as a philosopher and he supported taking a scientific approach. However as a pragmatist, he believed that the value of the scientific hypothesis was that it should illuminate people's real experience. For me, this means that evidence should resonate with me and not be abstracted to a point of scientific purity, at the expense of what is meaningful in practice.

In this section on evidence as it relates to therapy, it is important to flag that one of Mead's major contributions has been to an understanding of how the self arises in social interaction. This has informed significantly the development of therapeutic practice. Snyder, for instance, a psychotherapist working with couples, comments that "Mead perceived the primary aspect of human intelligence to be the capacity of the individual to 'put himself in the place of another' (Mead, 1934: 38). The implications of this for both individual and family psychotherapy and, in particular, its relevance to empathy and dialogue, are significant" (1994: 84).

## **CONCLUSIONS**

Finally, in returning to the imponderable question about whether psychology is a natural or social science, it seems to me that there is a continuum of interaction between the physical and the social, where self-awareness or consciousness arises. Mead addressed how behaviourism could have its place in an ongoing process of social interaction. As our technical ability increases in the 21<sup>st</sup> century to enable brain imaging, we can observe the anticipation of the brain (by the firing of neurons) in responding to stimuli before we are aware of them; illustrating that there is a continuous process in our ongoing interactions with others and with ourselves. Fonagy (2004) believes that improving understanding of our molecular biology will help in identifying biological/genetic vulnerability of children to adverse environmental factors, which will enable better targeted preventative interventions as well as psychosocial treatments. In this he seems to be seeking to overcome the traditional mind/body split and states “(f)uture psychotherapy research must entail the removal of the opposition between psychosocial and biological perspectives” (ibid.: 358). He even suggests that in the future, outcome measurements, as currently used, could be replaced by brain imaging, which can currently detect brain changes when two people interact. But this too could run the risk of atomising the ongoing process of human interaction if taken up in positivistic terms. Nevertheless it demonstrates the permeability of thinking that is possible if polarisation of positions can be avoided. I conclude, therefore, that it is not sufficient to treat psychological therapy as if it were a natural science, subject to efficient causality, with highly predictable outcomes. It is important, rather, to consider how it can be most helpful to people as it is applied locally.

## **REFLECTIONS ON IMPLEMENTING IAPT IN A LOCAL SERVICE**

In wrestling with these ideas in the abstract, I often feel that I need to immerse myself in the daily interactions of people working in IAPT services to discuss their experience of the practicalities of local implementation. This opportunity arose recently, when a colleague asked me to co-facilitate a team

learning process to help them review their practice. I was curious to see how far the IAPT model has been taken up as a 'blueprint' in their service.

The people in the room were a mix of counsellors and psychotherapists, who had been around for a long time, joined recently by newly qualified PWP's and High Intensity CBT therapists. When they felt able openly to express their views, it emerged that at the core of their conflictual feelings were their different ways of conceptualising the needs of their clients from their varied professional perspectives. There was no apparent animosity between members in the group, but there was strong concern about the complexity of the needs of the people entering their service; the narrow nature of the training of the new staff (CBT); the inappropriateness of the assessment scales; and what ideas they had hatched to reduce access by clients to manage their waiting lists. Their way of screening people was clearly not working and took up a lot of experienced practitioner time, but they were unwilling to support the PWP's to screen, as is recommended by IAPT, which had led to them developing long waiting lists.

We talked about the evidence base and the collection of data and I reflected to them that there was a difficulty in translating efficacy from research trials into clinically effective practice. They fell on this recognition with gratitude. Their clinical lead, a consultant psychologist, went so far as to say that, in her view, the rating scales were 'rubbish'. Although I had sympathy with this for the reasons outlined in the previous section, I was concerned that this might lead to further conflict and variable practice in the group. I found myself in an interesting intellectual and emotional position in these discussions. I felt more relaxed than I would have done a year ago because I had a better understanding both of the research evidence underpinning IAPT and its shortcomings and of the potential perverse nature of hitting their targets; I was therefore less defensive. However, I was also worried that the semi chaotic nature of their service was unlikely to enable them to give the best of themselves and hence to help their clients effectively. I felt myself reacting against their taken for granted view that the more experienced staff knew best. I was, however, also more aware of the Dreyfus 'expert' working into

the unknown and did not want to disrespect experienced professionals, whilst wanting to challenge them to encourage the new workforce. I therefore found myself in a paradoxical position. I reflected that Derek would feel no such ambivalence had he been there. I was able to confirm to myself that this was no blueprint.

## **EVIDENCE AS IT IS USED IN PUBLIC SECTOR MANAGEMENT**

I wish now to shift my focus from the nature of evidence drawn from research trials to the evidence drawn from data collection and performance management of IAPT targets in the NHS. These targets include: hitting *activity numbers*: high targets were set in year one; *waiting times*: although there are no such IAPT national targets, some PCTs have imposed these locally; and *recovery rates* which are low in some areas, potentially undermining the whole purpose of the programme. Ways have been found in local services to deliver on targets, which are not in the spirit of the target; for instance, rapid assessment followed by a lengthy wait for treatment, which is a tried and tested ploy in other NHS sectors. The national implementation process, although captured in numerous policy documents, has been variously understood, taken up or even read. One unlooked for outcome of the focus on CBT has been that some PCTs have decommissioned whole counselling services, using IAPT as an excuse to reduce services. Although there is discernible progress in the development of new IAPT services, in line with the national guidelines, there is also evidence, revealed more in conversations than in formal returns, that the roll-out is not going entirely to plan and that the blueprint has not been replicated at local levels.

### **Reflections on the assumptions behind evidence as it relates to the NHS.**

As a manager in the 1990's, I found it difficult to influence professional practice to change in ways that service users said would make a difference to them. I was therefore pleased when the first National Service Framework for Mental Health was published in 1999, identifying targets and funding. The 'must dos' did create opportunities to establish new services, such as Crisis



and Home Treatment Teams providing a real alternative to hospital admission, and it did result in changes in many places. I am struck, though, returning to work in a Trust ten years later, how some of these developments have occurred in a ‘countable’ form but not in practice. A former policy lead colleague described this as ‘hitting the target and missing the point’. I have to confess that I have been shocked by the paralysis that seems to have engulfed managers in making changes, which are patently required, because of a need to account to PCTs for delivering on targets. Lack of trust predominates: locally, between the commissioners and providers; within Trusts between clinicians and managers and nationally between central government and local commissioners. This target driven culture has had many unlooked for outcomes.

#### **A CRITIQUE OF THE IDEOLOGY UNDERPINNING THE TARGET AND PERFORMANCE MANAGEMENT CULTURE OF THE NHS**

So where did it all go wrong? To consider this, I have chosen to take up the work of Seddon (2008), who published a critique of the public sector and a “manifesto” for a better way to address management through systems thinking, based on the work of Taiichi Ohno, the person behind the Toyota Production System (TPS). I will compare his approach with that of Ralph Stacey (2005, 2010)

Seddon provides a sharp critique of the system reform regime, which has been adopted by successive governments since the 1980’s. He contextualises this to the economic position, changing since World War Two, when Keynes encouraged governments to intervene in the economy to increase public expenditure as a means to full employment. This became accepted wisdom until the early 1970s when a variety of unexpected world crises occurred, leading to economic stagnation and very high inflation, for which Keynesian economics was believed unable to account. This left the way open to different economic philosophies and specifically to monetarism. A key advocate, Milton Friedman, argued against public sector involvement to create employment, holding that the public sector should be treated like a free

market, allowed to run its self-correcting course, keeping government involvement to a minimum. Thatcher, the UK Prime Minister, brought monetarist policy into the heart of government by denationalising major industries such as British Gas. Where it was impractical to do this with public services such as the NHS, 'quasi-markets' were established. Seddon comments that this approach was underpinned by a belief that civil servants, managers and professionals were "essentially lazy and self-interested and needed to be 'motivated' by extrinsic forms of motivation: carrots and sticks" (ibid.: 4). This mirrors the perspective of Khurana (2007), who argued that the same economic changes led to a shift from managers being seen as professionals to entrepreneurial leaders, rewarded with shares and bonuses. One can see immediately how this attitude has undermined trust between stakeholders in the NHS.

Public choice and consumer interest, based on game theory, became central to this thinking, on the assumption that the power to choose would act as a lever on service providers. In 1988, the government established the "internal market", bringing in general management, separating commissioners from providers of services and establishing performance targets. Stacey (2005, 2010), in a critique of public sector governance, shares some of these views about the origin of the internal market in the NHS. More specifically, however, he reflects that the nature of the figuration of power at that time was of professions working in a collegial manner, making their own decisions about the use of local resources resulting in considerable local variation. He states that the government took the view that "(t)he whole public sector was held to be inefficient, irresponsible, non-accountable for quality delivery and far from innovative. Unfavourable comparisons were made with the private sector" (2005: 2). Reflecting on my own experience at that time, I welcomed the advent of general management, not because of a belief in the private sector, far from it, but because I was seeking a way of exerting power over professionals, whom I perceived were acting to protect their own interests and not responding to the needs of people using services. I was not alone in this, so I think there were a number of influential factors operating at that time.

Targets and performance management frameworks have been elaborated since then, becoming formalised in ‘public service agreements’ (PSAs), which underpin NHS management today. Stacey describes this as an ideological shift in power

...the particular form of power configuration which has emerged is sustained by a very different ideology to that which prevailed before. This is an ideology of efficiency, measurable quality and improvement. It is an ideology of managerial control to produce uniformity of service. It is an ideology of the market. (Ibid.: 3)

Seddon argues that successive governments have blindly gone down this route with no evidence of its effectiveness. Indeed his whole argument is that targets have made services worse and wasted money. As targets have been shown to deliver the wrong things, there has been a central move to refine targets, which Seddon describes as making “the wrong thing righter” (ibid.: 10), and to reduce the number of targets, “doing less of the wrong thing” (ibid.: 11). He describes how this “command and control” perspective has developed from the time of Adam Smith (1776) and argues that this is the model operating across the NHS and the rest of the public sector in England today.

His manifesto, an alternative to this command and control way of doing things, is to adopt what he describes as a systems approach. He does not contextualise this within broader systems thinking literature, but confines it to the work based on Ohno (1988) and TPS. He acknowledges that it is not appropriate directly to apply a system from manufacturing to public services, but emphasises the importance of *method*. The starting point is to think of the capacity of the system, which is to undertake ‘value work’ so that customers can get what they want and only what they want first time, and ‘failure demand’ (ibid.: 52), the time and activity taken up in dealing with failures or getting things wrong first time, which is described as ‘waste’; if waste is reduced, this increases the capacity to deliver more value work. The important thing is that managers need to observe directly what is going on,

not rely on abstractions of reports or figures. The starting point must always be to understand demand and its predictability, to design the service to meet that demand, train staff according to the demand, develop measures appropriate to that design and make the worker the inspector; all of this is through a process he calls 'check' (ibid.: 77). This is essentially 'lean thinking', which has become popular in the NHS in recent years. He is critical, however, of those who utilise tools and techniques of lean, which focus on 'end to end' mapping, without reference to demand and system conditions and he accuses those people of being "toolhead(s)" (ibid.: 81). His focus therefore is about improving local processes.

Macklis (2001) comments on a similar US approach to healthcare restructuring, aiming to improve safety. He states that an alternative to 'top-down re-engineering' and 'best practice mandates', which he perceives to be 'rarely successful' (2001: 1), would be local health initiatives, locally driven by people with credibility, the results of which would not necessarily be transferable or generalisable to other situations. Seddon refers to Ohno, who also warned against the much vaunted idea of 'best practice'.

He thought that it was a dangerous and misleading idea. 'Best' implies static, something 'good' that should be copied. He said that whenever you hear the word 'best', think 'better', because anything can be improved. Second, everything you need to know in order to make improvements will be found in your own system. If you go looking elsewhere, you will be looking in the wrong place. (2008: 173)

Groopman (2010), in a commentary on Obama's health care reform proposals, reflects, as a clinician, how he had once contributed to "misconceived 'best practice' (2010: 2)". This concerned a medical procedure for cancer patients which was recommended as a default option, and was subsequently found to benefit only a minority and increase risks for others. His review of the policy reform crossroads for the US healthcare system and the conflicting expert advice being received by the

administration, echo these different assumptions about human motivation, clinical judgement and science. He reports that Sunstein is advising that the President use a behavioural economic approach to ‘nudge’ people towards a different ‘default’ position (one which requires less effort to follow), being respectful to people making their own decisions. Orszag, another key advisor, promotes a different approach based on a lack of trust in doctors and administrators, suggesting that “(t)o alter providers’ behaviour, it is probably necessary to combine comparative effectiveness research with *aggressive promulgation of standards and changes in financial and other incentives*”, (ibid.: 1). Notice that there is a stark contrast in the view of human nature underpinning these two approaches.

Seddon asserts that the view of human nature, by taking his systems approach, shifts from one that is pessimistic to one that believes in motivation as intrinsic. He explores the work on “public value” (2008: 162) originated by Moore (1995). Here, public service managers are re-valued as “explorers” with expertise and political know how, who should be exploited, seeing their motivation as public value much in the same way as private sector managers see shareholder value.

Seddon reflects that evidence in the public sector is evidence of compliance to targets, not of efficacy, he does not however define efficacy from his perspective. Stacey commented earlier that the rhetoric of quality and cost effectiveness is hard to argue against, for to do so “amounts to challenging the dominant ideology and power figuration, so risking exclusion”. Furthermore, “thinking which supports the new (performance) model is so taken for granted, while an alternative way of thinking is not immediately apparent, that there seems no way out” (2005: 3). Seddon’s conclusion is that the current system has failed completely, and the only solution is “to get rid of the whole thing: to close it down and simply stop it” (2008: 193). Not surprisingly his views are not welcomed by the establishment and he has effectively been excluded. It is this dilemma that I feel with IAPT, in particular articulating what a realistic alternative might look like. He suggests that “stepping back from the regime would break the logjam at both political

and implementation level". His own manifesto is to change the locus of control, but

(t)o change the regime requires first a change in philosophy...To achieve that, we have to make public sector managers responsible. *They* have to be able to choose what to do, free from the obligation of compliance. (2008: 196)

He concludes by saying that in contrast with current practice

...the assumptions that I use are no less rational, but they are positive rather than negative: the new structures assume that people are motivated more by pride in their work than by money, that they are vocational - they want to serve - and they are capable of using their own ingenuity and initiative. It is also to assume that, in delivering services to consumers and citizens, cooperation will service our purposes better than competition. (Ibid.: 197)

It is interesting to reflect on Seddon's views as they resonate in part with my own experience of the perversion of targets in the current NHS. I have also had positive feedback about the use of Lean Rapid Improvement Workshops in redesigning processes in acute mental health inpatient settings, based on methods developed at the Virginia Mason Medical Centre in Seattle, referred to by Lee (2010). Seddon, however, is dogmatic in his certainty about the utility of systems thinking, which strikes me as unwise. He does not question the importance of rationality; his analysis does not take into account the different ways of power relating, in the NHS at least, where there are multi professional tensions; he appears to have no doubt that the public sector manager can stand outside the system in order to plan and implement a new philosophy; he appeals to the importance of evidence of efficacy but makes no reference to how this is obtained nor how it is distinguished from effectiveness. I am left thinking that his stance must be about practice based evidence as it is collected through measures developed locally and not in any way about evidence based practice drawn from research trials. Although he

seeks to distinguish Lean or TPS, as it relates to manufacturing, from how it relates to the public sector, he is not clear how he is differentiating the two. Finally, he has a touching faith in the positive nature of people in the workforce, who will be more motivated by vocation than by external or other rewards, which I believe to be a rather polarised view of the motivations of people at work.

### **COMPLEX RESPONSIVE PROCESSES AND THE IMPLICATIONS FOR EVIDENCE BASED PRACTICE AND EVIDENCE BASED MANAGEMENT**

The two challenges facing IAPT are how to achieve change within short timescales and how to sustain them in the longer term. Change and stability are at the heart of organisations of any kind, whether in nature or in human action. The taken for granted position of Derek and others is that it is possible to prove efficacy of psychological therapies through scientific research studies, and of John, the programme lead, that targets, levers and performance management are unquestionably the way to roll out a national initiative. Their philosophical starting point is positivism and of linear or efficient causality. This has its roots in Newtonian mechanics, universal laws such as gravity, and natural scientific method, “by which humans come to know the reality of both stability and change through careful observation, formulating hypotheses and then testing them empirically” (Stacey, Griffin & Shaw, 2000: 22). The emphasis in psychological research is to find ways of establishing causal links and hence predictability in order to control human behaviour. As Stacey et al describe:

This kind of hypothesis immediately focuses attention on cause and effect links having an ‘if-then’ structure applied to one part of the whole. The method involves isolating linear causal links, those of an efficient, or sufficient, kind. In other words the scientific method involved a reductionist approach in that attention was focused on parts of a phenomenon. Those parts were postulated to behave predictably according to efficient causality, while the interaction between them was accorded no significance. (Ibid.: 22)

The isolation of specific variables, such as a single diagnosis and a specific technique illustrates this way of controlling parts of the therapy process to achieve internal validity, as highlighted above by Roth and Fonagy. The results would hold good if replicated, irrespective of time and the focus is on getting the behaviour of the therapist right.

Stacey et al question these assumptions and review types of causality to underpin their critique of systems thinking in organisations and how complexity theory has been taken up in systems thinking. They argue that, as ways of thinking derived from the natural sciences are applied to psychology and sociology, they bring with them taken for granted assumptions about causality that simply do not hold good for human beings. They are arguing for looking at what actually happens in organisations as opposed to what is supposed to happen, according to systems and complexity literature and have developed thinking on complex responsive processes of relating, to offer a different account. This has relevance for me in trying to understand how targets in the NHS can go so wrong and how linear explanations of human interaction in therapy can be critiqued effectively.

Complex responsive processes of relating draw on analogies from the natural complexity sciences, concerned with phenomena that are characterised by nonlinear dynamics; the sciences of uncertainty. These include, for example, complex adaptive systems, where large numbers of interacting bodies, known as 'agents', adapt to each other, forming a system that adapts to its environment. Computer generated programmes have demonstrated that when large numbers of agents interact they form a pattern, which is said to be self-organised and for which there is no blueprint. Many of these simulations follow simple rules however, which do not fit with humans who are conscious and reflective. Stacey comments that because humans are interdependent, they will enable and constrain one another, which means that there are differing, but ever present, power relationships, which Elias (1978) also describes. Stacey refers to Mead to articulate how consciousness and self-consciousness arise in communicative interaction and how meaning does



not lie in the gesture or word but “only in the gesture taken together with the response to it” (2005: 14). He comments

Mead, then, was concerned with complex social acts in which many people are engaged in conversations through which they accomplish tasks of fitting in and conflicting with each other to realise their objectives and purposes. (Ibid.: 15)

He makes the important point that individuals may act in relation to what is common to all (generalising) but respond somewhat differently in specific circumstances in any present time period (particularising). ‘Social objects’ are gestures with tendencies to act or respond in particular ways; ‘social control’ is bringing the act of the individual in line with the social object; all organisations are social objects in Mead’s terms. Mead also described a similar process between the general and the particular, drawing a distinction between ideology or ‘cult values’ and their functionalisation or enactment in specific situations. In my case we could describe implementing evidence based practice as a cult value in the NHS and its implementation in local services as functionalisation. Stacey comments

(s)uch cult values present people with the image of an idealised future shorn of all constraints. If such values are applied directly to action, without allowing for variations contingent on a specific situation, then those undertaking such action form a cult in which they exclude all who do not comply. (Ibid.: 16)

IAPT and its strong push to implement CBT has seemed cultish to those who have been excluded. By the same token, the variability in local implementation has been puzzling and frustrating to PMG. But this is not surprising as Stacey says, ‘(f)unctionalisation of cult values inevitably leads to conflict and the negotiation of compromises around such conflict’ (ibid.: 16). Another way of thinking about this is described by Stacey in his most recent book (2010), where he distinguishes first and second order abstracting. First order abstracting refers to how we immerse ourselves in our

interactions, but also abstract from our experience, paradoxically, at the same time, by simplifying and categorising; so that we are reflecting and paying attention to what is happening as we are interacting. Second order abstracting describes how we need sometimes to talk, using maps and models, with less detail and often without reference to the people involved; this tends to be the dominant way of thinking in systems management.

