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Specification for interventions under the Wellbeing Service 17/22 to end the need for rough sleeping by 2020

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1 Summary of conclusions – disconnected procurement system

We are fortunate in England to have the best public health system in the world, but it is not sustainable, as nationally 50,000 junior doctors are on strike, and locally nearly all our 150 GPs are planning to take early retirement by 2020, and say 'nobody wants to be a GP.' Treatment of physical conditions is exemplary, but there is an epidemic of mental sickness which is iatrogenic (Whitaker 2010) caused by the drugs prescribed to treat it, creating a revolving door syndrome overwhelming primary care.

The Clinical Commissioning Group (CCG) and the Council officers spend their time in writing excellent strategies, such as the Health and Wellbeing Strategy, the Rough Sleeper Strategy, the Better Care Plan 2016/17, etc) which are adopted by the Health and Wellbeing Board (HWB). However, the good intentions expressed there in never become implemented as ***treatments*** received by patients, because ***intention*** and ***impact*** never meet. This is because the ***procurement*** system is left to separate staff in separate buildings who know nothing about what they are buying, so just recycle old performance based contracts every 3-5 years, whose treatments don't work, and may do more harm than good (such as drugs). This is currently happening to the Wellbeing Service contract, despite government's intention in 2006 to 'end the block contract, and replace them by outcome based contracts. We now have a once in 5 year opportunity to create a new service which could integrate health and social care, cure the crisis in primary care, clear the Council's budget deficit, which should not be missed.

2 Recommendation to the Health and Wellbeing Board (HWB)

a) Instruct the chief operating officer of the Clinical Commissioning Group, (CCG) John Child, and the commissioner for the Wellbeing Service 2017/22 (Anna McDevitt) not to recycle the old contract specification, but to ***redesign*** the Wellbeing Service to meet in full all the aspirations of the above mentioned strategies, including the following specification for the treatment of vulnerable citizens with complex needs, including rough sleepers, at Community Care Centres in every GP cluster which are mental A&E departments open 24/7/365 for patients and social care service users including children.

b) The Adult Social Care department (headed by Denise De Sousa) and the Childrens department (headed by Pinkaja Ghoshal) should therefore also be involved in the redesign of this new Wellbeing service 2017/22 contract

c) If this redesign cannot be done in the 6 weeks remaining before the planned date of issue of the tender documents on 15.6.16, postpone it until the redesigned system is ***right*** for the next 6 years.

3 Context of this paper – ending the need for rough sleeping by 2020

Brighton and Hove City Council has recently adopted the policy of ***ending the need for rough sleeping by 2020.*** To achieve this laudable outcome, the homeless, (more than 80) the hidden homeless, (hundreds) and those at high risk of becoming homeless, (more than 1,000) all need to be treated with effective interventions to heal and cure their addictions. These treatments have long been available for those who can pay, but not to the vulnerable because hitherto they have not been commissioned or provided free at the point of use on the NHS.

At the last meeting of the Health and Wellbeing Board (HWB) on 19.4.16, I asked the following public question: 'Will rough sleepers be treated under the Better Care Fund Plan (item 75) and the Wellbeing Service Contract 2017/22 (agenda item 74)' I was given the following response, which was minuted *(my emphasis)*

'With regard to the Better Care Fund: ***Yes***, they are included under the model included on pages 115-116 of the papers (pages 11-12 of the better Care Plan) With regard to the Wellness Strategy. ***Yes***, we do want rough sleepers to be able to access the support that is available both in the IAPT (Improving Access to Psychological Therapies) and the Community Wellbeing service, and we think it is important that ***people with complex needs, including people who are homeless, are supported to access these services, and the services are able to respond to help people prepare for a course of treatment or offering flexible appointments in a range of locations.*** **'**

I publicly welcomed this response, because as mentioned above, these people have generally not been treated with effective talking therapies under the NHS mental health service. The reasons given include the following. Lack of an address so they are unable to register with a GP. If talking therapy was offered, it was ***conditional*** on them dropping their addiction to, say, alcohol. However, such addiction may have been the cause of their homelessness, so if they ***could*** have become dry without the treatment offered, they would have. If they ***could not drop it,*** as with most addicts, they may have been labelled: ***'non compliant'***, ***'hard to treat,'*** and ***'treatment resistant'***. If they had been prescribed medication, such as antidepressants, but it had not helped, and they had stopped taking it, they may have been given the same labels.