Stacey's analysis of the NHS management culture identifies a number of cult values including performance and quality and describes how policy documents, such as RTB, are artefacts, "used as tools in the communicative interaction and power relating between members within the NHS" (2005: 16). These artefacts capture the generalisations and idealisations of IAPT but they will "only have any meaning in the local interactions of all involved in each specific situation" (ibid.: 17). We have seen the different ways that groups of clinicians, commissioners and managers have implemented IAPT across England.

Stacey goes on to suggest that the principles behind target setting and performance monitoring are derived from cybernetic systems thinking: effectively trying to design the NHS as a self-regulating system. This cannot be so as the taking up of the artefact of IAPT policy in so many local processes cannot possibly result in identical services, not least because of different understandings, different resources and conflicting professional views of what it does or should constitute. Nevertheless, there is an understanding of the importance of hitting targets, which can lead to avoidance, manipulation or even falsification. Stacey believes that current thinking treats the NHS as a homeostatic self-regulating system, akin to a giant central heating system, which is extremely naïve. This, I believe is what Seddon is also responding to in part. Where they diverge, I suggest, is that Seddon believes that if managers were empowered to stand outside the system, they could rationally lead the change process at a local level. Although he strongly implies that solutions must be locally determined, he believes that this can be planned and carried out rationally and systematically. He does not take into account conflict and power. He

continues to think in terms of planning before action with public value leadership from key managers. He postulates the need for adopting a (solely) positive view of the workforce, motivated by vocation. It is for the above reasons that I find his manifesto unconvincing. Complex responsive processes question these views in a way that resonates with my actual experience, but which leaves me uncertain about how I describe my usual way of viewing the world. I intend to explore further the theory of complex responsive processes to see if it can offer insights into the power and politics in IAPT.

### **REFLECTIONS ON PMG IN SPRING 2010**

My feelings of being silenced and excluded in PMG, have curiously abated at this time. Why should this be? I think a number of factors are at work here. The impending end of the programme; the shift to Strategic Health Authorities (SHAs) leading the implementation process; the expansion of therapies beyond CBT; these all feel as though they have caused a shift in the power balance in PMG. More specifically, Derek and Gerald are less in evidence; there are fewer irritable late night emails; there is an acknowledgement, despite the publication of RTB, that there will be inevitable differences that are beyond the control of PMG. Perhaps this feeling, common to us all, has reduced the internal conflict. Jack is clearly trying to build his power base on the back of the new therapies. I have found this annoying as he, like Derek, is straying very much into my jurisdiction. Nevertheless, as we have collaborated together a good deal, I feel less intimidated by him. Perhaps I have also begun to have more paradoxical detached involvement with PMG; I feel I have got a better understanding of the issues as they relate to evidence for the programme, so my confidence is improving. Interestingly, John has sought comfort in tighter project management to manage the uncertainty. He has employed someone steeped in Prince 2 methodology to produce a project plan of products, interdependencies, timelines and milestones. This person sent a first redraft of work I had given to him, which was completely incomprehensible. When this approach was described and sought approval for at the last PMG, I made

a point of being realistic and proportional about benefits of this approach. The DH mental health policy lead commented that he had spent a great deal of time developing such a project structure in his previous role, but before the project worker had time to brighten, he concluded that he had never followed it through... So, we see here the intention to act rationally again, the hope springing eternally to predict and control and the actual experience emerging differently in practice.

## **SUMMARY AND CONCLUSIONS**

I have found the importance of evidence to be very significant in its influence on developing the case for IAPT and for managing its implementation. I have been surprised that my initial preoccupation with the evidence from research trials for CBT and other therapies initially obscured my view of evidence as it is embedded in an NHS culture of performance management. The underlying assumptions behind both aspects of evidence arise from a belief in linear causality and positivism, drawn from the natural sciences. This is a taken for granted intellectualised view, which effectively silences dissenting views about the nature of this evidence. Science and scientifically developed evidence based practice are effectively cult values in everyday life and in the NHS. There is good reason for this. The history of the development of healthcare in the UK has been iterative and has been influenced as much by power and position as by effectiveness from the patient's point of view. Much of what is carried out in the name of care in mental health services has occurred in this way. One of the biggest difficulties has been the lack of information about what works for whom, even on an individual basis. This is why critics of IAPT and of NICE are poorly placed to argue their corner as they cannot effectively point to evidence that what they do works. The question is, though, can the evidence from NICE effectively demonstrate that the efficacy from trials can be translated into clinical effectiveness?

Psychology and psychological therapies hover in the tension between the natural and social sciences. The social sciences have largely moved away from positivism; and from quantitative to qualitative research methodology.

Whatever the methodologies and the nature of the evidence, there is a natural and continuing requirement to understand the complexities of our world, to predict what might occur and to try to control for what can be controlled. The tendency to date, certainly in the last 20 years in the NHS, has been to take a centralising, command and control position by making explicit targets, linking resources to them and monitoring activity (usually not outcomes). This approach has emerged from the internal market and its assumptions about professionals and managers. There are many instances of where this is perverse, Seddon wishes to tear it down and Stacey considers it to be naïve. There have, nevertheless, been significant advances during this period. Indeed, in IAPT, large numbers of people have been helped through therapy and significant numbers of staff have been trained and inspired, so it would be nonsense to suggest all this effort is wasted.

As we move into the final financial year for IAPT the question of sustainability in the longer term is looming. My guess is that there will be a gradual blurring of what is commissioned by way of psychological therapies; probably some disinvestment and re-badging by commissioners and providers; newly trained and qualified staff in the workforce may, in their turn, influence local processes. IAPT could unravel. Commissioners need to have local conversations with providers about what can happen locally. More types of evidence need to be forthcoming, whatever the drawbacks on methodology. Jack is gloomy about this prospect, however, as funding bodies are disinclined to fund research that is not linked to diagnoses. But perhaps outcome monitoring from IAPT sites will help inform the process and develop evidence from practice. Whatever happens will probably be as much to do with who is pushing and where the power lies nationally and locally in the coming years. *It is power therefore that I wish to explore in project four.*

## **PROJECT FOUR (2010/2011)**

### **HOW POWER RELATIONS INFLUENCE THE IMPLEMENTATION OF A THE NATIONAL PROGRAMME TO IMPROVE ACCESS TO PSYCHOLOGICAL THERAPIES**

#### **INTRODUCTION**

The three year programme is due to finish in March 2011, so at the time of writing, consolidation and planning for sustainability beyond that time are key considerations. It is also the last opportunity to facilitate the inclusion of a wider range of evidence based therapies for depression, beyond CBT. Two NAs, Gerald and Jack, have undertaken a lot of political lobbying behind the scenes and John, the Programme Director, has prepared a case for continuing funding for what the new coalition government is now describing as ‘Talking Therapies’. Fortunately, confirmation of continuity of funding of £400 million has been announced with the publication of the new mental health strategy, despite this being a time of serious funding cuts. This is on condition that access to psychological therapies will result in demonstrable reductions in the use of more expensive health services further down the line. In this context the following meetings took place:

#### **NARRATIVES EXPLORING THEMES OF POWER**

##### **Narrative one**

As part of a recent meeting of the IAPT Education and Training group, which Brian (the Education & Training NA) and I chair, I led a discussion on how the NICE recommended and IAPT approved therapies, commonly referred to as ‘non CBT’, could be presented in a consistent way for commissioners and services nationally. The usually consensus seeking ‘four modalities’ representatives were disturbed on that day by disagreements about which of them might lead some technical and accreditation work. It became clear that there was an emerging distrust of a professor representative from a powerful

university, whom although being personally well respected, was seen as trying to direct all the work to his university and thus challenging their positions and autonomy. To make matters worse the IAPT Core Team had attended the meeting to observe Brian and I at work and although I tried to achieve consensus and agree actions, I was constantly thwarted in this. I left the meeting feeling exhausted and somewhat of a failure in the eyes of the Core Team.

As luck would have it, the four modality representatives had suggested at a previous meeting that they would like to meet together as a group to discuss some of the detail of the work. I welcomed this suggestion as I felt there was much to do and their intention to collaborate, without facilitation, was encouraging. They therefore went off to have their meeting, whilst Brian and I went to a performance management meeting with the Core Team. Jack (the NA for Counselling and Psychotherapy), who has been directly involved in one of the modalities and had been in the previous meeting, took me to one side and said he was joining the four modalities and suggested that he therefore chair the meeting. My antennae were alerted at once: Jack was going to use his influence to drive outcomes that he favoured. I said that it was ok, as I felt I had no alternative, but explained that he needed to come back and brief me on the outcome and if NAs were going to be involved in their future meetings, I would chair them.

Brian and I were then taken through an elaborate project plan by the Core Team. Since there had been significant turnover in the team, this was essentially a briefing to get them up to speed. However, there was a lot of questioning about how things had been approved in the past and about audit trails, with thinly disguised disapproval of the sloppiness of our programme to date. Some of the Core team came and went, and as we were in small glass offices, I noticed Jack going into a neighbouring office and talking to John. I knew instinctively that he was discussing actions that must have arisen in the four modality meeting and was getting agreement from John before talking to me and to Brian. I felt angry, stuck in a silly meeting, whilst Jack was manipulating processes in such a bare faced way. I was also furious that John

was agreeing to be briefed by Jack when he knew I was leading in this area. I was also concerned that he was doing this because he thought that more progress would be made if Jack were given his head, which was therefore a comment on my performance. On the way out after my meeting, Jack rushed up with a short resume of what had happened, an email about which he wanted to send out that evening and a date for the next meeting (which I could not make). I said I wanted to see the email before it went off and went to catch my train, where I pondered on a wholly unsatisfactory day which had left me feeling undermined and inadequate.

That evening, Jack rang me to outline the content of the email before he sent it and it was just as worrying as I had predicted. We had a sharp exchange of words which resulted in me accusing him of being every bit as bad as Derek in how he was not working collaboratively and moving to manipulate events in his own interests. Since Jack dislikes Derek, this was quite an insult. I went to bed that night and continued to brood; I did not feel any relish for the cut and thrust of the politics of the programme.

This experience was closely followed by:

### **Narrative two**

The new coalition government moved quickly to freeze government spending, including the IAPT budget. This led to an emergency single issue (workforce) PMG being called, with an explicit aim of signing off the non CBT modality competence frameworks. The haste was because the competence frameworks needed to be published and launched at a national conference that Jack had organised in the hope that the new minister would attend. Before the meeting, I noticed Derek whispering to John in the corridor outside and then saw that Ivan, who was going to chair the meeting, had joined them. I walked up to them and asked, in a light tone, if this was where the decisions were being taken. This prompted Derek to say that having now read the competences, they were unsafe as they did not explicitly refer to depression, risk and outcome collection, that they were therefore dangerous



and he was going to close them down. As I did not know the competences off by heart, I was uncertain as to the veracity of his claim. In the meeting, the issue was discussed and Brian looked at the materials he had on his laptop and was able to throw some doubt on the absolute correctness of Derek's views. In the event, we agreed that there needed to be a little more work done to check his issues and that the publication would be produced in draft for comment.

### **Reflecting on my narratives**

When I worked in an NHS Trust in the early 1990's, I was a member of a senior management team that met every Monday morning. The chief executive was bright and innovative, but easily seduced by novel ideas and he came under the influence of the new director of HR, who was generally agreed to be clever and manipulative. Most of the team were men and it was routine for them to take a comfort break together and to come back having agreed some action or other that should have been decided in the meeting. The dynamics of the team were difficult and worsened over time to such an extent that I came to dread those Monday meetings. I believe this was the time that I became more sensitive to and critical of office politics. I can see that my reaction to Derek's behaviour has been coloured by experiences like this. I could have ignored it and just inwardly fumed but, since I knew he was talking about something to do with workforce, I felt justified in intervening. Although gender is an important issue in power relationships, and feminist authors such as McNay (1992), Diprose (1991), Bartky, (1990), Bordo (2003) have made critiques, for instance of Foucault whom I take up later, the feminist perspective is not one that I wish to explore in the DMan. This is not only because I do not feel it has been a major factor in my own career but also because it would deserve more space than this thesis will allow.

I perceive that my anxiety is usually about being undermined, about having my jurisdiction encroached upon, about losing face and about not being in control. I rarely feel comfortable with PMG colleagues as I feel that I don't quite fit and I take this now to relate to my identity as an 'expert' in

workforce in that group. I think that the reason I was so concerned about the professor's outburst was that I have felt more secure in my identity with that group because it has felt like a continuation of the work I led in my previous workforce programme director role. In that role, where I consider myself to have been challenging whilst seeking to move towards consensus, I have generally felt valued, competent and able to achieve things. I believe that challenging 'insiders' or the status quo is of key importance for me. This was originally in relation to service users versus professionals, then from the perspective of non- medical to medical professionals and now in IAPT, it is more focussed on broader based therapies versus CBT.

It is clear to me that the basis of good relationships is trust and respect; this holds good in personal as well as in professional relationships. I believe that this implies a reasonable balance in power relating, where people are effectively peers. I find, however, that I am not trusting people that I am currently working with. It is the uncomfortable feeling of the outsider.

It has become obvious that the reason the IAPT programme runs as it does is because John considers that he can exercise more control by dealing with people individually and separately rather than as a team. He therefore has little difficulty in wheeling and dealing on issues irrespective of areas of responsibility; he is quite combative in his style with an air of 'if it's too hot, get out of the kitchen'. This is his way of exercising power with what is certainly a difficult set of people and relationships. I have shifted in the last fifteen months from being someone of equal standing to him to someone, who is a NA only, with less involvement in the day to day running of the programme. John has unquestioned faith in the use of project management methodologies, which focus on paperwork rather than on practice. This leads, in my view, to a level of abstraction, which may be necessary to report on quantitative progress, but which can become reified and divorced from the reality of everyday local decision making. I see just this happening in the Trust where I am working: clinicians failing to turn up for meetings as they want to discuss practical issues and not project milestones and risk registers.

I feel that power struggles are intrinsic to the everyday discussions and decision making processes of IAPT, even more than in other areas of my work in the past.

### **Narrative three**

At the last PMG, the delayed and final drafts of the competence documents were discussed. They had been amended as Derek had taken exception to additional issues when I was on holiday. At the meeting itself, he began by praising the improved version with the exception of one issue which he described as *guildification*, restrictive practices or anti-new ways of working in the document. What he meant was that the specification that practitioners, who should be offered training for Couple Therapy for Depression, should be Couple therapists. His view was that they could equally be CBT therapists, a position he has held for some time and which has led him, in my view, to put barriers in the way of Couple therapists being the target group. As I have led on NWW nationally and I was aware of his barely hidden agenda, I was unable to remain silent and accused him of promoting practice restricted to CBT therapists. This led to an awkward silence in the room; Brian, in his best mediating manner, agreed with both of us. A member of the Core team suggested omitting the Couple Therapy section altogether from the document. After a pause, Derek said this was not his intention and Brian offered to add a form of words that would be acceptable to all. For a moment it felt that the power had shifted.

### **Further Reflections**

Throughout my career, I believe my way of approaching my work in organisations has been to take a rational approach to change: to plan, consult, seek consensus based on human values of equality, develop an action plan and to implement those actions, usually with some means of monitoring. I have firmly believed that if professionals listened to views of people who have been on the receiving end of services, they would change their views, and not to do so must be related to their egotism and fear of losing their

power and status. My frustrations therefore have been those people who are not compliant or who are actively oppositional to what I have strongly believed is the 'right thing'. I have experienced conflict as unpleasant, unhelpful and selfish. My perception is that those who have opposed me have largely been powerful, often because of their professional status. I have tended to see these people as possessing power by virtue of their social position rather than as experts and have, sometimes, been surprised when some have turned out to be decent human beings, with expertise.

I am conscious that in my early training as a psychologist, I was influenced by the predominant view that 'we' as a developing profession, were superior to nurses and competitive with psychiatrists, eager to avoid being under their control. Taking and having control, over my life and working practice, may be a way of thinking about power.

### **SUMMARY OF EMERGING THEMES OF POWER**

The emerging themes for me cluster around firstly, knowledge, evidence and expertise, influencing what constitutes the truth and therefore the rational underpinnings of the IAPT programme. Secondly, the inherent political struggle in day- to-day work: domination, conflict, manipulation and control, which give rise in me to feelings of shame and uncertainty about my professional identity and expertise. Finally, the way these perceptions and feelings arise in interaction with others and my own part in those interactions. I will therefore turn to authors to help me understand and evaluate my experiences.

### **COMING TO UNDERSTAND POWER IN MAINSTREAM ORGANISATIONAL STUDIES.**

The body of knowledge on power emanates from a variety of fields, including philosophy, sociology, business and organisational studies. Clegg, Courpasson & Phillips (2006) observe that the complex literature on power and the implications for the study of organisations are still "largely

unexplored” (2006: 6). They believe that power is central to sociological theory and therefore to organisational theory and that ‘power relations’ should be the focus of analysis. They point out, however, that the content of management training in elite business schools (and elsewhere) is very focussed on technical and rational approaches. They seek to build the foundations for different theoretical understandings of power to inform better practices of power within organisations. The Administrative Science Quarterly (AQS), an important journal in US organisational studies, published a forum on power in 2002, where key authors contributed their perspectives. Greenwood and Hinings, for example, posited that they would

...characterise a sociological approach to studying organisations as being concerned with *who controls and the consequences of that control*. The central question emanating from a business school, in contrast, leans more to understanding *how to understand and thus design efficient and effective organisations*. (2002: 411)

Clegg et al interpret this position as counterposing power and efficiency, which they argue is wrong, as the two are inextricably linked and subject to processes of domination and organisational enslavement. Greenwood and Hinings reflect a rich seam of thought in management literature, incorporating a utilitarian approach to efficiency adopted by Taylor (1911), which was (and still is) exceptionally influential in the technical design of the workplace and workforce; and Functional Theory (Parsons, 1964), construing power as authority and therefore as legitimate influence. At the same time, power is described as being linked negatively to uncertainty, which would indicate a practice in need of reform. Taylor and Parsons emphasised rational and scientific approaches to management, which took no account of politics or of the hidden side of power and influence. My understanding of knowledge as evidence, as I outlined in project three, has led me to question the taken for granted nature of the positivistic scientific approach that underpins these writers. I wish to explore what I perceive to be the hidden influence of power as it impacts on IAPT.

Contingency theory (Hickson et al 1971; Hinings et al 1974) considers organisations from the perspective of standardisation and centralisation processes, which implies rather than specifies power issues. On the other hand, resource dependant theorists such as Pfeffer and Salancik (1974) address power specifically but also from a wholly rational perspective. To elaborate, Pfeffer (1992) diagnoses the key problem in organisations as the “incapacity of anyone except the highest-level managers to take action and get things accomplished” (1992: 10). He therefore expounds a seven step model, which includes: establishing goals; diagnosing inter-dependencies and influential people; discerning their views; identifying their power bases; identifying one’s own sources of influence; selecting preferred tactics; and choosing a course of action (ibid.: 29). Although tools and techniques have their place in helping structure understanding of social interaction, these systemic approaches do not resonate with my experience of predicting and managing the complex nature of interactions, particularly in the highly political arena of IAPT.

Weber (1978) has been influential in articulating the importance of developing bureaucracy, a legal-rational approach in organisations, as a bulwark against arbitrary practices of those in charge with respect to their employees. He saw the relations of power (1978: 4) as a central aspect of all organised social life, and politics as the expression of resistance to the imposition of the will of others. He explicitly differentiated power (*Macht*) from domination (*Herrschaft*), which could be legitimate and was taken to mean Authority by people like Parsons (1964). Weber was pessimistic about the future of bureaucracy, however, because, whilst it would be subject to the rule of law, in his view, it could become an “iron cage of bondage” (1976: 181), where rules, regulations and standardisation would constrict the life of the person. As van Krieken put it: “being modern means being disciplined by the state (and other organisational forms), by each other and by ourselves” (1990: 353). I will take this up later in the context of Elias’s criticism of Weber and Foucault’s concept of subjectification.

Lukes published a short, but influential essay *Power: A Radical View* in 1974, where he posits that there are three models of power, all based on different moral assumptions. He describes them as *one dimensional* (liberal – Dahl, 1958), *two dimensional* (reformist - Bachrach & Baratz, 1970) and *three dimensional*, his own radical perspective. In summary, a one dimensional view of power, an empirical, ‘pluralist approach’ focusses on behaviour in making decisions over which there are conflicts of interest. A two dimensional approach broadens scope to look at intention including non-decision making and potential as well as actual conflict of interest. His own contribution addresses control over the political agenda, latent conflict and subjective and real interests (as opposed to policy interests); he concludes that power “is at once value-laden, theoretical and empirical” (2005 [1974]: 108). In his second edition, he recognises that these may be contradictory and proposes that there is a single generic concept of power, common to all cases which, in relation to both individuals and collectives, exhibits two distinct variants, the concepts of “power to” and “power over”(ibid.: 69). He outlines a conceptual map highlighting his view of the key elements to consider in the arena of “power to”, which include issue-scope (single vs. multiple); contextual range (context bound or transcending); intention and unintentional; active and inactive; together with the impact these may have on the interests, preferences or welfare of those concerned. He also examines in detail “power over” and specifically the concept of ‘domination’. In doing this, he takes up Weber (1978[1910]); Shapiro (2003); Scott (1990); Taylor (1984); Sen (2002); and Nussbaum (2000); In this, he explores issues of the legitimate and illegitimate use of domination, how this can be decided and by whom; the appropriateness of the term as it relates to normal interactions as opposed to extreme relationships, in slavery for example; identity and assumptions about (real) self and identities that are socially constructed. He concludes that the concept of power as domination is ‘essentially contested’ (ibid.: 124), which I take to mean that there are many perspectives that do not agree nor complement one another. Lukes spends a good deal of time in his later text critiquing the contribution of Foucault. He particularly questions whether

...after Foucault it no longer makes sense to speak, with Spinoza, of the very possibility of people being more or less free from others' power to live as their own nature and judgement dictate? (2005: 107).

He argues against this, but concludes his book equivocally, in my view, by stating that, as Spinoza observed,

...in spite of all that political skill has been able to achieve in this field, it has never been completely successful; men have always found that individuals were full of their own ideas, and that opinions varied as much as taste. (Ibid.: 151)

Other influential authors on power include Goffman (1961), Elias (1978); Critical Management thinkers (Fournier and Grey, 2000; Alvesson and Willmott, 1992), although Lukes does not mention them at all. Clegg et al (2006) comment that Critical Management thinkers like Alvesson (2002) and Willmott (1993), who critique an unquestioning belief in efficiency and 'value free' methods, are still only marginal to business and organisational science curricula and in organisational literature generally. Clegg et al also discuss the importance of Foucault in his approach to thinking about power but he too is absent from mainstream management training. Their major proposition is that there has been a trend throughout the last century to see organisational science too narrowly, to position it in rationalistic traditions, for it to be ahistoric (not learning the lessons of history or not existing in context); to be amoral in the sense that the treatment of human beings, and focussing on coercive power without explicitly addressing power in its analysis. This perspective resonates with my experience, which I begin to articulate in projects two and three. They particularly draw attention to major world events, such as the Holocaust, and how we have failed to consider how such events could occur, despite their use of efficiency and bureaucracy. On this point, Arendt, (1970) wrote extensively about the Holocaust, exploring totalitarianism, which people robbed of their ability to struggle, the potentialities and limits of political action and the importance of individuals taking personal responsibility for politics as a plurality of citizens. She stated



“...each person’s aims are continually liable to be frustrated by other people’s initiatives, although power and stability can be generated by agreements between human beings” (Canovan, 1992: 277). Scott (1990) studied slavery, positing that generalisations could be made to practice in everyday organisational life. He argued for a clear distinction between the formal, ‘public’ explanation and informal ‘hidden transcript’ of relationships, between what he called dominant and subordinated groups. Arendt and Scott do not feature in mainstream bibliographies.

Clegg et al muse on the future understanding and practice of power in terms of the changing nature of globalisation, risk from terrorists and the uncertainty this brings to business and to society. In looking in detail at such case studies, they adopt Foucault’s genealogical analysis method (which I take up later), where what is taken for granted as the truth in one era can be transformed to a different truth in another. The importance of Foucault is clear from these later authors and will therefore be central to this project.

### **Summing Up**

Mainstream conceptualisations of power have tended to take a rational approach to how power can be understood and managed. Large business schools do not tend to address power in their curricula as a significant issue nor do they tend to include authors who question such approaches and who are seeking to understand the unpredictability of everyday organisational life.

### **COMING TO UNDERSTAND POWER IN MY OWN CAREER**

Building on the approach of Parsons, Habermas (1987), from the Frankfurt School, took an optimistic, rational approach to power and political change. He argued that using constitutional approaches or ‘communicative rationality’ is how change can be achieved.

This communicative rationality recalls older ideas of logos, inasmuch as it brings along with it the connotations of a non-coercively

unifying, consensus building force of a discourse in which the participants overcome their at first subjectively biased views in favour of a rationally motivated agreement. (1987: 315)

Similarly, Chomsky, in a debate with Foucault, is described by Rabinow as defending the position that '(o)ur political tasks can be coherently informed by the universals of reason and justice' (1984: 5), thus articulating a rationalist approach to power and government.

Having faced the challenges of changing NHS services, I have welcomed formal government policy documents, intended to change organisational and professional practice in the direction of valuing service users and carers, translated into national targets. For me, these documents have become ammunition that can be used to dictate to professionals what they cannot see the sense of doing of their own accord.

Furthermore I have felt that teams, which form the operational unit of service delivery in the NHS, have the best knowledge of their problems and the potential solutions. I have therefore invested energy in working with teams to reach consensus to solve local problems. In this process however, I often experience frustration with nurses, for example, continuing to defer to doctors, even to those who are junior or clearly incompetent. Arendt (1970), Goffman (1961), Scott(1990) and Willmott, (2003) suggest that a move to deliver a single vision (such as NWW or IAPT) can lead to unlooked for outcomes in terms of silencing difference, which in some (extreme) circumstances can lead to totalitarian practice. At the same time as reflecting on what I take to be my rationalist approach however, I am aware that my views have been more complex than this. I have sought to empower other professions to challenge doctors, whom I have often seen as authoritarian or dominating. I have always felt that in challenging professionals, returning to the needs and rights of the service user is a way of unifying professional discord.

I am aware that my approach to service change has been underpinned by the principle of ‘equal value’ of citizens, irrespective of their differences. Indeed a key piece of work that I instigated was the production of the ‘Ten Essential Shared Capabilities Framework’ to underpin practice in the mental health workforce. One of the capabilities included the value of *Practising Ethically*: “acknowledging power differentials and minimising them wherever possible” (Hope, 2008: 15). When I have advocated this in public, I have noticed silence or disgruntlement among some professional staff, showing clearly that they do not share this value. Even more concerning to me have been bigoted and prejudiced comments from some service users. I notice that I have tended to idealise their position based on their shared experience of mental ill health and ignore their necessarily divergent values and views as human beings. So, I am coming to the view that there are conflicting values underpinning mental health policy and its implementation by people in practice, which cannot be resolved solely by consensus building. This has led me to consider other ways of thinking about power, based on the nature of human relating.

## **POWER AS INTEGRAL TO HUMAN RELATING**

Elias (1978), unlike Parsons, wanted to explore how sociology could address more meaningfully the nature of society and avoid aping the natural sciences in their method of enquiry. He argued that society was not merely a set of individuals, whose responses could be aggregated to understand it, nor an abstract concept where people were not to be found at all, echoing the views of Follett (1918). He posited that the language used to describe issues was itself part of the problem in that terms such as the ‘individual’ and ‘society’ tended to reify concepts and to abstract and obscure them. He sought rather to show how interactions between people or ‘figurations’ should be the focus of a study of power, which he did by using the analogy of games. Elias discussed the importance of interdependencies between people and the functions that they serve as they interact with one another. In considering these interplays, he talked about people “measuring their strength against each other” (1978: 73), which in itself is the exercise of power. He chose to

talk about “power ratios”, which are usually unequal “power balances” and commented that balances of power are not only relevant in relations between states but are also “an integral element of all human relationships” (ibid.: 74). Power is inherent in child-parent, manager-employee relationships and so on, in that each has a function for the other. This in turn means that they exercise constraints on each other, which could be thought of as legitimate authority. But there has, according to Elias, been a tendency to avoid acknowledgement of the subject of power in mainstream organisational theory (as I outline above) because of its negative connotations. Furthermore, power has been reified and treated as an ‘amulet’ possessed by one person and not by another, as if it were a “magico-mythical relic” (ibid.:74). Like Foucault, as I will discuss later, he comments that power is a structural characteristic of relationships and of itself is neither good nor bad. He poses common questions that underpin continuing struggles to establish any relationship, for example, who is more or less dependent, or in IAPT terms, who can steer the business in their own direction?

Elias (1978) criticised Weber’s assumption that contemporary bureaucracy is a rational form of organisation and that the behaviour of its officials is equally rational. Specifically, he comments

...bureaucracy tends to reduce complex social interdependencies to single administrative departments, each with its own strictly defined area of jurisdiction, and staffed by hierarchies of specialists and oligarchies of administrative chiefs who rarely think beyond their own areas of command. (1978: 31)

This has resonance for me in that much of the current politics of IAPT are focussing on how further investment in the programme can be realised in a nationally dispersed field of competing priorities. Keeping a strong and uncompromising focus on prescribed standards to give clarity of model and process, as insisted upon by key IAPT NAs, is at odds with pragmatic tactics being exerted throughout the NHS. Commissioners and employers are required to make £20 billion savings, but are being allowed to reinvest this in

different services such as IAPT. At this time of economic stringency, this is recycling of investment not new investment. However, the deputy prime minister publically announced it as new funding. This led Ricky (an NA) to share his outrage at such dissimulation with the press, for which he was promptly and publically sacked. My interpretation of this situation is that IAPT, as a single programme and one that is seen as important and privileged, is (not unreasonably) fighting for its rightful place in prioritisation. This is not a corporate endeavour with the NHS to reach compromise given the impossible pressures being placed upon it, but rather an attempt to protect its jurisdiction. However, the IAPT position is a rationalist one, to seek to persuade through the soundness of argument. The announcement demonstrated the political manipulation of the message from government to the public. Whilst everyone in the NHS knew it not to be true, Ricky chose not to be silenced, but blowing the whistle was not politically acceptable. The Department of Health, a supreme bureaucracy publically reflecting the view of the current government, took action, demonstrating that power does determine what is accepted as truth, at least officially.

Elias's analysis of games helps illustrate the growing complexity of interactions as more people become involved. Starting with a single dyad, as the number of people grow, the number of possible relationships grows exponentially; for example, two people can only form two possible relationships; 3 people: 9 possible relationships; and 10 people: 5110 relationships. The sheer numbers are staggering and nicely illustrate the complexity of possible relationships and interdependencies even in a relatively small group. PMG has approximately 15 members and there are rarely fewer than 10 people present at any meeting. Elias highlights that as the numbers increase, the power balances shift. Where there is a more even power ratio between participants, there becomes increasing uncertainty about the outcome. In thinking about the relative power balances in groups, Elias comments that a single dominant member can be constrained by weaker members if they co-operate to do so. By the same token, if the group has internal tensions, as in the IAPT NA group for example, their power to change the direction of the group is more limited. This resonates with me, as

in PMG meetings, the conversation is dominated by Derek and John, with interjections from others; typically, the conclusions are checked by the chair with them to see if they are acceptable. Elias's attention to the use of language, however, highlights how it is all too easy to fall into assuming that power is an entity, which resides within people. I am coming to think that I view Derek in this way. As Elias says: "In thought we hold them responsible for the constraints to which we feel ourselves subject" (ibid.: 94). Elias emphasises that the 'intertwining' of people's actions, may result in "social consequences which no-one has planned" (ibid.: 95). This opens up the possibility of the emergence of novelty; it also highlights the difficulty of scientific prediction and reveals the impossibility of achieving explanations of figurations through "reducing them to their individual components (individual people) as in psychological or biological forms of explanation" (ibid.: 97). This is highly relevant to my critique of evidence in IAPT. But as Elias says, we have developed habits of thought because "we have all been reared in traditions which lead us to expect to find an explanation for every apparently inexplicable event in a single cause" (ibid.: 99).

Elias and Scotson (1994) studied an English community where the process of power relating, which he described as 'inclusion and exclusion', could be clearly observed. This community, anonymised as Winston Parva, consisted of two similar social groups, distinct only by virtue of the length of time that each had been established in that location. Those who had moved there first were the 'established' and the newcomers were the 'outsiders'. In their detailed qualitative study, Elias and Scotson found that the established group felt itself to be superior in terms of its values and behaviour and that the newcomers were accordingly less lawful, poorer achievers and so on. They concluded that the established wanted to maintain their order and status whilst the newcomers wanted to improve theirs, leading to conflict and to excluding practices. As there was no difference in class, colour or income levels, they posited that this practice was based on power ratios rather than on specific characteristics of people, sustained through occupying politically important positions in the community.

How might this be relevant to my thinking about IAPT? Power differentials have been exhibited by the dominance of CBT over other therapeutic modalities. This has shifted a little in IAPT in the third year of the programme, and certainly the time that Brian and I have devoted to developing therapies additional to CBT has been significant. Although expanding choice of therapy has been a key focus of our reports to PMG in recent months, this ‘airtime’ becomes less impressive when I consider that the number of training places that will be provided for these additional therapies. This will amount to a total of around 300 places at a cost of approximately £500,000, in comparison with CBT with 3600 places (including funded posts) at a cost of around £170 million. One can see how this is seen as a ‘fob off’ for the workforce and professional bodies who are not CBT based. This issue has led to conflict throughout the therapy world, although there have been efforts from counsellors and psychotherapists to cooperate in the hope of future inclusion of their approaches in IAPT. The territory of evidence based therapies has been a particular battleground, with CBT therapists and their advocates creating, so it appears to me, a sense of their own superiority. This has a clear feel of an insider (CBT) outsider (everyone else) dichotomy. Being outsiders in these terms, the non CBT groups have not helped themselves by falling out with each other over evidence and regulation. The United Kingdom Council for Psychotherapy (UKCP) elected their president on the ticket of opposing regulation and the governmental policy commitment to NICE based evidence. This internal conflict has served only to increase the power imbalance between therapies and policy makers. Elias and Scotson’s reflections on Winston Parva seem pertinent in terms of the stigmatising processes that I can see happening to CBT protagonists with respect to their non CBT counterparts.

(T)hey fight for their superiority, their status and power, their standards and beliefs, and they use in that situation ...humiliating gossip, stigmatising beliefs about the whole group modelled on observations of its worst section, degrading code words and, as far as possible, exclusion from all chances of power”. (1994: 158)

Elias comments that power as a subject has been neglected because the social phenomena to which it refers are very complex. When it is addressed it is often oversimplified, whereas it is in fact “polymorphous” (1978: 92) and is inextricably linked with emotions because of the conflict inherent in this social interweaving. He argues that it is for this reason that power should be “understood unequivocally as a structural characteristic of a relationship...neither good nor bad... We depend on others; others depend on us” (1978: 93). Elias (1991) comments that no matter how powerful one person may be they cannot single-handedly achieve change. Using an example of an emperor of an agrarian feudal society, seeking to transform his country, he says “(h)e is tied to the tensions between bondsmen and feudal lords on the one hand and between competing feudal lords and the central ruler on the other” (1991: 50). I see a parallel here in the Trust where I am working, where directives from the Board, passionately supported and articulated by the CEO, are frequently ignored by clinicians and teams.

Elias spent much of his life reflecting on what he described as *The Civilising Process* (1994 [1939]) of history, a particular feature of which was how “the self-constraint apparatus becomes stronger relative to external constraints” (Goudsblom & Mennell, 1998: 238) as part of human development and relationships. For me this echoes a strong theme in Foucault of how power relationships are sustained through ‘subjectification’. Elias, however, was not a political activist and his analysis of issues was academic, despite being personally affected by World War II, which significantly constrained his career. Foucault, in contrast, was passionate about the issues he addressed in his work and politically active as a result.

## **THE IMPORTANCE OF FOUCAULT**

I will now turn to Foucault as a key author because, as McHoul and Grace assert in their overview of his work, Foucault’s retheorisation of the concept of power is of “critical importance (and) cannot be overstated” (1993: 57). Although he was not interested in offering a theory of power, he wanted to



find a different way of looking at how power relating was enabled or constrained at specific times and in different places. Foucault states

...power relations are rooted deep in the social nexus, not a supplementary structure over and above 'society' whose radical effacement one could perhaps dream of. To live in society is, in any event, to live in such a way that some can act on the actions of others. A society without power relations can only be an abstraction'. (1994a: 343)

Foucault considers that the point of political struggle is 'to alter power relations' (Rabinow, 1984: 6).

In reading Foucault, it is firstly important to understand his terminology, and specifically his use of the term 'discourse'. McHoul & Grace state: 'Foucault is the first major writer to pose the question of power in relation to discourse' (1993: 22). They take this to mean that

(i)n any given historical period we can write, speak or think about a given social object or practice (madness, for example) only in certain specific ways and not others. (Ibid.: 31)

Foucault himself, in discussing method (1994a), describes how his interest lies not in seeking truths or universals, but in opening up areas of question and by making propositions that others can engage with. Rabinow suggests that 'his consistent response is to historicise grand abstractions' (1984: 4). His main interest is not in 'what' or even 'why' but 'how' things occur, and not in institutions or theories but in 'practices' (1994a: 224-225) with the aim of grasping what makes these acceptable at the time. His method therefore is to analyse a regime of practices that could include: places where things are said, rules that are imposed, reasons given, the planned and the taken for granted and the interconnection between them all. He developed his thinking over time in this respect, which I will explore later.

More specifically, McHoul & Grace suggest Foucault is thinking of discourse in terms of bodies of knowledge linked to the concept of disciplines and consider that disciplines should be taken in two ways:

(A)s referring to *scholarly* disciplines such as science, medicine, psychiatry, sociology and so on; and as referring to disciplinary *institutions* of social control such as the prison, the school, the hospital, the confessional and so on. Fundamentally, then, Foucault's idea of discourse shows the historically specific relations between disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility). (1993: 26)

Rabinow describes Foucault as a 'founder of discursivity' (1984: 26). He compares him with Kuhn (1970: 1987), who formulated the phenomenological evolutionary scheme for the natural sciences, as sharing a 'systematic ability to comprehend exactly those phenomena of "shared practices" ... which constitute scientific activity' (1984: 26) and an ability to move beyond them. Comparing with Weber, he comments '(b)oth see a form of critical historicism as the only road to preserving reason and the obligation...to forge an ascetic ethic of scientific and political responsibility' (ibid.: 27). Gordon, in his introduction to Foucault's works on *Power*, describes him as neither a philosopher nor a political theorist but someone interested in finding new and more effective political ways of seeing, particularly concerning the relationship between power and knowledge; quoting Foucault himself,

...the exercise of power creates and causes to emerge new objects of knowledge and accumulates new bodies of information... The exercise of power perpetually creates knowledge and conversely, knowledge induces effects of power. (1994a: xv-xvi)

It is this seeking of 'knowledges'(sic) that underpin his method of discourse, in order to question techniques of power that may have been portrayed with

‘apparent neutrality and political invisibility’ (ibid.: xv) and to extend ‘our capacity for suspicion, or at least for vigilance and doubt’ (ibid.: xvii).

In selecting areas of practice in the human sciences, most notably in madness, punishment and sexuality and exploring them from a variety of perspectives, he is seeking to lay bare taken for granted assumptions but not to come up with answers or a general theory for the future. It is to this that he attributes the irritation he evoked in his critics, saying clearly that ‘(t)he effect is intentional’ because he wants professionals to ‘no longer know what to do’ (ibid.: 235) and to question and potentially change their practice. In his final lecture in 1973 on psychiatric power, he states that he is not interested in developing an historical sequel to his work but is interested in its political effects on subjects - prisoners, patients and the like.

It is perhaps this method of discourse that I am seeking to explore in relation to the DMan generally and to my exploration of power in IAPT in particular. I am questioning and thereby coming to understand not only the far and recent past but also the present conditions which enable and constrain what can be said about the development of psychological therapies.

### **Mental Health as a context for considering Power**

Foucault is important in my field of study because of his work on mental illness, described in *Madness and Civilisation* (1961), in which he traces the concept of madness over the centuries. The reason he did this was that he wanted to consider how language, practice and government influenced what could and did occur with respect to people who were seen as mad. He looks at three key elements: dividing practices, normalisation and subjection, which I began to explore in projects one and two. I am interested though, that Foucault, in reflecting later on this work and talking about power specifically, says:

When I think back now, I ask myself what else it was that I was talking about in *Madness and Civilisation*...but power? Yet I am

perfectly aware that I scarcely used the word and never had such a field of analyses at my disposal. (1994a: 117)

He went on to say that he felt this was because there was no interest at that time from colleagues on the Right or the Left in the issue of power, except to condemn it as it was perceived to exist in the other 'camp' i.e. as totalitarianism or class domination respectively. Furthermore, when he expounded the view that he wanted to study how power was exercised concretely in medicine and psychiatry, these areas were criticised as not sufficiently scientific. His perspective on power changed in 1968, as a result of the student uprisings. He concluded that he had been too timid and that his thinking had been constrained by the context in which he had found himself only a few years before. This is what makes history and an understanding of context vital in understanding abstract issues such as Power and Truth. Diffuseness of meaning and abstraction do not further understanding, so he was critical of Structuralism as a prevailing mode of thinking at the time, which sought generalisable meaning behind the superficial surface of experience. He was, however, also critical of Hermeneutics, which posited that interpretation was the most vital and that human experience could transcend anything. Foucault sought to manoeuvre between the two in that he felt it was possible to draw some general themes from specific experiences and that there were limits placed on human thinking by historical contexts.