This attitude to addicts puts them into a catch 22 situation which denies them treatment and writes them off as beyond the help of the NHS. Such rejection would not be acceptable if they suffered from any physical illness or affliction, (such as a broken bone) and it is no longer legally acceptable for mental illness or afflictions, (such as a broken heart) as ***parity of esteem*** was established by the will of Parliament in 2015. Effective treatments for this client group have been available for decades for this client group in North America, (see references) in the private sector in the UK, and for participants of SECTCo's intervention, as we only ask donations. These treatments should now be commissioned by the CCG, as described below.

4 The procurement department is not planning to amend the old Wellbeing Service contract

The new Wellbeing Service 2017/22 contract documents went out to tender on 1.4.16. As SECTCo wishes to bid for a subcontract to provide MBCT courses and supporting meditations, I have registered an interest. I also spoke on the phone to Dr Helen Curr, manager of the present service, who told me that she expects the new contract specification to be the same as the old one. The contract value (£4.3 mpa) is only increased from the present £4 mpa by the expected price rises to 2022. I therefore suspect that the procurement department will just recycle the old Wellbeing Service contract documents. Prequalification Questionnaire applications for main contractors close next week (10.5.16) and the tender documents are due to be issued on 15.6.16, and the contract awarded in November.

The current contract started in July 2012, so naturally could not incorporate any of the changes required by the Health and Social Care Act 2012, nor any of the many excellent new strategies adopted by the HWB in the last 4 years. Not to amend the service is unacceptable, particularly as I have published scores of papers showing how the service should be redesigned. It only achieves a claimed recovery rate of 37%, whereas it should get at least 50%. The referral to treatment (RTT) access times are still nearly 6 months, which should average 6 weeks. It only provides 3 MBCT courses pa, but should provide hundreds, because the MBCT course is 100 times more cost effective than one to one CBT.

5 This vulnerable client group has the most to gain, and can yield the greatest rewards

This client group has probably been traumatized by neglect and abuse in childhood, as their parents may also have been. Left untreated, their health deteriorates, and their behavior becomes increasingly anti-social, including drug dealing. They tend to become frequent users of mental hospitals, secure units, and prisons, and before they die, (average expectation 47 years) wreak havoc in society, spreading addiction throughout their neighbourhood. They can annually each cost public services a six figure sum (£100,000) which may continues for decades, totaling £millions over their short lives. However, they also represent a huge opportunity, as society can save these huge costs if they can be turned round by an effective early intervention. This makes it well worth while making the effort to treat them with the latest evidence based interventions, for which this paper calls.

Healing and curing any condition requires identifying and eliminating the root cause of their problems, which for this client group is known in psychology as ***'avoidant attachment from their primary caregiver'***. This causes ***'affect disregulation'***, meaning that they cannot control their emotions, because their amygdala (smoke detector of the brain) is hyper vigilant, and shouts 'fire' when there is no fire.

Although attachment theory originated from psychiatrist Dr John Bowlby in UK in 1959, most of the research and clinical development of treatment pathways for it has been done in North America, financed by insurance companies. There is now a huge evidence base that this treatment approach can rewire their brains with more functional programming, so that they become normal law-abiding citizens. Some, (like Dave O'Brien, mentioned in the House of Lords report 'Mindful Nation UK' report

published 20.10.15) who did a MBCT course with Breathworks Manchester in 2011 and became a missionary is now giving keynote addresses teaching others how to kick their bad habits. (9.103)

We in SECTCo have based our intervention on this evidence, and estimate our recovery rate to be 75% with this client group, and save £7 for every £1 invested (9.76). We therefore recommend that it be trialed in the new Wellbeing Service, as described below. However, readers should be warned that this is a radically different treatment pathway to that which the Wellbeing Service currently provides and it requires a new cultural attitude from the staff which is a paradigm shift.