Goldstein (1984) compared Foucault's approach to disciplines with that of other sociologists to the development of professions. Essentially positive about his contribution, he described Foucault as taking an archaeological approach to history, which sought to " 'defamiliarise' the phenomena of man, society and culture" (Hayden White, 1973: 50), in a way that also highlighted the relative instability of objects of discourse (Goldstein, 1984: 172). Rather than taking disciplines as occupational groups, Foucault related disciplines more to the "ordinary population which is willy-nilly on the receiving end" (ibid.: 175) and as "methods, which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, (which) might be called

disciplines” (Foucault, 1977: 137). Those who administer to this population are professionals in the traditional sense and Graham concludes that “(p)rofessionalism, as rewritten by Foucault, becomes a ‘new ‘microphysics’ of power, indeed the quintessentially modern mode of wielding power” (ibid.: 176), which includes a conflation of social power-wielding activity and knowledge.

### ***Dividing Practices***

Foucault’s key focus in his early work was on total institutions as they evolved into the 20<sup>th</sup> century. Today, they have all but closed (I am working in the last one in England) and services are now delivered largely in or near people’s own homes in the community. This, for me underlines the veracity of Foucault’s view that what we consider to be truth or thinkable at any given time is affected by our context. Similarly, Goffman, in *Asylums* (1961), delivering a sharp critique of the nature of total institutions, described hospitals and the medical profession as generally harmful to the patient; but concluded:

Nor in citing the limitations of the service model do I mean to claim that I can suggest some better way of handling persons called mental patients. Mental hospitals are not found in our society because supervisors, psychiatrists, and attendants want jobs; mental hospitals are found because there is a market for them. If all the mental hospitals in a given region were emptied and closed down today, tomorrow relatives, police, and judges would raise a clamour for new ones; and these true clients of the mental hospital would demand an institution to satisfy their needs. (1961:334)

Fifty years on, we can see how he much he was constrained by the limited thinking at that time. Now we have more effective interventions, public attitudes have altered so that living next door to a person with a mental health problem can be considered to be no different from any neighbour and, most importantly, we have a different narrative, articulated by people with lived

experience, resulting in a (slight) shift in the power of the patient. Foucault later rejected his focus on the institution per se and began to focus on power relating between the psychiatrist (and his staff) and the patient.

Today, IAPT is an example of a dividing practice as it is a different model of service delivery, which has challenged the current established order of provision of psychological therapies. IAPT's distinct stepped-care service model has been imposed across England based on specific standards of staffing, training, supervision and practice. As a result it has displaced existing services and excluded those that do not conform to those standards, most notably counselling services. Indeed, some have been decommissioned as a result and some counsellors themselves sent on IAPT courses, against their wishes. This process has inherently separated and set different values on CBT from other therapies and therapists. The new policy, extending wider therapies to broader groups, promoted by an influential collaboration between the third sector and professional bodies, only now begins to challenge this privileged position of CBT within IAPT.

### *Normalisation.*

The second key theme of Normalisation focusses on classification, to identify how individuals differ from the norm, for instance, in terms of conditions, IQ and so forth. Ironically, Foucault comments that this led to greater individualisation (of differentness) as well as to totalisation, a blanket response to all as if they were the same (1994a: 332). This has been reflected in the practice of psychiatrists as the profession has developed historically. It has also been an accusation against IAPT by its dissenters, who see the medical categorisation of people with anxiety and depression and its 'one size fits all solution' (Lee, 2010) of CBT as a 'simplistic worldview' (Woolfolk & Richardson, 2008).

The use of standardised measures to assess depression and anxiety, used at every session, forms the basis of IAPT outcome measurement and the data collected are seen as vital in evaluating the success of IAPT. 'Recovery' has

been defined as a reduction in symptoms to a level below ‘caseness’, which is the cut-off between what is considered normal and abnormal for the population. As Recovery rates stay stubbornly below 50%, (the rate predicted from the research literature and therefore the target) the data are being examined more carefully, and ‘improvement’ is now being talked about as an alternative measure. These ways of categorising the patient population and describing the nature of their change on what were recently called ‘objective’ measures can be seen as normalising principles in Foucauldian terms. Of particular interest is the shift in language about what constitutes success to avoid the political fall-out if results are disappointing. This re-interpretation of the evidence could be seen modifying forms of evidence and therefore what we consider to be the truth in IAPT.

### ***Subjectification***

Foucault emphasises the importance of his third theme of subjection or subjectification because his “objective...has been to create a history of the different modes by which, in our culture, human beings are made subjects” (1994a: 326).

Foucault was fascinated by the Panopticon, the concept developed by Bentham, a physical space, where the subject could be observed at all times; so, even if not being watched, the subject came to behave as if they were and became self- disciplined. The Panopticon became the basis for the design of prisons and concentration camps, and Foucault was interested in what gave rise to such ways of thinking. He went on to compare this spatial model with the relationship that madmen had with their doctors, where, he posited, that they came to adopt their identity as interpreted to them by the physician, who performed the role of father and judge with an intention of improving their moral behaviour. It is likely that Parsons would have portrayed the authority of the doctor as benign and the docility of the subject as a rational acquiescence, although we have seen the unfortunate results when such power goes unchecked. Interestingly, Spinelli (2001) suggests that CBT

largely ignores the power imbalance in the therapeutic relationship and insists on the authority of the therapist to interpret the model for the client.

Foucault attributes two meanings to the term 'subject'.

(S)ubject to someone else by control and dependence, and tied to his own identity by a conscience or self- knowledge. Both meanings suggest a power that subjugates and makes subject to. (1994a: 331)

McHoul and Grace put it slightly differently.

'Subjection' refers to particular, historically located, disciplinary processes and concepts which enable us to consider ourselves as individual subjects and which constrain us from thinking otherwise. These processes ...are what *allow* the subject to "tell the truth about itself" (Foucault, 1990: 38). Therefore they come before any views we might have about 'what we are'. In a phrase: changes in public ideas precede changes in private individuals, not vice versa. (1993: 3-4)

In other words, our identity is formed through our social interactions, which develops an argument that is similar to Mead's position on the development of self and mind (1934). What is important in relation to power however is that the subject is then part of the mechanism of power, and serves to sustain power relating, even where they occupy a subordinate role.

In his lectures on *Psychiatric Power* (2003 [1973/4]), Foucault reflects that his focus in 1961 on the history of madness, his archaeological method, and his views on violence, the institution and the transferability of the concept of the family into the asylum, were "rusty locks" (ibid.: 14), that needed to be renewed. In a further wide ranging analysis concerning 18<sup>th</sup> and 19<sup>th</sup> century practices and informed by the more recent anti-psychiatry movement, he puts forward a different conceptualisation of power, which is not confined by spatial analogies (such as institutions) but an analysis of the *dispositifs* of



power. Here, he questions ‘to what extent can an apparatus of power produce statements, discourses and consequently, all forms of representation that may then derive from it’ (ibid.: 13). The translation of *dipositifs* as ‘apparatuses’ of power has been disputed as it can conjure up an image of a system or state machinery, thus leading to potential reification, whereas Foucault was trying to describe: ‘a configuration or arrangement of elements and forces, practices and discourses, power and knowledge, that is both *strategic* and *technical*’ (ibid.: xxiii). This way of thinking led him to explore the nature of the power of the psychiatrist specifically, together with that of supervisors, servants and the patient. Foucault distinguishes between sovereign power and disciplinary power, and says the latter could also be described as Panoptican power, which is silent in its actions and takes a ‘total hold...of the individual’s body, actions, time and behaviour’ (ibid.: 46). He suggests this resulted in two differing perspectives of the individual: the juridical (or rational) individual (ideological, with rights and freedoms) and the disciplinary individual (the subjected body). Although Foucault is describing disciplinary power in specific areas he is positing that this is a feature of current society in that we are all being subjectified in our power relating and to suggest that we, as individuals, could be freed or ‘desubjectified’ (ibid.: 57) from such oppressions is a nonsense, the stance that Lukes (above) criticises (2005: 107). This suggests to me a similar position to Mead in that we are formed by and forming social relationships continually and to think of ourselves as independent and outside of this is equally untenable.

Foucault discusses a shift in the perception of the mad person from being wrong in their judgement of what constitutes reality and therefore for intervention to be one of correction of faulty judgement, to one where the mad person was seen as wilfully convinced of their own correctness. This latter perspective pointed to intervention as a struggle between the psychiatrist and the patient, the former aiming to subdue the will of the patient to his greater knowledge and expertise. Foucault, however, makes repeated reference to the lack of a coherent body of psychiatric knowledge in terms of diagnosis and treatments (which I draw attention to in project two) and therefore he suggests the psychiatrist came to impose his will (or

disciplinary power) over the patient, directly and through institutional routines, to effect change in the individual. The data concerning cures are anecdotal and are drawn from case notes of significant psychiatrists of the period, including Pinel, Esquirol and Charcot, in true Foucauldian method.

I am left wondering how all of us are made subjects in our own worlds, as well as being people who can dominate or have authority. Self-silencing in a context like PMG is a form of subjectification, where to question the truth of evidence is to be seen as incorrect, wilful or irrational. However, in narratives two and three, I was conscious of the dominating voice of Derek and of the resistance that I felt to being over-ruled and effectively losing the battle. In directly accusing him of supporting restrictive practices, I felt that I was standing up to him, as few others do. When he backed down somewhat, I had a sense of achievement. This was for me a clear example of resistance against domination.

### **HOW FAR IS POWER DETERMINED BY KNOWLEDGE AND EXPERTISE?**

I reflect on professionalism, competence and expertise in project two and conclude that IAPT is dominated by professionals perceived as experts in their field by virtue of their academic and clinical achievements. Dreyfus and Dreyfus (1986) describe the “proficient” and “expert practitioner” as going beyond observable competences or recognisable rule governed behaviour to demonstrate intuitive practice and clinical judgement. This concept can serve to mystify expertise, however, and to emphasise the power and authority of the expert. In IAPT, three NAs are university professors and respected educators, researchers and practitioners and would describe themselves as (expert) evidence based scientist practitioners, which elevates their status in the programme. As Foucault concludes, towards the end of his analysis on power:

In the history of the West since the 18<sup>th</sup> century, the appearance of philosophers, men of science, intellectuals, professors, laboratories

etc., is directly correlated with this extension of the standpoint of scientific truth and corresponds precisely to the rarefaction of those who can know a truth that is now present everywhere and at every moment. (Ibid.: 247)

Flyvbjerg, in developing his argument for making social science matter, draws on the work of Dreyfus, who traces back the origin of what constitutes theory to Socrates (2001: 38-9), in order to test out how far *phronetic* social science could claim to be a science. Dreyfus identified six defining elements of (predictive) theory, which include being: Explicit; Universal; Abstract; Discrete; Systematic; Complete and Predictive. He concludes that if social sciences adopted these principles, using *decontextualized* (my italics) features, ‘predictions, though often correct, will not be reliable’ (1982: 8). Flyvbjerg also draws on Bourdieu (1977: 1990) and his argument of ‘the decisive role of timing and tempo for human expertise’ (2001: 41), to support his argument to move away from scientism to what he calls *phronetic* social science. The purpose of this is

...not to develop theory, but to contribute to society’s practical rationality in elucidating where we are, where we want to go, and what is desirable according to diverse sets of values and interest. (Ibid.: 167)

I take this to mean that there is a different way that expertise can be conceptualised, building on Dreyfus’s ‘expert’ with tacit knowledge, made understandable by context, which in its turn can be utilised technically and ethically.

Goffman (1961), quoting Sullivan, said “(a)s defined in this culture, the expert is one who derives his income and status, one or both, from the use of unusually exact or adequate information about his particular field, in the service of others” (ibid.: 287). In addition, he argues that “the server’s (*doctor’s*) work has to do with a rational competence, and behind this a belief in rationalism, empiricism, and mechanism” (ibid.: 287).

How relevant is this analysis today? Many people would think that this goes without saying. As part of the work I am undertaking in an NHS Trust, I observe on a regular basis, the interaction between psychiatrists and nurses as one of master and pupil, irrespective of the seniority and expertise of the nurse. The ‘magical quality’ of ‘clinical experience’ (ibid.: 322) is still accorded a value by which the final word is left to the doctor. This suggests that there are some generalisations that can be made across time and place and that cultures of power-relating survive across generations, particularly in professions. I would like, therefore, to take up further in my synopsis how the views of Foucault and Dreyfus illuminate my understanding of expertise and power.

### **DOES POWER DETERMINE TRUTH?**

Philosophers since Plato have sought eternal truths that hold good irrespective of place and time. Descartes took as his goal the establishment of a universal system of physics expressed in mathematical form, which triggered a series of scientific enquiries that was, as Dewey later commented, a ‘quest for certainty’ (Toulmin, 2001: 32). This culminated in Newton publishing his *Mathematical Principles of Natural Philosophy* in 1687. Toulmin suggests that the ensuing period in history led to a split in what constituted *human reason*, where natural philosophers or ‘exact scientists’ sought rational theories and deductions, whilst humanists used the term *reason* to mean reasonable practices that were grounded in personal and social practices. He argues for reasonableness rather than rationality and proposes that at the heart of the debate about rationality is a presumed link between rational thought and scientific method, which is universal and invariable. “In brief, a fully rational method would comprise universal, self-evident rules from which we deviated only at the risk of irrationality” (ibid.: 84). This, I suggest, may be taken to be a ‘truth’ for many in the scientific sector and certainly for key players in the IAPT programme. But in social sciences, this positivistic stance has lost credibility with many, so how can these beliefs about what constitutes truth be sustained?

Foucault (1994a) takes a different position from the rationalists and is clear that truth is not a universal absolute but is determined by society.

Each society has its regime of truth, its “general politics” of truth - that is, the types of discourse it accepts and makes function as true; the mechanisms and instances that enable one to distinguish true and false statements; the means by which they are sanctioned; the techniques and procedures accorded value in the acquisition of the truth; the status of those who are charged with saying what counts as true. (Ibid.: 131)

Graham, in a lecture on discourse analysis, reflects that: ‘The critical relationship to truth enabled by a Foucauldian problematisation does not mean that there is no truth – it means that truth is always contingent and subject to scrutiny’ (2008: 4). Foucault (2004a: 131) himself suggests that the political economy of truth is centred on a number of principles: scientific discourse and the institutions that produce it (e.g. NICE and relevant universities); on “the demand for truth as much for economic production as for political power” (the rationale for IAPT is not only intended to reduce suffering but to reduce costs to the exchequer); it is the object of diffusion, for example, through education (such as the cascading of training places for CBT across England); it is produced under the control of political and economic apparatuses (such as the Department of Health and NHS); it encompasses ideological struggle (NICE recommended therapies: CBT versus others). All in all, it is easy to see the direct application of these traits of truth, as he posits, throughout the IAPT programme.

So why does NICE recommended evidence dominate IAPT as a truth that cannot be questioned? If Foucault is correct, this is, at least in part, because of the influence and therefore power of the ‘specific intellectual’ in this case in the form of Derek. This points to his role occupying a privileged position linked to ‘the general functioning of an apparatus of truth’ (1994a.: 131), by which Foucault means ‘the ensemble of rules according to which the true and

the false are separated and specific effects of power attached to the true' (ibid.:132). What I understand Foucault to mean here is, that the criteria for what constitutes truth is determined by people in certain privileged positions and therefore it is not so much about science and ideology per se but about power. This echoes Flyvbjerg's analysis of the administration of the Aalborg project (1998). It also seems to be related to subjectification, the issue of the professional who defines what constitutes meaning for the patient (or subject) where s/he provides the explanatory framework to enable, but also constrain, the person or subject to understand their own problem. Foucault considers that power relating can only occur where there is the opportunity to resist and Arendt (1992) argued that conflict is essential to democracy.

Clearly in IAPT, there is a distinct difference between the public face of the programme as depicted in formal documents, interpretations of data and ministerial speeches and the conflicts and manoeuvrings that occur on a daily basis, locally and nationally.

## **CONCLUSIONS**

Geertz (1995) complains about the meaninglessness of abstract representations of power as domination, which leave us: 'with hardly anything to say but that big fish eat little fish, the weak go to the wall, power tends to corrupt, uneasy lies the head, and master and man need one another to exist: the dim banalities of theory' (1995: 40). Mainstream organisational literature favours the rational and systemic discourses and pays little heed to authors offering a different perspective. I have therefore sought to show how some 20<sup>th</sup> century philosophers, sociologists and thinkers, Foucault in particular, offer a different discourse with an analysis of power in a practical, historical context. This can offer insights not only to past practices but can also inform sense-making of current practices of power relating. For me, this means that power is integral to human relationships of every kind and is not a characteristic of an individual. I perceive I have been attributing power in this way, however, and since I do not believe this at all in personal relationships, I

think I have been equating power with status and real or presumed professional expertise.

I have been clear from the outset of the DMan that power is a major issue in my career. Power as a concept is rather abstract to deal with and it has been helpful to consider Elias and Foucault in terms of how power can be judged through an analysis of local interactions, which enable and constrain what is possible at any given time. This has been important in considering my own work in IAPT: how daily struggles between people influence how policy is formulated, defining what is considered to be the right, based on what is considered to be the incontrovertible truth of evidence based practice. The issues that have surfaced for me, in considering power, relate to my sense of professional identity, which I am coming to feel relates to some uncertainty about my expertise, being more generalised and managerial rather than specialised and clinical. The latter is clearly more valued and dominant in PMG. I think that my rather petty assertions of wanting to chair meetings within my jurisdiction emerge from a need to be in control to avoid this domination and the resultant humiliation.

I realise with some force, having read Foucault, Elias, Arendt and others, that my habitual professional style has been one of seeking consensus through formal processes. I have never been inclined to seek to manipulate people outside of meetings and have tended to take the moral high-ground over of others who do. I realise, reflecting on Habermas and the broader rationalist position, that this is hopelessly naïve. On reflection, I think I have unconsciously used organised meetings as ways of holding conversations rather than as formal ratification processes, and this has enabled, sometimes, new and creative solutions to problems to emerge. This way of working is more difficult in IAPT, however, as there is a dominating, strongly held conviction about what has to happen and a small inner circle that leads this, resulting in me and others feeling outsiders. In this context it seems easy to become subject to such domination and hence to undergo subjectification in Foucault's terms. As power is immanent in the interactions in PMG, underpinned by clinical and academic expertise that is esteemed, I have come

to realise that the possession of power is not an individual characteristic, but the product of those interactions. I realise that I and others, (the outsiders) are playing our part in maintaining this process. Hence, my relationship with Derek and other members of PMG is not one solely based on personalities, it is also how we co-create the patterns of conflict and manipulation. This is a significant movement in my thinking, although it does not prevent intensely visceral experience in moments of interaction.

I have always felt that the clear value of doing the right thing by people who use services, which I suppose is what is truth for me, should be persuasive in itself. I now see this cannot be so, and I am astonished that I have been able to achieve anything in my career. I feel, however, it is important to have a clear ethical position and belief about what one is trying to achieve. I think I have perceived power as Parsons would have depicted it: as positive where I have been able to influence processes but negative where I have found a lack of co-operation in professionals, who are therefore fair game to reform. I have tended to blame people, both in IAPT and in other settings, based on my deeply felt beliefs, but this does not seem a sustainable way of understanding what is going on between us as intensely social beings.

So I am left reflecting what else may be going on and what I have drawn from the authors I have cited. The issue of conflict and its necessity to prevent a totalising process, where everything becomes the same, is new and challenging to me. This is because I perceive asymmetry of power-relating in teams and the continuing dominating voice of the psychiatrist in specialist mental health services, which could be seen as a mirror of PMG. As I am currently working with a variety of professional staff in a Trust, I do see more clearly the need for the emancipation of the non-medical workforce to help them avoid making themselves subjects in the process of power relating.

I have never considered myself to be an expert in terms of skills and knowledge, but I have felt that behaving humanely and with humility is of the utmost importance; it is this way of relating that I have valued and championed. But on reflection, have I done this with professional colleagues?



This understanding of bodies of knowledge and expertise and their bearing on power is what I want to develop further in my synopsis.

## **SYNOPSIS & CRITICAL APPRAISAL**

*We shall not cease from exploration  
And the end of all our exploring  
Will be to arrive where we started  
And know the place for the first time*

*T. S. Eliot 1944: 4*

### **PURPOSE**

The purpose of the synopsis is to review my thinking as it has developed through four projects. It is intended to enable me explore whether the themes of professionalism, evidence and power, which I drew out from my first project, have proved to be at the core of the question that has sustained my research enquiry. It also allows me to consider, in more detail, aspects that I believe need further inquiry in order to develop and defend my argument. To this end I have drawn, to a limited degree, on new authors to support my thinking on identified themes. Finally, the synopsis provides the platform on which to present and defend my argument.

### **INTRODUCTION**

I have come to the DMan programme after a long career in the National Health Service. This has meant that I have seen organisations and practices emerge and metamorphasise over time, presenting situations which are at once both familiar and different. Issues that appeared incontrovertible to me in the past have become less so as I have read and reflected on my experience. Research within the DMan has been about taking my experience seriously in order to come to a better understanding of what is and has been going on in my working life. I am putting forward this thesis as written documentation of this movement in my thought.

I have worked as a clinician and a manager in specialist mental health services, which has led me to question the training and practice of professionals. This interest in workforce issues resulted in me leading a national workforce programme in mental health. One aspect of this work included advising on the workforce elements of the national programme to increase access to psychological therapies (IAPT). It is the involvement in this programme that I have used as the basis of my thesis.

The DMan approach to research has enabled me to tease out how this national programme has been influenced by an overriding belief in science as a good thing. Scientific method generates evidence that is seen as incontrovertible. Management science, despite having little evidence base according to these criteria, has a significant impact on the management of such a programme. The main proponents of science have had a stronger voice, by virtue of their specialist expertise and association with academic research, practice and teaching. The interactions in a management group exercise disciplinary power and enable and constrain what can and cannot be said, resulting in the identity of group members being felt as 'insiders' or 'outsiders'. The working of the IAPT programme management group (PMG) is an example of what many of us experience at work and in our relationships. I am positing that the insights that I have gained through my reading and reflections are generalizable to other managers and practitioners working together to achieve what are understood to be common goals.

I argue that the current idealisation of science, informing the discourse on evidence, is based on assumptions of linear and rational causality; that this can only offer a partial solution not only because of the differences between research efficacy and clinical effectiveness in practice but also because such evidence only claims to help a percentage of clients. I take up complex responsive processes of relating as a way of thinking, based on Stacey et al (2000, 2001, 2007), which in turn draws on the complexity sciences. These take seriously unpredictability and uncertainty to offer a different way of thinking about research method in my thesis.

I explore taken for granted assumptions about developing the professional workforce and about the use of competences. I problematize the position taken by Dreyfus and Dreyfus (1986) on their conceptual discontinuity between competent and expert practitioners and I posit that evidence based practice can only be accounted for by observable rule governed, competence based processes. I argue that expert practice develops in non-linear ways, which cannot be prescribed in an explicit manual, and which therefore is simply not available as a blueprint to follow. I therefore conclude that the card of evidence and the hand of science have been overlaid.

I present the evidence of narrative accounts and argue that this ideology has prevailed in IAPT, in a difficult to contest and silencing manner, through the power relating of specific players or intellectuals, (Foucault, 1994a), who have sought to narrowly define what constitutes evidence and therefore the *truth*. This silencing and the taking up of the idealised notion of science could also be described in Mead's (1932b) terms as a cult value. By the same token, the functionalization of IAPT in local services, and the implementation of evidence based medicine generally, is influenced by professional perspectives, expertise and identities of those involved locally.

Furthermore, I argue that both clinicians and managers as NHS professionals generally have differing allegiances and identity: clinicians to their professions and managers to the corporate goals of their organisation. This has historically formed a gulf between managers and clinicians, which has come to define the politics of everyday life in the NHS. The evidence base for clinical interventions is limited and evidence for management approaches even thinner, (Stacey, 2010) yet particular ideologies of management science, e.g. performance management, are thoroughly embedded in the public sector. This suggests that its influence is one based on ideology (whether market or equality focussed) and on disciplinary power, rather than on science.

I conclude that whatever rational arguments and processes are marshalled centrally, they will inevitably be taken up differently in implementation, which is by definition local and context dependent.

I will now summarise the key themes and issues that have arisen for me through my four projects.

## **PROJECT SUMMARIES AND THEMES**

### **PROJECT ONE: PROFESSIONALISM, EVIDENCE AND POWER: INFLUENCING CHANGE PROCESSES IN MENTAL HEALTH SERVICES IN THE NHS.**

This project focussed on my main area of work to date, which has been in secondary, specialist mental health services. Ironically, I make only slight reference to the IAPT programme.

My training and work as a psychologist focussed extensively on science and its relationship to human behaviour. Skinner (1953) was a key influence on my thinking and practice, in his searching for fundamental laws that could predict behaviour. My disillusionment with the adequacy of a behavioural perspective to account for the complexities of organisations and to offer ways of thinking about alternatives led me to refocus on values and human rights issues. This took me away from thinking scientifically. The growth of a cognitivist approach in psychology, which led to the development of CBT, took place in mental health about the same time and had no impact on me. This is a factor that I now realise has influenced my work in IAPT. The whole area of what constitutes scientific evidence and method was a key issue for me early on and emerges as a key theme in this project.

The role of professions and the nature of their inter-relationship, particularly the status and influence of the doctor both individually and as a multi-disciplinary team member has had a burning relevance to me, which has significantly affected my ways of viewing the world.

My view of power as something ‘wielded by clinicians’ now reveals to me that I have had a negative and reified view of power, which I feel particularly keenly in IAPT PMG. As I reflect, however, on the work undertaken by the programme I led on NWW, it is clear that I, together with colleagues,

exploited the weak position of psychiatrists in early 2003 to take steps to limit their future span of control. This was a way of exercising intention which could also be seen as manipulating events and setting an agenda, which was political and not so different from IAPT processes. The difference is perhaps that my position of influence is different. I describe how evidence is selectively used to attack or defend personal positions and am persuaded by Flyvbjerg's (1998) position of power determining knowledge, which he takes from Foucault (1994a).

There is a striking consistency in the themes that I identify at the outset of the DMan and how they have remained with me, those of *professionalism*, *evidence* and *power* and how they impact on the delivery of a national programme of policy change.

## **PROJECT TWO: HOW ISSUES OF PROFESSIONALISM ARE SUSTAINING AND CHALLENGING THE POWER RELATIONS IN A NATIONAL NHS PROGRAMME**

As I introduce fully, for the first time, IAPT PMG, I outline the structure and nature of the national advisors (NAs). Here I note that I distinguish between those NAs, who have specific expertise in psychological therapies and others who have been inherited, including me. I have therefore immediately placed myself outside what I am defining as the expert group. As all NAs are professional advisors, this suggests that there is a hierarchy of authority within the group that relates to power and authority.

I highlight key aspects of professionalism, which I have drawn from the literature, which include:

1. Having specialist knowledge and skills; the more esoteric and abstract the body of knowledge, the more highly qualified and respected the profession.

2. Exercising discretionary judgement, variously described as ‘intuition’, having the ability to make inferences, ‘metacompetences’, clinical judgement and expertise.
3. Having control over one’s own work, including control of what constitutes knowledge, entry to and expulsion from professional bodies
4. Having a privileged economic and social status, including being culture carriers of ethical standards.

As I have observed the fallibility of professionals, I find this a highly idealised set of principles, but I perceive that they are implicitly assumed to apply to those NAs in PMG, who are a combination of researchers and clinicians. Science and specialist knowledge derived from research trials are the source of their authority. In contrast, those of us with more generalist experience, such as in NHS management or in general medical practice, are not specialists. We are, rather, experienced in managing service change with its diversity of views and practice, and pragmatic in negotiating solutions. In voicing these realities as we see them, however, we are seen as over-complicating matters and not being fully supportive of NICE guidance and its direct application through a prescriptive national approach (which may be described as a blueprint). Whilst frustrated with such oversimplification, I do not believe that huge variability in practices and services is helpful either, so I am partly persuaded by the argument. In any case, I do not have an alternative blueprint.

Interestingly, on re-reading project two, I see that I mention the NAs for service users and carers only once and never again refer to them. How can this be? I have been driven by the focus on improving services for people on the receiving end my whole life. I notice that I have felt critical of those NAs for not being critical and questioning, which is what I would have expected from service users in the past. Indeed, one NA has already stated the benefits of receiving CBT personally, so *improving access* to CBT is the major challenge as they see it. Furthermore, CBT is intended to be carried out collaboratively between the therapist and client, therefore there appears to be

less overt asymmetric power relating than I observe in specialist mental health services. However, the voices of these NAs are not sought out.

I review the role of the doctor, of psychologists as scientist practitioners and of psychological therapists more generally and conclude that the role of doctor has little influence in IAPT, unlike in specialist mental health services. Less predictably, I find that I am reconsidering the role of management as a profession and realise that I am ambivalent about owning the professional identity of a manager. I conclude that there is still something of the psychological scientific practitioner in me as I work as a manager and in IAPT. Reflecting more fully on my position as a manager, however, I realise I have not taken up what it has meant for me to focus on workforce as an area of specialisation, I will therefore consider this under management as a profession. Perhaps it is not surprising then that I find myself without a very coherent voice in PMG: I feel this relates to permeable jurisdictions of professionalism, specialist versus generalist bodies of knowledge as well as a privileged interpretation of what constitutes evidence. These factors have resulted in me and some other NAs silencing ourselves.

Finally, I discuss competences and capabilities and how I have turned to them as a way of getting away from professional boundaries. I was and am now even more uncertain about these. Although I take up Dreyfus and Dreyfus (1986) more fully, I feel I do not get to grips with their distinction between calculative and deliberative rationality. I will therefore explore more fully the key themes about *management as a profession*; and the assumptions behind *professionals as experts*.

### **PROJECT THREE: HOW THE DISCOURSE AROUND EVIDENCE-BASED PRACTICE AND IMPLEMENTATION HAS COME TO DOMINATE A NATIONAL PROGRAMME FOR CHANGE IN THE UK NHS**

Project three gave me the opportunity to consider the nature of the evidence put forward by NICE on which IAPT is based and promoted. I take up Roth



and Fonagy (2005) as key authors on evidence in relation to psychological therapies. On reflection, I am struck by their temperate tone as they critique assumptions about vital issues such as the contested nature of the diagnosis of depression. They point to the potentially reductionist approach of translating procedures into the propositional language (Tsoukas & Hatch, 2001) of manuals if they are taken as *the* way of practising therapy rather than as *a* way. They highlight the need therefore for flexibility both of method and type of therapy delivery. This is in sharp contrast to the way that CBT is proselytised in policy and implementation. Nevertheless, Roth and Fonagy, I would suggest, recognise the political nature of the debate. They do not question the basis of mainstream scientific method, the need for evidence nor the demand for the production of competences, in which they have been very instrumental. The perspectives provided by G. H. Mead (1934) and Charles Taylor (1995) offer an alternative way of thinking about therapy as human interaction and the importance of *phronesis*, that is, linking context and practical knowing, which takes me back to the theme of clinical judgement and intuition.

The aspect I raise concerning measures of recovery not fully reflecting the experience of service users in an IAPT evaluation, highlights the issue I point to in project two, where the service user and carer voice is muted in IAPT.

What surprises me most in project three is how I have overlooked the evidence associated with performance management in the NHS. Both clinical research trials and this type of management thinking are based on positivism. My relatively unreflective acceptance of this management approach, seems to mirror my poorly articulated sense of my own identity as a manager. How different approaches make divergent assumptions about human nature is something I will explore in thinking about *managerialism*.

The key themes from project three are therefore *method* and *managerialism*.

## **PROJECT FOUR: HOW POWER RELATIONS INFLUENCE THE IMPLEMENTATION OF A NATIONAL PROGRAMME TO IMPROVE ACCESS TO PSYCHOLOGICAL THERAPIES.**

All my work to date has pointed to power being a major factor influencing how the NHS and IAPT have been developed and managed. In the context of a new global belief in evidence based medicine, the National Institute of Health and Clinical Excellence (NICE) was established in England in 2000 to identify what treatments had evidence to support their efficacy and therefore what should be commissioned and delivered in practice. This direction, embedded in NHS performance management and public sector agreements, was utilised to make the argument for the funding of the IAPT programme. As NICE guidance on treating anxiety and depression recommended CBT as the therapy of first choice, the scene was set for the focus and locus of power relating in PMG and more widely amongst the professions, commissioners, service, and education providers. The nature of the power relating has been different in those contexts, but PMG has been the main context of my enquiry. I have been enabled to make sense of my experience through considering how power has been enacted in practice rather than in the abstract; by drawing on the work of Elias and Foucault.

How power determines what is considered to be knowledge (or evidence), truth (or evidence) and expertise (or professionalism) has proved fascinating and problematic at the same time. I understand this to be because of the different assumptions that underpin approaches to philosophy, science and sociology which I will also address under method. Within this, the role of the 'specific intellectual', bringing to bear his specialist body of knowledge or research, as described by Foucault (1994a), adds complexity to the issue of expertise, which I will take up as a theme.

In summary, the themes I will take up will be *method* and *expertise* from project four.

## OVERVIEW OF THEMES.

This short reappraisal of my projects has highlighted the need to re-examine the following themes: *management as a profession*, including what I understand is meant by managerialism; *expertise* as a way of thinking about professionalism, learning and practice, *power* and its relationship to evidence and knowledge; and how this influences my understanding of *method*.

## REAPPRAISING MANAGEMENT AS A PROFESSION

I have not identified myself as a professional manager. This insight has been important as it has uncovered much that I have taken for granted in my practice.

Clarke and Newman (1997) posit that there were two underpinning aspects of the NHS, established in 1948. Firstly, *bureaucratic administration*, a rational approach ‘to promote the efficient and impartial administration of public businesses of all kinds’ (1997: 5) concerned with stability and predictability, based on Weberian principles. Secondly, *professionalism* which, in contrast, stressed ‘the indeterminacy of the social world as necessitating the intervention of expert judgement’ (ibid.: 6). Furthermore, ‘(p)rofessionalism lays claim to an irreducible autonomy - the space within which professional judgement can be exercised and must be trusted’ (ibid.: 6). They describe this combination of perspectives as ‘*bureau-professionalism*’ (ibid.: 8), which offered an idealised representation of the welfare state, where all stakeholders were committed to the value of ‘public interest’ and the ‘public good’.

This positive philosophy came to be questioned as a result of the changes in the world economy in the 1970’s impacting on political thinking and economic policy making (Seddon, 2008). The so-called neutrality of bureau-professionalism was also brought into question by increasing public awareness of social factors such as gender, disability and race equalities and the slowness in responding to these issues by the (particularly medical)

professions. This was exactly my experience. Furthermore the uneasy alliance of bureaucracy and professionalism was not proving to be effective in managing budgets. Hoggett comments

...it was precisely because human services were so difficult to rationalise, that, if costs were to be kept under some kind of control, the need to rationalise them was so great. But the attempt to control professional service workers in this way was almost doomed to failure, given the discrepancy between bureaucratic and professional modes of control. (1994: 42-3)

Policy shifted in Britain to introduce quasi-markets into the public sector, in what Pollitt calls a 'neo-Taylorist' form of managerialism.

The central thrust, endlessly reiterated in official documents, is to set clear targets, to develop performance indicators to measure the achievement of those targets, and to single out, by means of merit awards, those individuals who get "results". (1993: 56)

The Griffiths report (1988), commissioned by the Conservative government, heralded the importance of managing increasing demand for treatment and argued for the need for general management in the NHS, based on commercial principles. I remember making an alliance with an ambitious dentist, who wished to become a manager and leader, and how we looked forward with eager anticipation to the Griffiths report. We felt this would enable us to drive forward changes that would empower service users and challenge professionals. Not long after, he became the chief executive of one of the first NHS Trusts, and I went to work for him in the mental health sector to close the local psychiatric institution.

I think my distrust has been of clinicians, not of management. Management as a profession blossomed in the NHS, following the Griffiths report, with a huge growth in MBAs and consultancies, leading Clarke and Newman to argue that this growth enhanced the status of managers. This appears at first

sight to be in contrast with Khurana (2007), who described the profession of managers in the private sector, as descending from ‘higher aims’ of professionalism in the first part of the 20<sup>th</sup> century to the entrepreneurial and essentially self-interested position of ‘hired hands’ in the latter half of the century. Perhaps the difference lies in the perception that the demise of the bureaucrat in favour of the manager in the UK NHS, was a shift from administrators who enacted clinical decisions, to general managers who challenged professional practice, through a motivation to improve services for the public good. Certainly, as NHS managers are not shareholders, the power relationship is different in the public sector. I certainly saw myself as a challenger of professional practice. Clarke & Newman describe concepts such as moving from being controlling to empowering and from hierarchies to flat structures (1997: 49). This was the language that I used on a regular basis in the absolute certainty of the rightness of my own beliefs. Managerial ‘discourse of change’ (ibid.: 50) spawned language which made it difficult to argue against: ‘change’ as a good thing and terms like ‘efficiency’, ‘productivity’, ‘cost effectiveness’ and ‘user-centredness’ were all difficult to counter without appearing destructive.

Professional culture and identity are linked and, as I describe in project two, the identification of professionals is first and foremost with their own profession rather than with their employer. This attitude is contrary to managerialism, the mission of which was ‘to create a homogeneous and shared culture which would bind all workers to the pursuit of corporate objectives’ (ibid.: 62). I have rarely come across managers relating to each other as professionals in the way that clinicians do, perhaps because in the NHS most have trained as clinicians. Modernisation, a managerialist concept, has played a major role in the NHS and other public services in the last decade; stressing the importance of giving up parochial loyalties in favour of the corporate culture. This was the *raison d’être* of new ways of working (NWW), which I led for six years.

Willmott (1993) critiques the idea of ‘corporate culture’, advocated by Peters and Waterman (1982), which aspired to win the hearts and minds of

employees through persuading them to sign up to and reach consensus on a set of values devised by management. He argues that in going beyond the requirement for employees to just do the job, management was aiming to influence the affective domain of the workforce to identify with the product and with the organisation. In doing so, Peters and Waterman (and others) were denying the identity and individual values of the workforce. In 2003, Willmott revisits this critique and reflects “(f)rom an employee standpoint, efforts to ‘strengthen culture’ may (therefore) be experienced and resisted as unacceptably manipulative and intrusive upon their sense of identity and dignity” (2003: 76). He considers that there is a growing realisation that imposing values on the workforce to achieve culture change is naïve. He points out, however, that, although there has been a move towards focussing on the team or work group, nevertheless the original intention is the same. This is to encourage identification by employees with values and priorities set by management to play the game in a type of double bind. Stacey (2011), in an analysis of leadership, suggests that those who resist such coercive persuasion (Schein, 1961) or disciplinary power (Foucault, 1977) may resort to *hidden transcripts* and to the *arts of resistance* (Scott, 1990).

Willmott’s analysis of managerial approaches to culture resonates with me in that both winning hearts and minds from a top down perspective and the bottom up involvement of key professionals and teams, have figured in my change management style. The clear articulation of values has proved a continuing frustration for me and led to the production of the *Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce* (2004). I have sought to persuade professionals of the importance of valuing service user experience, the importance of evidence, team working and so on. The paradoxical nature of these processes are evident from Willmott’s analysis, as are the dangers of totalisation (and in extreme circumstances of totalitarianism), in seeking to avoid conflict. It is interesting to note that Willmott’s work has been influenced by Foucault and others, whom he describes as poststructuralists, in recognising the importance of subjectification, identity and disciplinary power in understanding how organisations develop. Furthermore, he states that “(o)rganisations, of course,

can do nothing. Only their members are capable of acting...” (2003:83). In some respects, therefore, Willmott has shared perspectives with complex responsive processes, recognising the importance of local interaction, but he does not question the assumptions of the corporate culture theories he critiques in terms of being able to manage cultural processes.

Eighteen years on, it is interesting to reflect that managerial discourse has taken even stronger hold in the public sector, particularly ownership

...of missions and targets, budgets and responsibility for results - has been one of the sought after effects of the managerial revolution, constructing commitment and motivation among the staff in the pursuit of corporate objectives. (Clarke and Newman, 1993: 427-441)

This could aptly summarise the rationale for IAPT at PMG level. There has been what I perceive to be a conflation of this managerialist performance perspective with the evidence based practice model drawn from cognitive behavioural research; resulting in a coercive argument which it is difficult to resist.