6 Principles that should underlie the specification for interventions under the new Wellbeing Service 2017/22 and Better Care contracts.

a) Non stigmatizing The new Wellbeing Service 2017/22 should be non stigmatizing, so that participants are not labelled with a diagnosis of mental illness which could affect their careers. This means changing the cultural attitudes and ***rebranding*** the nomenclature, as described below.

b) The ***bio psycho social*** model belief system of mental disorders caused by ***affect disregulation*** should be adopted, in place of the old medical model belief system of ***chemical imbalances in the brain***, as this has been disproved by neuroscience. (Robert Whitaker 2010, and 9.105)

c) The interventions should be called ***'education' or 'training'***, rather than 'treatment'. The participants in these interventions should be called ***'participants'*** rather than ***'patients' or 'service users'***.

d) The venues should preferably be educational establishments, and called '***Community Care Centres'*** open 7 days per week, rather than surgeries or clinics.

e) The facilitators should be called ***'facilitators', or 'teachers'***, rather than ***'therapists', 'clinicians', or 'counsellors'***.

f) Facilitators should treat their participants with what Karl Rogers called: '***unconditional positive regard' (unconditional love).***

g) The active ingredient in every intervention that facilitators should teach participants by example is ***meditation***, (being present and centred at all times) to heal and cure dysfunctional thought patterns. This can only be done by going beyond the mind, in meditation. All participants should be taught to become centred in their bodies, in the present moment, rather than miles away in their minds in the past or the future.

h) The core meditation teaching is ***mindfulness***, (being present without judgement by watching the breath) as in the NICE recommended Mindfulness Based Cognitive Therapy (MBCT) 8 week course, (see SECTCo's course book, 9.91) which teaches emotional intelligence, and self regulation.

i) The MBCT course is usually too advanced for this client group of 'avoidant attached', who should be prepared for it through being offered ***music and movement meditations*** to get into a more

relaxed state of body mind, and ***family constellation*** groups to heal inherited trauma from their ancestors.

j) Access should be through ***self referral or direct GP referral without assessment*** as with other ***primary care*** services, (such as A&E) This eliminates the delay of independent assessment, and cultivates the skill of self-assessment and self-responsibility in participants, which is necessary in healing and curing their condition.

k) Referral to treatment (RTT) times should be a few days, or a maximum of a week.

l) A ***menu*** of meditative interventions should be provided ***daily***, from which participants can pick and choose at will, without any sanction, from a 7 days per week daily ***programme,*** such as the following.

8-9am dynamic meditation (music and movement to a CD to prepare participants)

9.30-12am MBCT course, with refreshment break in the middle, to help participants to self regulate their emotions (affect) when triggered.

12-1pm kundalini meditation (music and movement to a CD to help participants to embody what they have learned)

2-5pm Family constellation group to heal inherited trauma from their ancestors.

6-7pm kundalini meditation, as above

7-9.30pm MBCT course, as above.

m) All interventions should be ***group*** sessions, for maximum cost effectiveness. One facilitator plus one assistant facilitator can teach up to 15 participants at a time, and participants acquire peer support from the others in their group. This can make MBCT courses 100 times more cost effective than 1 to 1 CBT. Participants who want or need one to one talking therapy should apply to their GP to refer them to existing ***secondary*** care mental health services.

n) The venues should be called ***'Community Care Centres'*** (as required by the Better Care Fund legislation 2013) which should be open 24/7 as ***'mental A&E's'***. A resident caretaker should be available at night for crisis care management, with emergency sleeping accommodation for those in need for, say, battered women, rather than sleeping rough. This will relieve pressure on GP surgeries and A&E departments, and if provided sufficiently (ideally one in every GP cluster) thereby solving the crisis in primary care.

o) Most people do not want to be dependent on ***drugs (prescription or recreational)*** for the rest of their lives, so the service should help participants to detoxify themselves from whatever drugs they may be on. The body can provide its own drugs through meditation, so the interventions provide methods of getting into altered states of consciousness without the use of any drugs. By

providing a programme of such interventions daily, we encourage participants to replace drugs with meditations, under a slogan of ***'medication to meditation.'***

p) MBCT courses should be re-branded MBSR (Mindfulness Based Stress Reduction), and their facilitators should not need to be clinically qualified to teach participants.