## **REFLECTION ON MANAGEMENT AS A PROFESSION**

What I was not aware of, when the quasi-market NHS was established, was the emerging impact of performance management of national targets on local behaviour. I remember feeling perplexed at how these new managerial imperatives, such as waiting time targets, were being managed in order to avoid financial penalties, rather than to address service improvements. This is what I explore further in reading Stacey (2010) and Seddon (2008) in project three.

My work with the professions on NWW was entirely ‘to bring the professionals on board’ (Pollitt, 1993: 95), to build their alliance with service users and with the organisation rather than with their professional colleagues and professional bodies. This deeper exploration of managerialism illustrates

clearly what a profound effect it has had on me. Although never formally owning the identity of a manager per se, I have believed and expressed all the sentiments identified above. Whilst I do not condemn myself for this, it helps me to reflect how much I have been drawn into this discourse. I also find it fascinating to reflect on how two distinct influences have converged in managerialism i.e. the rise in monetarism (Friedman in Seddon, 2008: 2) and the impact of equalities and human rights legislation. Perhaps a common factor is the focus on consumerism, empowering the customer to get the best service or product. This is linked with some scepticism about professionals, seen as self-interested rather than interested in the public good. However, I suggest there is a different starting point from a human rights perspective, which is not so much about individuals but about the groups to which they belong and any associated stigma. Foucault's concept of normalisation is directly relevant here, in that society has devised many ways of classifying people according to how they compare to a norm. The purpose has been to develop dividing practices to deal with stigmatised individuals and groups in ways that society thinks fitting at the time. Segregation of education for people of different races, religion and learning difficulties are all cases in point. Although many overtly discriminatory practices are now illegal in the UK, they keep emerging covertly, arising from unconscious values, about groups with which a person may be identified. Rational legal approaches, although necessary, are not sufficient to overcome the attitudes and values that may be implicit in professional practice. This is the distinction that Foucault makes between sovereign and disciplinary power, which is what I have detected in professional groups and have sought to challenge.

I reflected in project two, that I was still unconsciously identifying with psychologists as a profession and with their scientist practitioner stance, using this way of thinking to guide my management actions. Reflecting further, although I acknowledge a certain admiration of the profession (in comparison with others), I can now see that the twin influences of human rights and managerialism have been the strongest influences on my practice. But this clearly points to the fact that my skills are now generalist and managerial rather than specialist and clinical. I wish now to turn briefly to the



work that I have undertaken on workforce development, to consider how far this too is a managerial role.

### **CONSIDERING WORKFORCE DEVELOPMENT AS PART OF A MANAGERIAL ROLE**

My role as a manager in the NHS led me to question the professional workforce. Following an ostensibly successful service re-organisation, I discovered that I had had no impact on the (unhelpful) nature of the doctor-patient relationship. The problem then became how to shift professional attitudes and practice to become more person-centred. My first port of call was to consider the role of education and training and how to prepare practitioners from the outset to be fit for practice. This meant thinking about initial training and the nature of curricula. These are widely diverse for each profession and can be different in how they are taught even within disciplines. Furthermore, all trainees in health and social care professions must have supervised placements, so the beliefs and practices of supervisors, as well as the milieu of the workplace, have a profound impact on their learning. As these contexts will vary enormously, even specific curricula, will be taken up slightly differently in practice. Immediately then we can see the difficulty of trying to achieve consistency in learning experience and outcomes except at quite an abstract level (e.g. qualifications).

I came to realise that education and training could only be part of any process of improvement. This has led me to be resistant to IAPT being portrayed as a training initiative. Workforce planning, which is intended to assess and predict the numbers of staff required in the NHS, was something that I needed to understand. Essentially this requires reasonable forecasting of what services will be required for the population and therefore commissioned, often over a five year period. It requires translating demand into numbers and types of staff required, an understanding of the current workforce profile (numbers likely to retire, working part-time) and the potential supply of any new workforce. The product of this exercise is supposed to be a workforce

plan that will inform the number of training places that should be commissioned on an annual basis.

What I have found is that this process is perplexing to organisations, resulting in predictions, based on what they did the year before. This, of course, is an inherently conservative process as it does not challenge numbers, skills mix and traditional practice nor the advent of new technologies. The publication of the Mental Health National Service Framework (1999) led to the establishment of the national workforce programme, of which I was the director. Over the ensuing six years, we produced 'how to' workforce planning guides, supported local pilots; focussed on values based training and worked with all professional bodies to develop NWW. This included changing professional practice, extending traditional roles and developing new roles for people who were not traditional professionals. As far as I can judge, all of these initiatives have had variable and limited effects.

My learning from this experience has been how challenging it is to influence this multi-faceted process. The unpredictability of the future in terms of needs and resources and the apparently irresistible force that draws people back to what they have always done (particularly professional roles) are real challenges. I do not consider that there is a specialist body of workforce knowledge from which accurate predictions can be made. There are, of course, specialist workforce organisations set up to assist in this endeavour by developing toolkits and models to aid trend analysis. There is also an elegant IAPT workforce model, with which I am closely associated. Nevertheless, I have come to believe that workforce planning and development is a well-intentioned, rational approach, but that the unpredictability of the future and the complex factors involved make it fatally flawed. This complexity has led people, in my experience, to disavow any expertise in it and endow it with a magico-mythical quality. I judge that this body of generalist knowledge does not have a strong (traditional) evidence base; furthermore, it is only of interest to professions insofar as it increases their numbers.

## CONCLUSION

I conclude that workforce development is a management role. I am generally expected to be a workforce expert and although I have expertise in workforce (and in management) this is generalist expertise, in a subject for which there is little underpinning evidence as it is generally understood. Stacey highlights that “there is no comprehensive, reliable scientific evidence for currently dominant management prescriptions” (2010: 19). He states that this is due to an erroneous reliance on the sciences of certainty for method, which could be addressed more appropriately if organisations were conceptualised as “patterns of nonlinear interactions between people” (ibid.: 20).

I will now turn to my second theme: expertise as it has emerged from professionalism, and its implications for thinking about evidence.

## COMING TO PROBLEMATISE EVIDENCE THROUGH THE CONCEPT OF EXPERTISE

I have come to think that professionalism is synonymous with expertise. Professionals, particularly those who have risen to senior roles in their careers, are expected by the public to be experts in their subject. Professionals expect this of themselves and to receive the status associated with this expertise. I would like to consider more fully the thinking that underpins competences and the implications this has for the understanding of expertise and evidence.

### **The limits of calculative rationality**

Dreyfus & Dreyfus developed their concept of *novice to expert* in 1986. To contextualise, their argument was developed to counter the emerging belief at that time that the growth of Artificial Intelligence (AI) would eventually replace human reasoning. Hubert Dreyfus, a philosopher, concluded,

however, that problem solving, by computers could never address the unpredictable. With his brother, a computer specialist, he states that

...digital computer language systematically excludes three fundamental human forms of processing (fringe consciousness, essence/ accident discrimination, and ambiguity tolerance). (Ibid.: 9)

Since this book was published, there have been exciting breakthroughs using computer modelling to develop Chaos theory and Complex Adaptive Systems. Here, computers have been shown to be able to demonstrate emergence of patterns which can be unpredictable through following simple rules (Reynolds, 1987). Nevertheless, the fact remains that rules need to be explicit to enable computers to function (Stacey, 2007: 254). The explicitness of rule governed behaviour and how this only partly reflects the actual human experience of developing and exercising skills in real life became the basis of the Dreyfus *novice to expert* work.

They argue that rules are important in early learning and practice. The *novice* acquires skills based on facts that are 'context free' (ibid.: 21). The *advanced beginner* begins to apply these in practice, becoming exposed to situational factors. The *competent practitioner*, with more practical experience, is able to carry out fairly complex sequences of activities in a specific context but may have difficulties when faced with competing priorities. All in all, these skills remain at the level of *conscious* decision making. This process is exactly that used in the IAPT national training programme.

They go on to argue that there are two further levels: *proficiency* and *expertise*, which are based on intuition, defining these as "understanding that effortlessly occurs upon seeing similarities with previous experiences" (ibid.: 28). The proficient performer will be deeply involved in their task and respond to factors that may be difficult to identify, such as situational cues; or they may be using "holistic similarity recognition", by which they mean an intuitive ability to respond to the pattern without deconstructing it into its constituent parts or rules. A common example is that of driving a car. The

difference between the proficient and the expert practitioner is that the “expert’s skill has become so much a part of him that he need be no more aware of it than he is of his own body” (ibid.: 30). Dreyfus & Dreyfus summarise their argument as follows:

What should stand out is the progression *from* the analytic behaviour of the detached subject, consciously decomposing his environment into recognisable elements, and following abstract rules, *to* involved skilled behaviour based on an accumulation of concrete experiences and the unconscious recognition of new situations as similar to whole remembered ones. (Ibid.: 35)

They distinguish, then, between the first three stages which they describe as calculative rationality (linear causality), much the same as would be used in artificial intelligence; and the expert stage as arational, which they describe as deliberative rationality. They argue that at an expert level, “if learning is to occur, some part of the mind must remain aloof and detached” (ibid.: 40). This may be seen as a similar concept to first order abstraction (Stacey, 2010) or the paradox of involved detachment from the perspective of Elias (1978).

What can explain this apparent discontinuity or leap from a rational to an arational process? Dreyfus and Dreyfus do not offer a clear explanation about how this might happen in practice, so I will consider this more fully.

### **Accounting for the concept of expertise as deliberative rationality**

Clinical judgement is a term used in medicine and in psychological therapies; I judge it to mean the same as ‘intuition’ in Dreyfus and Dreyfus’s terms. There is a similar conceptual leap in IAPT. A key part of the work has been to produce competence maps to underpin training and practice. Each map not only contains basic and specific observable competences but also ‘metacompetences’, examples of which include ‘capacity to use clinical judgement when implementing treatment models; capacity to adapt interventions in response to client feedback’ (Roth & Pilling, 2007: 12).

Dreyfus and Dreyfus suggest that deliberative rationality can account for intuition, but it is not clear how they explain this. They draw on Aristotle's concept of contextual judgement, although not naming it as *phronesis*, but appear still to locate the process within the individual expert capable of 'detached and rational' thinking (1986: 167). I will now explore two ways of thinking about expert practice, drawn from the complexity sciences, addressing a continuum within and between bodies.

### ***Physical and neurological underpinnings of expertise***

Turning first to a potential physiological source of understanding, Harth (1993) explores how the brain and the mind can be understood without reverting to dualism. He argues that "a single brain, unlike a computer, is continuously changing its characteristics in response to its contact with the rest of the world" (1993: 102-103). He outlines mechanisms that assist in pattern recognition in the brain and suggests that important factors will include "the raw sense data that are received, expectations based on preceding events, stored knowledge, and random fluctuations" (ibid.: 143). One can see immediately the similarity here between this position and the process that Dreyfus & Dreyfus suggest is underpinning expert practice.

But what understanding of causality is being assumed here? Harth is clear that the brain is subject to non-linear causality in the sense that: "there is no limit to the smallness of events that can trigger a sequence of thoughts" (ibid.: 146-7). He goes on: "strange and awesome things happen in the non-linear world, such as bootstrap processes (*self-referencing*) in which something appears to arise out of nothing. Totally new phenomena may occur". He argues that time as a linear concept has no real meaning in understanding the brain and the mind: "Consciousness is not a point in time. It straddles broad sections of the past and reaches out into the future" (ibid.: 144-5). His argument is based on the rapid and multiple neural responses in the brain that make them impossible to disaggregate. He argues that consciousness, the self-awareness of a phenomenon, occurs in the brainstem,

not in the cerebral cortex. He also argues that a vast amount of activity occurs of which the person is unaware; this has been demonstrated elsewhere through the use of MRI scanning. This could support the Dreyfus view of intuition, where an expert may find it difficult to articulate what (s)he has done, arguing, in any event, that this may be post hoc reasoning.

### *A social interpretation of expertise*

Turning to the social context and to Mead (1934), he proposed that the self arises in social interaction. The child is born into a relationship with its mother and from the earliest stage is interacting physically and emotionally to form a bond with her. It is clear that there are predisposing capabilities in the infant to recognise configurations of the human face to enable recognition and attachment to take place. The way that this will play out will, however, depend on the quality and frequency of those interactions. He argued against the traditional view that the individual is presumed to have primacy, where mind and a sense of self develop internally and then impact on others. Instead, to reiterate, mind

...starts with an objective social process and works inward through the importation of the social process of communication into the individual by the medium of the vocal gesture. (Ibid.: xxii)

So, man's physical and neurological characteristics (the biological 'I') play into these interactions and enable him to use language symbolically and enable him 'to be an object to (him) self' (ibid.: xxiii) and hence demonstrate consciousness (the 'me'). The person influences and is influenced by his interactions. In the process of socialisation, the individual is able to reflect and direct his actions in anticipation of responses of others. This also holds true for actions in relation to non-linguistic or inanimate aspects of the context. Mead's view is therefore that the self and mind arise through social interaction and the psychological is social and not individualistic. (1934: 224).

So where does this leave us? I find Mead convincing as he describes the social nature of human development. There are interactions occurring between people continuously, whether in day to day conversation, in formal learning or therapeutic settings. For some there are explicit rules, for others there are ways of doing things which are implicit and difficult to describe precisely, as they are highly contextualised and complex. Taylor (1995), like Dreyfus and Dreyfus, takes up Aristotle's concept of *phronesis*:

The person of real practical wisdom is less marked by the ability to formulate rules than by knowing how to act in each particular situation. There is a crucial "phronetic gap" between the formula and its enactment, and this too is neglected by explanations that give primacy to the rule-as-represented. (1995: 177)

Taylor shares Mead's view that social interaction is circular in that we engage with intention with another, but that there is no certainty that responses will conform to this intention, so that ongoing adjustment occurs, as in therapy. Mead described taking the attitude of the other (empathy) as being deeply human. This idea of empathy has significantly influenced the development of therapies.

A contested area is how far the outcome of therapy is related to the technique (rules), to 'therapist variables' or to the nature of the relationship (e.g. Castonguay & Grosse, 2005). IAPT (based on CBT) favours techniques of the therapist, but other professionals and researchers consider the therapeutic relationship most important. Taylor argues that "rules are transformed through practice" (ibid.: 178). I take this to mean that causal relationships or rules identified through research trials have been shown to be inadequate in accounting for social interaction, beyond early stages of skills development. Taylor, drawing on the work of Bourdieu (1980) describes the importance of 'habitus' in providing a (cultural) context, which is difficult to articulate. He argues that rules or representations (which may also be described as cognitions) are formulations, which 'are only islands in the sea of our unformulated practical grasp of the world' (1995: 170). An individualistic (or



monological) perspective will not do in understanding practice which is essentially social (or dialogical) (ibid.: 171). This reflects the stance taken by Dreyfus and Dreyfus, but offers a way of understanding what may be occurring using social rather than what I would argue are individualised accounts. It appears to me to be clear that there is a continuum of interaction between the physical and the social. As new brain imaging technology develops, we are able to see the anticipation of the brain responding to stimuli before we are aware of them; illustrating that there is a continuous interaction with others and within ourselves, which may not be conscious. The danger is to locate this process solely within the individual, developing mental models of the outside environment, on which (s)he can deliberate and intervene rationally: this is a cognitivist position. More persuasive, I suggest, is that there is on-going interaction between bodies (understood to include the brain and not separating mind and brain) in a given context, which is a social process. In the past, I have tended to think of expertise as being primarily individually rather than socially determined, but I no longer consider this to be the case.

My initial reaction to Dreyfus and Dreyfus' categorisation of the levels of skill acquisition was mixed. I recognised that competences make sense for early skill development. I had been concerned, however, that they run the danger of being both atomistic and reductionist if taken out of context. I therefore recognised the authors' description of this process as one of calculative rationality. I felt, however, that their account of deliberative rationality was a leap to intuition, which was not plausible in the way they argued it. I consider, however, reflecting on the complexity sciences, including Harth's perspective on brain complexity and the argument for ongoing complex responsive processes that there is an alternative basis for accepting such an interpretation.

## REFLECTING FURTHER ON EXPERTISE IN IAPT

I find it interesting to reflect on what this means for the position that we have taken in IAPT. We have developed competence frameworks and taught skills based on those competences, within published national curricula. We have, further, ensured that trainees, once they have learned the theoretical basis of the model, are enabled to practise their developing skills and competences, initially in role play with actors and then with real service users under supervision. It is only the requirement for trainees to sit in and observe experienced therapists, which seems to offer an opportunity for learning in more tacit ways. It should be remembered however that the dominant discourse in IAPT is one of cognitivism, which assumes that

(c)ognitive behavioural treatments aim to help the patient change his or her problem behaviour directly. Although a good therapeutic relationship can be important in cognitive behaviour therapy it is not regarded as the main vehicle of change. The approach is best regarded as an educational and problem solving one, with the therapist using his or her specialist knowledge to guide the patient towards a solution to his/her problems... (There is an) emphasis on the systematic assessment of change using scientifically derived assessment measures and carefully evaluated techniques. (Marzillier & Hall 1999: 39)

It is therefore assumed that everything is describable and measurable. But the development of expertise has not been explicitly addressed. The introduction of the concept of 'metacompetences', which describe higher level skills, begins to describe what is termed 'clinical judgement', but without any theorisation of how these may come about.

## **Summing up Dreyfus and Dreyfus: Problematising expertise and evidence.**

Dreyfus & Dreyfus do not take into account covert influences on practice, such as status and power, nor do they address the importance of social interaction in the process of learning, preferring to focus on the learning of skills and behaviours of individuals. Indeed, Harth, as a physicist, more fully highlights the importance of the social in shaping the individual. Expertise is generally ascribed to the individual and assumes a monological view of the world. It thus tends to become reified as a concept. It has proved difficult to explain how experienced practitioners can act into uncertainty. I have sought to draw on thinking based on the complexity sciences to answer this difficulty. I suggest now that expertise is a skill that arises in social relating.

The concept of the expert as working through intuition problematizes the concept of evidence, which, by definition, must be measurable and predictive, relating logically only to rule governed behaviour. Intuition and expert practice are not rule governed and logically cannot be described as evidence based in the currently accepted discourse.

## **MOVING TO POWER**

### **INTRODUCTION**

The concept of the expert has become important to me in thinking about power. I had not considered this fully at the outset of my thesis due to my scepticism about professionals. As I have researched the assumptions behind scientific method and the extraction of evidence from positivistic, cognitivist perspectives, I have become more inclined to view power as an over-riding and immanent influence in IAPT. Specialist expertise in IAPT, based on a belief in scientific evidence, is perceived to be located in specific individuals. The context of PMG enables dialogue between people adhering to this way of

thinking and constrains people with more generalist expertise and different ways of thinking. Working expertly in such a context is not confined to particular individuals, but I will argue that it is power relating that influences what emerges in practice.

### **POWER AND STATUS OF THE EXPERT AS SCIENTIST.**

As I observe in project four, in IAPT, three NAs are professors and would describe themselves as (expert) evidence based scientist practitioners. I argue this elevates their status in the programme. Gordon describes how Foucault does not disavow natural science (1994a: xvii). His interest is, rather, how truth and knowledge are valued because of their ‘reliable instrumental efficacy’. I take this to mean how they can influence policy and practice. He comments that knowledges (sic) such as psychiatry (in which I would include psychological therapies) will never have the status of the physical and natural sciences, but does not criticise them for that (ibid: xviii).

In considering the changing role of the intellectual in France, Foucault considers that the role of the ‘universal’ intellectual as a thinker has lost credibility and that the role of the ‘specific intellectual’ has emerged to replace it. He suggests that this has emerged with the atomic scientist, who has not only had to defend his scientific body of knowledge but also the political implications of this knowledge. More generally, he posits that the specific intellectual is “a savant or expert” (ibid.: 128), whose role began to develop post Darwin. “At all events, biology and physics were to a privileged degree the zones of formation of this new personage...” (ibid.: 129). In arguing that each society has its own “regime of truth”, he suggests that the specific intellectual influences by bringing to bear his body of knowledge or research on “the general functioning of the apparatuses of truth” (ibid.: 131): this increases the importance and influence of this intellectual. He describes how political conflict can occur concerning what is defined as truth, wherein “the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true” (ibid.: 132).