Mindfulness courses have become big business, with Google flying a team of facilitators round the world to teach hundreds of business people a 2 day course in emotional intelligence and affect regulation. These mindfulness courses started in the USA, where the Mindfulness Based Stress Reduction (MBSR) 8 week course was first provided in mainstream health care in 1979, whose facilitators do not need to be clinically qualified. The MBCT course was adapted from it when Dr Mark Williams introduced it to the NHS in Bangor in 1995. It got NICE recommendation for depression in 2004, but facilitators need to be clinically qualified if teaching patients (9.94). This unnecessarily restricts the number of facilitators available to teach mindfulness to this client group. The differences between MBCT and MBSR are described in the statement in appendix 2.

q) An 'intervention' should be 10 weekly sessions of one or more of the above meditations. The objective of these interventions is to heal and cure the participant, by rewiring his/her brain to behave more functionally. This requires going beyond the mind in meditation to allow a new healing attitude to emerge. It needs to be kept in mind for at least 40 days (6 weeks) so that the brain hardwires accordingly to effect a permanent cure.

r) How many sessions signifies a 'completed' intervention? The participant should have attended at least 5 sessions (half the total of 10). This is more than the present Wellbeing Service, where 'completed' interventions may be designated with only 2 attendances.

s) Friends and family test. At the end of every intervention, participants should complete a questionnaire asking whether the course was very satisfactory, satisfactory or unsatisfactory, and whether they would recommend it to their friends and family.

t) Payment of facilitators and administrative staff. To incentivise staff to run good courses, payment will be only be given to staff in proportion to numbers of participants who ***complete*** courses (by attending at least half of the sessions) and sign ***satisfactory*** feedback questionnaires.

u) The intended recovery rate aimed for should be 75%. This is double the present claimed recovery rate of 37%, which is well below the 50% required by the Department of Health.

v) The new service should involve, coordinate and pay for services which are now provided by the Community and Voluntary Sector, and charities such as St Mungo's, Groundswell, Just Life, Shelter, the Salvation Army, Mothers Uncovered.

7 Conclusion. Vision for Community Care Centres as mental health A&Es for all adults and children who need it.

This paper primarily seeks the redesign of the specification in the tender documents for the new Wellbeing Service contract 2017/22, whose annual contract value is £4.3 mpa, sufficient to pay 150 full time equivalent staff. However, it begs the following related bigger questions:

a) **Better Care Plan**. This was initiated 3 years ago by the government to provide better care for the most vulnerable (and expensive) citizens, personified as Rachel (65, depressed in sheltered accommodation) and Dave (40 alcoholic and homeless) A budget of £20 mpa was allocated to the city last year, and a further £20 mpa this year, none of which has been spent in treating either Rachel of Dave to date. An excellent 30 page update report was presented to the last HWB meeting on 19.4.16, which was noted, but it contained not a word about any ***plans*** showing how those good intentions can be translated into treatment for Rachel and Dave (as called for in this, and previous papers of mine). I hope that the councilors on the HWB will refer this report back to Ramona Booth, and asked her to consider this budget can be used to treat Rachel and Dave, perhaps by augmenting the £4.3 mpa for the Wellbeing Service.

b) At the meeting I circulated a pink paper showing how the HWB is responsible for the integration of the budgets of health (£370 mpa) and social care (£187 mpa) totaling ***£552mpa*** which is ***half*** the Council's total budget of £1.1 bnpa. I was pleased to hear that the chairman knows this, as he said several times: 'we are responsible for health and social care'. The Community Care Centres for which I call should be equally available to ***social care*** service users, as well as those ***adults*** and ***children*** referred for their ***health*** by their GP or A&E departments. This means that the Adult Social Care department (headed by Denise De Sousa) and the Childrens department (headed by Pinkaja Ghoshal) should also be involved in the redesign of the Wellbeing service contract, as in my recommendation above..

c) The present priority objective of the HWB should be solving the present crisis in primary care. As I have written before, the way forward is to create a Community Care Centre as a mental health A&E department, open 24/7/365, in every one of the 6 GP clusters. I acknowledge that this is a radical new care pathway which should first be trialed in one venue for say a year, before rolling it out in every cluster. I own the freehold of 86, Church Rd Hove BN3 2EB, which I offer for the purpose. The building is on 5 floors, and contains 5 other group rooms, and 4 individual treatment rooms, which could be used as offices for administration. Other possible venues are the Synergy Centre, at 78, West St, Brighton, and St Leonards Church, Aldrington, for which the Church commissioners are looking for new uses. We in SECTCo are ready and willing to work with all others who want a better mental health service in the city.