This suggests to me that the specific intellectual is influential, that (s)he may have a body of scientific knowledge that is important, but that the most significant characteristic is the power to influence what is considered to be truth. I find that this characterisation fits well with my perception of PMG. There is circularity about truth being determined through scientifically validated evidence, articulated by specialist or specific experts, who in turn have a high status based on their research practice and who influence what is issued as policy. Issues of variable implementation are identified as errors to be corrected, including those who articulate those issues.

Foucault, on the other hand, also proposes that the intellectual's role "is to overturn whatever we believe to be self-evident and to dissipate what we take for granted; it is not to shape the political will of others or to tell them what they ought to do". He asks: '(b)y what right would he do so?' (1994b: 676). This is an important question and echoes Elias's view that scientists should be 'destroyers of myths' (1978: 52). There are points in time when what is accepted knowledge and practice, for instance psychoanalysis, is challenged, in this case by cognitivist research evidence. Now, however, we see proponents of cognitivism seeking to silence questioners; defending evidence based practice to the exclusion of other approaches, which may work for some people. Scientists are human beings after all and are subject to socialisation, subjectivisation and the current discourses. Veyne states that

(t)his whole setup (dispositif) forms both science as an object and individuals who will only recognise truth in whatever is said in conformity with the rules of an exact science. (2010: 87)

So experts, accorded status through their knowledge, cannot be the objective scientists they are so often (self) portrayed to be, as they cannot stand outside social processes. They are drawn in, influence and are in turn influenced by the interactions in the scientific and therapeutic communities. This, for me, is not acknowledged in IAPT; a positivist view of science is promoted as disciplinary power.

I will turn now to method to illustrate how natural sciences and their presumed objectivity cannot stand outside of social and historical processes.

## **METHOD**

### **INTRODUCTION**

I intend to show in this section how the method that I have taken up in the DMan, which is based on a reflexive use of narrative, has been influenced by the use of discourse by Foucault and by the theoretical assumptions that arise from the perspective of complex responsive processes of relating. A key theme throughout my thesis has been the differing traditions arising from Plato and from Aristotle, which can be characterised as rationalist and humanistic approaches respectively in philosophy and in the philosophy of science. The dominance of rationalism and its success in underpinning an understanding of the natural sciences has had a lasting influence on the human and social sciences. I will argue that the research method I have used does not rely on rationalist assumptions, but rather is informed by the complexity sciences.

### **APPROACHING METHOD REFLEXIVELY**

#### **FOUCAULT'S DISCURSIVE PRACTICES**

Veyne states “(t)he originality of Foucault’s research is that it works on truth in the context of time’ (2010: 14). Using the analogy that every era has “its own fishbowl”, Veyne states that discourse dictates what may be taken for granted as the truth, (for example that Jupiter was considered a god in antiquity), which will be overtaken by new beliefs or truths. Foucault questioned “how is it that in a particular period one can say one thing but another is never said?” (1994b: 787). From one period to another, different truths emerge and every thinker wants to be the one to “bring the age of error to an end” (2010: 15). However, Veyne (and Foucault) question: ‘(i)s it any

safer to believe in human rights than it was to believe in the god Jupiter?’ (ibid.: 85). Today this seems a frivolous question because “(w)e are sure our convictions are true”(ibid). I have reflected on how I have held the foundationalist view that if only professionals could see issues from the service users’ perspective then all would be well, as the truth would be revealed to them. I recall being disgusted when psychiatrists commented that the concept of ‘an ordinary life’ (1981) for people with disabilities was ‘just another fad’. I realise that I would not have held this view 50 years before and different views may be taken by others 50 years hence.

Foucault’s method in interrogating how it is that truths come to be accepted historically is based on the assumption that the “object, in all its materiality, cannot be separated from the formal frameworks through which we come to know it”, frameworks that Foucault calls “discourse” (2010: 6) or discursive practices. Discourse is precise description of individual differences; not general ideas. Foucault holds that generalities led historians and others to be selective in their analysis and ignore small things which might question their hypotheses. Foucault does not believe in universals or ‘isms’ (Veyne, 1971: 172) and seeks to understand what was going on in any given period by examining differences in concrete practices: the “principle of singularity that causes history to be a series of ruptures” (1994b: 580). By reducing large concepts or ‘kernel(s)’ (1971: 159) to ordinary experience and historicising them “then, in the place that was previously occupied by the big thing-that-goes-without-saying, there appears a strange little “period” object that has never been seen before” (1971: 159). I suggest that the undisputed nature of a scientific approach and the evidence it yields for human behaviour in the form of psychological therapies is just one of those kernels.

Through his career, Foucault’s method shifted from a detached archaeological approach that sought to provide rules for an objective analysis of discourse to one, which incorporated this approach as a technique, but took up “genealogy as a method of diagnosing and grasping the significance of social practices from within them” (Dreyfus and Rabinow 1982: 103). They describe his method as neither structuralist (which he was accused of early in

his career) nor entirely hermeneutics, but as ‘interpretive analytics’ (ibid.: 133). Here, he was deliberately avoiding theorising in order to address both the object and the subject and how they could be understood in the sciences of man (as opposed to the natural sciences). His three areas of research, mental illness, prisons and sexuality, all form part of the human or ‘doubtful sciences’ (ibid.: 116) forming a context in which he considered how it was that practices were made possible historically. Dreyfus and Rabinow describe this as a ‘history of the present’, which is not an attempt to write a true history, but rather a pragmatically oriented historical interpretation. In doing this, he is seeking to bring alive the human experience and to defamiliarise (or see anew, see below) the reader with the practices influencing that experience, in order to bring them to a new and better understanding. It has been Foucault’s interpretive analysis of mental illness which has drawn me in, and this contextualisation that has resonated with my experience.

His archaeological technique requires the careful analysis of materials of the day: data, events and phenomena documented and cross referenced, including small details, prior to any hermeneutic interpretation. Flyvbjerg describes this process as describing practices as events and suggests that the researcher is essentially removing her/himself: ‘to allow him or her to disinterestedly inspect’ (2001: 135) the material. This splitting of the two processes could be problematic if it implies that it is possible for the researcher to stand outside and therefore not influence or be influenced by the process, however, it could be understood as Elias’s paradoxical involved detachment. Foucault is clear that he wants to unearth from records of the past *how* it was possible for practices to occur. It is important to be able to evidence what is being described, with an interpretation, for it to be understood by others. Nevertheless the key point is ‘the primacy of context’ (Rabinow and Sullivan 1987:8), an understanding of which can be drawn from ‘a feel for the game’, as Bourdieu describes it (1990: 9). Flyvbjerg (2001) argues that this is phronetic in nature. It is also what can or cannot be perceived at any given period of history.



Different “discourses” respond to different questions. Each time, we apprehend a reality that is no longer the same (Veyne, 2010: 55).

## **REFLECTING ON TIME**

I began this synopsis with a quote from the *Four Quartets* (1944) because Eliot’s portrayal of time has resonance for me, as I have experienced a continuous process of trying to make sense anew of situations and relationships as they have played out repeatedly. This is very much part of Foucault’s discursive practices and is perhaps the essence of the research method in the DMan programme. I would characterise these components as: describing my experience in the context where it is happening (in the ‘living present’), detaching myself from it in order to consider it reflexively, taking up authors who might throw light on the themes and comparing their perspectives in order to triangulate my understanding and inform what emerges as my argument. I then return to where I started and seeking to understand it as a differently thinking person and “know the place for the first time”.

What has informed this process of seeing familiar things as novel has been Mead’s argument, in *The Philosophy of the Present* (1932a). He develops a critique of science based on Newtonian principles, and embraces the theory of relativity, addressing how it can be thought about in relation to human beings. This requires us to make a radical reappraisal of the nature of time and to question the assumptions behind science that there exists an objective reality, both in the past or to be revealed in the future. He posits that reality can only be found in the ‘living present’ and that the past (event) is not just an antecedent to (or cause of) the present, but that the past is both ‘irrevocable and ‘revocable’ (ibid.: 120). I take this to mean that the past cannot be changed as an event experienced at the time, but that it can change in the light of re-interpretation from the present perspective. Similarly the future cannot be predicted fully based on the past and the present, but behaving with intention will influence processes and people, who in turn will respond, which will give rise to a changing understanding in a new present.

Interestingly, Mead argues that novelty can occur in the present, which cannot be accounted for based on the past, however

(w)e speak of life and consciousness as emergent but our rationalistic natures will never be satisfied until we have conceived a universe within which they arise inevitably out of that which preceded them. (Ibid.: 126)

Mead portrays the scientist as seeking rationality in the universe.

He is simply occupied in finding rational order and stretching this back, that he may pre-empt the future. It is here that his given world functions. If he can fit his hypothesis into this world and if it anticipates that which occurs, it then becomes an account of what has happened. If it breaks down, another hypothesis replaces it and another past replaces that which the first hypothesis implied. (Ibid.: 125)

Reflexivity relies on an ability to engage with the present, which changes moment by moment, to be paradoxically deeply involved, but able to monitor and be aware of what is happening and to be able to give an account of the inter (and intra) actions. It is here that I would like to discuss the importance of narrative as an important means of enabling reflexivity.

## **THE USE OF NARRATIVE**

We have already seen that 'how' is Foucault's (1994a: 224) most important question in trying to understand how some things can be discussed and others cannot. McIntyre observes that history is vital to understanding the past because humans are 'story-telling' animals (1984 [1981]: 215). 'What am I to do?' he suggests, can only be answered, if we can answer the prior question, of 'what story or stories do I find myself a part of?' In an analysis similar to that of Mead (1932), he argues that we become who we are through learning from

others from the outset, passed on through stories and myth. Flyvbjerg puts it like this

(n)arrative enquiries do not - indeed they could not - start from explicit theoretical assumptions. Instead, they begin with an interest in a particular phenomenon that is best understood narratively. Narrative inquiries then develop descriptions and interpretations of the phenomenon from the perspective of the participants, researchers and others. (2001: 137)

Bruner (1986) discusses two ways of ordering experience: the logico-scientific and narrative modes of thought, which although complementary are not reducible to one another, because they imply different assumptions of causality (1986: 11-12). Tsoukas and Hatch (2001) take these distinctions and explore the implications for method in relation to complexity theory. They favour a narrative approach, arguing that “a narrator communicates and captures nuances of event, relationship, and purpose that are dropped in the abstraction process that permits categorisation and correlation in the logico-scientific mode” (ibid.: 998).

What I believe the method of narrative and reflection in the DMan programme achieves is an opportunity to look at a given context and really to try to understand it. In describing the work of PMG and the actors within it, I have not been making up a story nor seeking to offer an objective account of the facts, but, as White puts it, producing: “narrative discourse...(which) works up the material in perception and reflection, fashions it and creates something new” (1987: 178). I believe that I have (inadvertently) adopted a Foucauldian approach in the DMan programme. I hope that I will have defamiliarised the reader with processes and interactions that have influenced how the IAPT programme has been developed and implemented.

## **CONTEXTUALISING THE DMAN METHOD WITHIN BROADER APPROACHES TO RESEARCH**

### **QUALITATIVE APPROACHES**

Qualitative research methods are now well accepted in the fields of management and organisation and becoming more so in clinical fields like nursing. They take as their starting point the perspective of the subjects studied. Denzin & Lincoln comment “...qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (2005:3). Reflexivity is an important underpinning theme, meaning that serious attention is paid to how linguistic, social, political, and theoretical elements are drawn together in the process of knowledge development, whilst empirical material is constructed, interpreted and written. Empirical material in this context means interpretations of ‘reality’, which is reflected upon carefully. Alvesson & Sköldbberg describe the research process as constituting a “(re)construction of the social reality” (2000:10). They argue that empirical work must be linked closely with philosophical positions, because “(i)nterplay between philosophical ideas and empirical work marks high-quality research” (ibid.: 10). They conclude that “both ‘recipe book research’ and ‘theorising in a vacuum’ should be replaced by reflective activities (or) reflexive interpretation” (ibid.: 316). I take this to mean that although they are critical of positivistic methods, they are not convinced by the polar opposite of post modernism and that there can be benefits from what they describe as being ‘provisionally rational’.

My IAPT colleague, with whom I have shared my work, asked me if I was familiar with ethnomethodology, as it struck him that this was the method that I was following. Garfinkel first wrote about the concept in 1967 when he was seeking to study features of everyday life in a practical setting. He coined the phrase ‘ethnomethodology’ in 1974, when working on a project to research how jurors arrive at decisions. The term drew on Phenomenology,

which was critical of natural science having distanced itself from everyday life. Garfinkel went on to posit that raw experience was not chaotic, and that members of groups develop procedural behaviours, methods and practices and carried out ‘experimental breaches’ to surface how social practices are subject to rules that are not generally visible. Heritage (1984) describes Garfinkel’s theory of action as being a new departure (from Parsons for instance) stressing “that action is through and through a *temporal* affair that is *reflexibly accountable*” (1984: 308). Drawing on the framework developed by Schutz (1962, 1967 [1932]), Garfinkel wanted to explore

...how men, isolated yet simultaneously in an odd communion, go about the business of constructing, testing, maintaining, altering, validating, questioning, defining an order together. (1952: 114)

He criticised social scientific formulations of objectively rational courses of action as drawing attention away from the ‘reasonableness of action’ (1967: ix) in a similar way to that argued by Toulmin (2001).

#### **QUANTITATIVE APPROACHES: THE DOMINANCE OF NATURAL SCIENCE ASSUMPTIONS IN IAPT**

Ironically, through the IAPT programme, I have found myself immersed in traditional quantitative research, based on positivism. Although this approach has many critics, I have argued that its’ influence persists (see p 183). In summary, its’ basis can be

...conceived as the creation of true, objective knowledge, following a scientific method. From what appears, or is presented as data, facts, the unequivocal imprints of ‘reality’, it is possible to acquire a reasonably adequate basis for empirically grounded conclusions and, as a next step, for generalisations and theory building. (Alvesson and Sköldbberg, 2009: 1)

I describe how IAPT is dominated by CBT. Alford and Beck (1997), considered to be experts within the CBT community, seek to persuade doubters from other therapeutic modalities of *the integrative power of cognitive therapy*. A key argument they put forward is the robustness of their theoretical, scientific framework, drawing on Popper (1959), whose definition of a rigorous theoretical system is one that is ‘axiomatized’, where

(t)he axioms must be free from contradiction; they must be independent, so that axiomatic statements are not deducible from others within the system; the axioms must be sufficient to permit the deduction of all statements belonging to the theory; and, finally, the axioms must be necessary for derivation of the statements belonging to the theory. (1997: 15)

They go on to list ten formal axioms of cognitive therapy and posit that, as thought is cognition and as all therapies rely on thinking, cognitive theory is the ‘theory of theories’ (ibid.: 44). Their tone is eminently reasonable as they seek to address the common criticisms of CBT, but they do not question their individualistic and rationalist assumptions, based on positivism and the natural sciences.

I want to turn now to the paradoxical assumptions between the natural and human social sciences.

## **TOLERATING PARADOX ACROSS NATURAL AND HUMAN SOCIAL SCIENCES**

A key issue in my research has been whether the research evidence posited for psychology and psychological therapies can reasonably be drawn from the natural sciences, i.e. is psychology a natural or a social science? Drawing on the work of Mead (1934), I have concluded that social psychology, and clinical psychology, is a social science as it is entirely about the interaction between human beings. Logically, therefore, it should lend itself more to qualitative than quantitative approaches. But reflecting more deeply, I believe

that such polarisation is not helpful as it implies a total rejection of quantitative approaches. At a recent conference on counselling and psychotherapy (not CBT), I was struck by the pains each speaker took to accept evidence based practice drawn from RCTs, whilst advocating the development of evidence from practice and how this could be more effectively supported. My interpretation was that there is not only an acceptance of the reality that CBT works for some people, (so why criticise it?), but also the acceptance that the current political culture exercises disciplinary power, which will not accept as valid any approach that does not make this accommodation.

In project three, I conclude that there is a major difficulty between what is shown to be efficacious from the research evidence and what is shown to be effective in practice. In essence this highlights the two opposing methodologies. Firstly, the natural science approach which seeks to achieve generalisable rules, extracted from large scale, quantitative, controlled studies with decontextualised subjects, indicating probabilities. Secondly, the developing social science approach within the context of day to day therapeutic practice, where variables cannot be removed and must be worked with. Flyvbjerg describes this as the ‘deadly paradox of social theory’ (2001: 38) and concludes that

...a theory which makes possible explanation and prediction, requires that the concrete context of everyday human activity be excluded, but this very exclusion of context makes explanation and prediction impossible. (2001: 40)

Although the positivist approaches of the natural sciences are still very influential and underpin what constitutes evidence for NICE and for IAPT, this is not relevant to the method of the DMan. Toulmin (2001), reflecting on how rationality has come to dominate the history and philosophy of science, at the expense of ‘reasonableness’, states that, rather like form should follow function, method should follow the area of research investigation.

One aspect of the standard view of ‘rationality’ is the assumption that a single method can turn any field of enquiry into a ‘hard science’ like physics. A more balanced view will allow any field of investigation to devise methods to match its problems, so that historical, clinical, and participatory disciplines are all free to go their own way. (2001: 83)

Alvesson and Kärreman (2011), speaking from a constructionist, post-modernist perspective, offer a root metaphor for thinking about good social science as *mystery* (2011: 63). They critique current inductivist and deductivist approaches for separating theory from data, trusting in data to inform theory and downplaying the subjectivity of the researcher (e.g. Freese, 1980; Glaser & Strauss, 1994; Eisenhardt, 1989). They comment that although the critique of (neo) positivism is enormous, “...this does not stop the majority of researchers from doing normal science more or less as if nothing has happened” (2011: 7); this is a key issue in considering what should and what does happen in research practice. In IAPT, for example, it is the RCT evidence that is focussed upon and the practice based evidence that has not been taken up in any significant way. They re-iterate the concept that data are inextricably linked with theory (e.g. Denzin & Lincoln, 2005; Kuhn, 1970) and therefore that empirical material should be opened up rather than constricted in research work (ibid.: 14). They propose a “constructionist” approach, where data are constructed rather than collected (ibid.: 24), and comment that even where there may be a high level of consensus among researchers about “received truth...there may be good reasons to look seriously and sceptically at the assumptions and construction processes involved in the production and reproduction of this truth” (ibid.: 25). They suggest that although sharing work with a community of researchers is an excellent discipline in testing argument, it can also constrict discourse to the received wisdom of that research community. This is what I argue in relation to the assumptions behind NICE, which excludes non RCT evidence.

Alvesson & Kärreman, in promoting the importance of exploring issues that are not predicted or may be “breakdowns in understanding”, suggest five principles that can assist in opening up research questions and exploring



further what strikes researchers as interesting, where past understanding has been found to be inadequate (Weick, 1989: 525).

1. *(De) fragmentation* (avoiding premature ordering and treating variation seriously).
2. *Defamiliarisation* (interpreting social phenomena in novel ways compared to dominant distinctions).
3. *Problematization* (systematic questioning of received wisdom and offering a constructive (re) formulation of research questions).
4. *Broad scholarship* (extending the researcher's interpretive repertoire to encourage rethinking).
5. *Reflexive critique* (openness to values and to limitations of understandings to critique perspectives, including of one's favoured discourse) (2011: 41).

They recognise that such an approach is high risk for most researchers, so will not be taken up widely. They therefore suggest three types of exploration of 'breakdowns' (ibid.: 115): *focussed*, *sensitive* or *considering*. What they are suggesting is that researchers can choose firstly, to focus on mystery or breakdown, secondly, to follow a more conventional route with more openness to surprises, or finally, to carry out controlled and focussed studies but be aware that unpredictable results (e.g. Lincoln & Kalleberg, 1985) may lead to recommendations for further research (as usually happens). I consider that Alvesson and Kärreman, whilst offering a different way of approaching research method that takes account of the lack of predictiveness of theory and the limitations of empirical data, are nonetheless still assuming that the researcher and the research community can be detached observers and deliberately choose their approach. I would argue that the DMan method encourages all the above five principles, but rejects assumptions about such autonomy.

## **ASSUMPTIONS UNDERPINNING METHOD IN COMPLEX RESPONSIVE PROCESSES**

In common with many qualitative research approaches, the starting point for method, in DMan research, is one that has at its core taking experience seriously. This experience is borne of the view, in terms of complex responsive processes, that there is no split between the individual and the social, so everything, including the mind, emerges in local social interaction. Although there may be artefacts, idealisations or ‘cult values’ (Mead 1932b), such as national policy or organisational vision statements, these are particularised in local micro interactions. This means they get taken up in different ways which makes it impossible to predict with accuracy what will occur as a result. This therefore makes the process of implementation uncertain, which is at odds with the conventional discourse, which is based on the natural sciences of certainty. There are three underpinning assumptions of causality in natural sciences, firstly, *efficient*, demonstrable (if-then) causality, which underpins RCTs, *rational* causality, where the autonomous individual can choose rational goals, as in a cognitivist perspective and finally *formative* causality, emerging from concepts from evolutionary theory, where the end is already enfolded, such as in the growth of organisms. In contrast it is the common experience of people in everyday life that things rarely turn out as planned (the best laid plans), but there persists a belief that thought comes before action, that people can stand outside of their social environment in an objective manner and that it is possible to be value free in undertaking research.

Complex responsive processes of relating draw on the complexity sciences as an analogy, which are the sciences of uncertainty. Here, change can emerge, where there can be amplification of small differences and where patterns can be produced that cannot be forecast in advance. Indeed a key feature is that there is no blueprint and no grand plan. There is only self-organisation, where patterns emerge, so there is no need to think of any causal agency outside of human interaction itself. Paradoxically, people and interactions are forming and being formed at the same time, which can lead to both predictable and

unpredictable effects. This may be described as non-linear *transformative* causality (Stacey & Griffin, 2005). There is a focus on temporal rather than spatial metaphors in describing our experience, this means that there is no 'whole', no levels of differentiation between the individual, the group, the organisation or society. This is challenging to current organisational and research ways of thinking.

In research method, the natural sciences are trying to do something different in isolating causal factors and behaviours that anyone can pick up to replicate, falsify or verify. This makes no sense in terms of local social interactions. *Generalisability*, a key requirement in the natural sciences, means, in complex responsive processes, pulling out (or illustrating) issues that resonate with one's peers more generally. My reading of narratives written by people working in similar situations to me (Stacey 2007), for example, drew me to consider different ways of approaching organisational change and led to me applying to join the DMan research programme. In adopting a narrative about experience of particular social interactions, as part of this research method, the outcome is uncertain and emerging, in contrast with more conventional case studies that are carefully crafted and have a beginning, middle and end. There is a paradoxical perspective in that, as social beings, we are immersed in the 'game' of everyday life, which is what we pay attention to in our narratives, but to make sense of this experience we must detach ourselves to reflect on our experience, in what Elias (1978) described as paradoxical 'detached involvement'. Stacey (2010) differentiates first and second order abstraction, meaning that our reflection, including categorisation and interpretation of our experiences, is first order i.e. it is close to the reality of what is going on. Second order abstraction is necessary where higher level abstraction is required, for instance where a policy department may need a population overview, where individuals are not relevant. Finally, complex responsive processes has as its basis human interaction with its inherent paradoxical co-operation and conflict, which brings with it inevitable emotion and power relating.

## **TAKING UP THE DMan METHOD**

The DMan research process uses human interaction as its basis, both in terms of using current work-based experience and in active discussion with DMan colleagues. The process for me has been challenging.

Project one gave me freedom to be biographical, helping me to pay attention to values and assumptions that have been influencing my practice. Moving to project two, however, I had to learn the discipline of exploring assumptions in my narrative by reading relevant authors and then contrasting them with complexity perspectives. This was a new intellectual challenge and it forced me to critique ways of thinking which I had held and honed over years. I found it hard to make connections between authors and my experience; and I felt exposed by my lack of grasp of concepts, which led on many occasions to me silencing myself in DMan group meetings. It has taken time to appreciate that group meetings are, in effect, a microcosm of everyday life, as we interact into the unknown with one another. The challenge is to find meaning in the DMan social interaction, which can throw light on my interactions at work. An important insight for me is that I have become acutely aware of people who do not talk in groups (including myself in IAPT), feeling more curiosity about their lack of participation and less frustration with them (and myself) than I have done previously.

To keep focussed on each of my research projects, I have found it important to return to the themes and questions in my narrative at every step. I have had to wrestle with the balance between the 'story' in the narrative, recognition of my emotions and the intellectual rigour of study. Initially, I found it difficult to write in the first person, as third person objectivity was *de rigueur* in my psychology training. The DMan process is the reverse: it has a deep focus on the social self, recognising the importance that emotion, arising from existential anxiety, inevitably plays in the social processes of everyday work. This is how I experience research in the DMan community, where exploring new ways of thinking with others can be exposing, affecting my sense of identity, sometimes in a transformative way.

Reflecting on this, I know that some of my IAPT colleagues would not consider the qualitative approach adopted in the DMan to be scientifically robust. Toulmin & Gustavsen comment on the prevailing emphasis on 'hard science' and the scepticism about qualitative research by saying "It may be OK in its own way, but don't call it 'research' let alone 'science'" (1996: 203). Would another recognise my narrative and analysis as a reasonable account of what goes on in IAPT or do I have a distorted view? Does it matter if I do? This leads me to the important issue of ethics.

### *ETHICS*

Foucault comments, in an interview with Dreyfus and Rabinow on the genealogy of ethics, that "...it's not at all necessary to relate ethical problems to scientific knowledge" (1982: 236). He would consider the traditional approach to seeking informed consent for research purposes to be part of current discourse that is subject to sovereign and disciplinary power. Gaining informed consent at the outset of a research project is a requirement of every university as part of their formal (sovereign) research protocols. The DMan research method focusses on the process of social relating, in my case in a management group. It clearly points to the fact that who is involved in social relating and in what way cannot be prejudged, so seeking consent is a live issue throughout the research period. Furthermore, I had no hypothesis that I was testing, nor variables that I was seeking to control, therefore it was unclear to what participants might be consenting. . The ethical implications have become clearer as my work has unfolded. As I have gradually explored, in turn, professionalism, evidence and power in the workings of a small group, there have been points where the assumptions and values of participants have come into conflict; for example with the slow development of the four modalities additional to CBT. I have sought to understand this in terms of assumptions about the nature of evidence and the operation of disciplinary power in the group. This has therefore inevitably resulted in some personalisation in my narrative and reflections. I have sought to address this, because IAPT is a high profile national programme by using

pseudonyms to protect identities. I have also stayed in dialogue with key people with whom I work, by discussing it with my line managers. Most importantly for me, I have shared projects and my final thesis draft with a colleague in IAPT who attends the PMG, which is the focus of my narrative. He reports that my narrative and reflections resonate with his experience and that he considers that I am fair in my analysis. This is important as I feel uncomfortable writing about others without their prior knowledge and permission. Equally I could be vulnerable in my role if my narrative were made public too early. I have therefore sought and had approval for an embargo on publication of my work until 2013.

Recent events in IAPT have shown the impracticality of seeking prior approval from those involved. Informal conversations have been recounted about which NAs should be included and excluded (me) in the future programme. This underlines the messy reality of researching interactions of people with different beliefs, identities and power relating. From this perspective, “the ethics of what one does as a researcher...is contingent upon the situation and the emerging and on-going negotiation with those with whom one is interacting” (Griffin, 2002: 216). For Foucault, ethics are “ultimately an interpretation to be judged in terms of its resonance with other thinkers and actors and its results” (Dreyfus & Rabinow, 1982: 264).

#### **SUMMING UP METHOD.**

I have sought to argue that the way research method is currently understood in NHS policy is constrained by what is accepted as truth, based on assumptions about time and causality taken from the natural sciences. Qualitative approaches, favoured in organisational and sociological research, in contrast to positivism, hold that context, interpretation and meaning are crucial. Nonetheless, as I have attempted to point out, many qualitative approaches are equally based on rationalist assumptions. The DMan, based on a reflexive use of narrative, argues a different position on time and non-linear causality arising from the theory of complex responsive processes of relating. I have taken up the DMan method as a way of understanding and

questioning my taken for granted assumptions about my experience. I believe this has led me to develop a deeper understanding of the processes at work and of my own role within them.

## **MY CONTRIBUTION TO KNOWLEDGE AND PRACTICE.**

### **EVIDENCE BASED PRACTICE**

I believe I have contributed to knowledge and practice by problematising how evidence is equated with rule governed and observable behaviour. RCTs are the gold standard of research method accepted by NICE. They are based on assumptions from the natural sciences, including linear (if-then) causality or what Dreyfus and Dreyfus (1986) describe as calculative rationality. This assumes that components of behaviour can be isolated, observed, controlled for, recorded and measured, which I describe as rule governed behaviour. Dreyfus & Dreyfus acknowledge that this can only account for performance up to what they describe as the level of the *competent practitioner*. In IAPT, competences have been extracted from manuals used in trials to describe the behaviour of expert trial therapists. These competences now underpin explicit curricula and learning materials and form the basis of accreditation. Hence evidence based education and training has been prescribed to develop a workforce which, in turn, can deliver evidence based therapies.

But this leads to a problematic: how do competent, rule governed practitioners develop proficiency and expertise? Dreyfus & Dreyfus state that this is through deliberative rationality, which is essentially ineffable. If it cannot be described, as they and others acknowledge, how can it be captured and measured as evidence? This is, of course, not to say that proficiency and expertise do not develop; they clearly do. They do so, however, in ways that are much more difficult to account for, relating more to experience drawn from a large variety of therapeutic interactions with service users. I have sought to account for Dreyfus and Dreyfus's proposed deliberative rationality as a way of understanding this discontinuity, by drawing on complexity theory based on nonlinear causality. From a complex responsive processes perspective, this would be described as transformative teleology (Stacey, Griffin & Shaw 2000: 51). Therapy is a form of interaction and as such the interpretation of the therapist and service user of what is being addressed will



lead to an intense and iterative conversation. I suggest that this will inevitably lead to some variability and deviance from the prescribed approaches in evidence based medicine and practice. As practice is constantly changing in the therapeutic relationship to take account of this inter relating, novelty arises, which can be creative or destructive. I suggest this cannot logically be described as evidence based in the taken for granted, rule governed way that is currently proselytised in the NHS generally and in IAPT in particular.

I have demonstrated how evidence drawn from natural science methodology and applied to human interactions, can offer only a partial means of understanding and supporting people with psychological problems. I have shown how such evidence has generally been taken as authoritative because of an unquestioning belief in science in society. I have further shown how evidence on CBT has dominated the agenda of a national programme, not so much because of the efficacy of the research but because of the nature of disciplinary power in that context, which has constrained what can be considered as evidence and truth by key players in the group. I have shown that the power and importance of evidence has been promulgated by professional experts; defining what constitutes the knowledge base, the methodology and what the scientific community considers acceptable. Whilst this promotes rigour, it also restricts perspectives and can exclude others, who do not share assumptions of objectivity and universal laws. This conflict continues to play out in day to day politics and local practices.

## **ORGANISATIONAL CHANGE**

In seeking to understand the discourse of current organisational change in the NHS, I have shown that managerialist arguments about modernisation, effectiveness and efficiency are difficult to argue against as they seem profoundly rational. I have argued for them too, but now realise they are simply not the whole story as they are presented. I have come to believe that a managerialist approach, exhorting adoption of a corporate culture and shared values (Willmott 2003) and the frequently articulated need to win the hearts and minds of professional dissenters to enter into a corporate

consensus, has a slim chance of success. This is because professional (and personal) identity is deeply embedded and resistant to what can be perceived as bureaucratic and political motivations of the state and of employing organisations. The current domination of the political agenda, not only in the IAPT, but everywhere in the NHS, is about how services should be prioritised and made more efficient. This is driven by the latest policy imperative *Quality, Innovation, Productivity and Prevention* (QIPP), which is predicated on NICE guidance. This NHS performance management process is entirely driven by assumptions in management science which are ideological and for which there is little evidence (Stacey, 2010). The nature of any such evidence would, however, equally need to be critiqued.

### **MY PERSONAL JOURNEY OF DEVELOPMENT**

My personal understanding of organisational change has altered during the process of undertaking this thesis. It has illustrated for me the importance of conflict, silencing and disciplinary power in influencing how decisions get made and how actions are often (not) implemented as intended. Conflict is usually portrayed as negative, and I too have sought to avoid it in the past and to seek rational discussion to reach consensus. I have, however, come to appreciate that conflict in the form of people taking different points of view, which can be robustly debated and shape what emerges, can be highly productive. In contrast, where conflict or difference in views is overtly discouraged or silenced this constricts debate and leads to feelings of inclusion and exclusion and associated behaviours. This process has taken place in IAPT, I believe, and has resulted in reduced opportunities for potentially creative thinking.

I have also come to believe, however, that I and others, have not only been subjected to this way of thinking, but we have also disciplined ourselves to protect our own (professional) positions and identity. I have outlined how I have been self-silencing in IAPT and seen others do the same. This has been a powerful message: disciplinary power is immanent in our interactions, it is not invested in one person; people have power because others allow it (unless

we are in a totalitarian state). I have felt like an outsider in IAPT and felt a heavy constraint in trying to influence it. This is partly because I believe in its benefit in comparison with a traditional medical approach. It is also partly because articulating a different approach to evidence based practice and promoting practice based evidence is potentially exposing: I perceive that I have, therefore, co-created the situation. This analysis has enabled me to think differently about what has been happening; and the enabling constraints of the changing context will inevitably influence what happens from now on, in an unpredictable way. Like Foucault, perhaps, I have problematized how the context of IAPT has made it possible for CBT to dominate the agenda and sought to defamiliarise it, without providing theoretical or practical solutions.

Finally, I am struck how I have sought to find *the* answer to how service users can get a service that they value, to correct the errors of the past to achieve an agreed (universal) solution. I have come to see that this foundationalist position is similar to that taken by scientific experts in IAPT and to those exercising psychiatric power. I am now actively questioning my own assumptions and therefore changing my everyday practice, where the context enables it.

I am, of course, a person of my time, and although I have seen issues re-emerge over 30 years, they are never identical when I review them in context. This suggests to me that Foucault's method of interpretive analytics is plausible as method in helping me make sense of this research and to "know the place for the first time".

## CONCLUSIONS

As I began this thesis, I was sceptical of much of the work carried out by mental health professionals (particularly psychiatrists). I felt that the way they conceptualised the experience of people in biological and medical terms either did not help or was only part of a solution. I observed that the psychological and social needs of people as human beings, essential as part of recovery, were regularly left unaddressed. I found this incomprehensible, but have come to understand that the authority of the doctor is one that is socially constructed and that it has been particularly powerful in psychiatry because the framework for understanding human mental distress has been medically conceived and imposed on patients to interpret their problems. Foucault's analysis of psychiatric power raises questions about how it is possible for the nature of the doctor-patient relationship to develop in institutional settings. Ultimately, this is in terms of disciplinary power. This pattern of power relating persisted after institutions closed essentially because it is human relating that is key, irrespective of the space in which it occurs. What is most persuasive is that the means of understanding mental illness, the truth if you will, has been prescribed by the medical profession, based on its status and long authority in society rather than on its effectiveness in promoting the recovery. I recognise afresh that power therefore determines what can be considered to be the truth.

The advent of IAPT heralded a new departure from the grip of a medically dominated understanding of mental health. Its location in primary care has separated it from the influence of psychiatry. Its claim, to be scientifically valid and economically effective, through the implementation of evidence based psychological therapies, has been persuasive in securing significant funding. Psychologists, professional rivals of psychiatrists, have dominated the programme, nationally and locally, because they have largely been responsible for developing the clinical and academic research and specifically that relating to CBT. The assumptions behind the evidence are based on the natural sciences with associated rationalist beliefs resulting in a nationally

prescribed process, effectively seen as a blueprint for services and the workforce. Although widely welcomed, the dominance of CBT has increasingly become a cause of concern for those clients whom CBT cannot help (a significant but unknown number), and for those professionals who practise other therapies (and who claim effective outcomes). This has led to a muted debate, which has been dominated by specific experts, who argue that everything must be based on scientific research. Ironically, for me, the nature of the discussion has come to have a similar flavour to that of psychiatric power: the means of judging what is scientific is provided by those who undertake that research, and challenges to science are seen as irrational. In the context of a management group, this has clearly emerged as disciplinary power, resulting in self-silencing, which in Foucault's terms is subjectification.

I have argued that evidence, both in terms of RCTs and through data produced through NHS performance management processes, is taken for granted. I have concluded that IAPT cannot be solely based on evidence drawn from trials, translated into competences and taught to a new workforce. This is part of the picture but cannot offer a comprehensive account. An open debate about this, seeing conflict as potentially creative, would be helpful in my view. This would include *practice based evidence* as well as *evidence based practice*. Both are articulated in policy documents but the former remains in IAPT as a polite footnote to what is promoted as vital: NICE recommended, evidence based therapies.

I am finding that new ways of thinking are beginning to affect my practice in the Trust where I work in a more open way. I am much less inclined to seek solutions myself or to be dominated by project management plans. I am more inclined to engage in conversation with people of different professional groupings and encourage open discussion of conflictual issues to enable local decision making. I do not consider this to be a new technique, but rather a different way of understanding how people work and interact together.

This thesis is an exploration and interpretation of my experience. It has taken me back to where I began, but with a different understanding of myself and of processes that I have, as I now perceive it, co-created with others with whom I work and interact. Going forward, I would like to take up more fully the concept of phronesis, which Flyvbjerg (2001) uses in his proposal for a different way of researching social science, to explore further how we interact (expertly) together. It may be helpful to open up to further enquiry the importance of hermeneutics to an understanding of Foucault and critique the analysis of Dreyfus and Rabinow (1983). For now, I have tried to illustrate how the daily interaction in a group responsible for delivering a major service development in England has been influenced by themes of professionalism, evidence and power. What I have learned is not the end, nor the answer, but it is, I hope, an illumination of social processes that are always at work.

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## APPENDIX ONE

### IAPT STEPPED CARE MODEL (*Realising the Benefits*, 2010)

(Based on NICE's recommendations for the Psychological Treatment of Depression and Anxiety Disorders)

Staff	Disorder	Recommended Intervention
<p><b>Step 3:</b> High intensity service</p>	<p>Depression: moderate to severe</p> <p>Depression: mild to moderate</p>	<p>CBT or IPT<sup>1</sup>, each with medication</p> <p>CBT or IPT<sup>1</sup></p> <p>Behavioural Activation (BA)<sup>1,2</sup></p> <p>Behavioural Couples Therapy (<i>if the patient has a partner, the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy</i>)</p> <p>Counselling<sup>1</sup> or short-term psychodynamic therapy<sup>1</sup> (<i>consider if patient has declined CBT, IPT, BA, or Behavioural Couples</i>)</p>

		<i>Therapy)</i>
	Panic disorder	CBT
	GAD	CBT
	Social Phobia	CBT
	PTSD	CBT, EMDR
	OCD	CBT
<b>Step 2:</b> Low intensity service	Depression	Guided Self-Help based on CBT, Computerized CBT, Behavioural Activation, Structured Physical Activity
	Panic disorder	Self-Help based on CBT, Computerized CBT
	GAD	Self-Help based on CBT, Psycho-educational Groups, Computerized CBT
	PTSD	n/a <sup>3</sup>
	Social Phobia	n/a
	OCD	Guided Self-Help based on CBT
<b>Step 1:</b> Primary Care/IAPT service	Recognition of problem	Assessment/Referral/Active Monitoring
	Moderate to Severe Depression with a chronic	Collaborative care <i>(consider if depression has not responded to initial course of high intensity</i>

	physical health problem	<i>intervention and/or medication)</i>
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## Notes

*CBT = cognitive behaviour therapy. IPT = interpersonal therapy. EMDR = eye movement desensitization reprocessing therapy (considered by many to be a form of CBT). Behavioural Activation is a variant of CBT. Active Monitoring includes careful monitoring of symptoms, psycho education about the disorder and sleep hygiene advice.*

<sup>1</sup> *NICE's recent (October 2009) updates on the treatment of depression come in two parts: recommendations for the treatment of "depression" and recommendations for the treatment of "depression in people with a chronic physical health problem". The two guidelines are very similar. However, it should be noted that the "depression with a physical health problem" guideline does not recommend IPT, behavioural activation, counselling or brief dynamic therapy as high intensity interventions.*

<sup>2</sup> *Although the recent update of the NICE Guidance for Depression recommends Behavioural Activation for the treatment of mild to moderate depression, it notes that the evidence base is not as strong as for CBT or IPT.*

<sup>3</sup> *NICE does not recommend any low intensity interventions for PTSD and recommends that you do NOT offer psychological debriefing.*

*NICE has not yet issued guidance on the treatment of social phobia. However, there is a substantial body of evidence supporting the effectiveness of high intensity CBT. Low intensity versions of CBT are being developed by several groups around the world and are likely to play a useful role in the future. At least one trial has also demonstrated that IPT is effective.*