Appendix 1 What is 'avoidant attachment', and how can it be successfully treated?

'Avoidant attachment' is a technical term from clinical psychology, which typically characterizes this client group of those who are at high risk of homelessness because of their inability to relate to others well enough to keep a relationship, a job, a home, etc. They are usually the offspring of avoidant attached parents. Attachment theory was introduced by John Bowlby in England 1959, but has mostly been developed in North America, where research and clinical funding has been available from insurance companies. Over the past few years I have heard many visiting speakers who have

had many decades of providing successful interventions for this client group, including Dr Dan Siegal, (Mindsight Institute) Bessel van de Kolk (Trauma Center, Boston MA) and Lisa Ferenze. On 29-30.4.16 I attended a 2 day conference by Prof Robert Muller, PhD, clinical psychology at York University, Toronto, Canada. His book: '***Trauma and the avoidant client – attachment based strategies for healing'*** 2010, sets out the treatment pathway. The following is copied from the dust cover:

'Avoidant clients – those who avoid attachment, closeness, and painful feelings, and have a tendency to withdraw from therapy, or not fully disclose their painful past experiences – are the most difficult clients to treat. How can clinicians draw out and engage individuals who aren't so sure they want to be helped, and cannot admit their own vulnerabilities? How do clients who have suffered painful attachment experiences learn to trust their therapist, and talk honestly about their hidden pain? Labeling this clinical population 'treatment resistant' may seem like the easiest answer, but there are ways to offer them help. Drawing on a wealth of clinical experience, attachment based theory and research, as well as numerous case examples, Muller offers practical guidance, specific intervention strategies, and hope for transforming the lives of avoidant clients.

Through the lens of attachment theory, Muller explains the defensive and interpersonal patterns seen among avoidant individuals, laying out the nuts and bolts of effective treatments. He introduces focused intervention strategies that are necessary in the very early phases of therapy to identify points of entry without compromising the therapeutic relationship. Readers are taught how to help avoidant clients connect with, and commit to, the treatment process and how to facilitate mourning to help clients face the loss associated with trauma.

Muller offers candid (and personal) advice on dealing with counter transference, exploring the problematic ways in which therapists may act on feelings that get provoked in the course of therapy with avoidant clients. Detailed case examples and vignettes highlight the steps for building a strong clinician/client relationship, but also serve as a warning for how easily avoidant clients can disengage with the therapeutic process. Also covered is the issue of early termination and what to do to keep clients on track and engaged throughout treatment.

Trauma therapy is hard enough as it is, but working with help-rejecting traumatized individuals is that much more challenging. With an arsenal of practical tips and practice protocols, this book provides clinicians with a road map, offering hope for effective treatment. *Trauma and the avoidant client* will enhance the skills of all mental health practitioners and trauma workers and will serve as a valuable, useful resource to facilitate change and progress in psychotherapy.'

Appendix 2 Differences between MBCT and MBSR taken from University of Massachusetts, www.umassmed.edu/cfn on 30.3.16

'MBCT is an adaptation of MBSR (Mindfulness-Based Stress Reduction) that uses the same basic format and structure – an 8-week class with an all-day retreat; a class structure that includes psychoeducation, formal meditation and movement practices, and teacher-led discussion and inquiry; and daily home practices and exercises.

As in MBSR, participants learn to recognize habitual, unhelpful, reactions to difficulty and learn instead to bring an interested, accepting and non-judgmental attitude to all experience, including difficult sensations, emotions, thoughts and behavior. MBCT replaces some of the content of MBSR with a focus on specific patterns of negative thinking that people with depression are vulnerable to, but which we all experience from time to time.

MBCT was developed to treat depression and research has shown it to be effective in preventing relapse in people who have recovered from depression. **The key difference in MBCT is an explicit focus on turning toward low mood and negative thoughts early in the program so that participants gain experience with recognizing these symptoms and confidence in their ability to respond skillfully.**

MBCT was developed to prevent future episodes of depression in people with a history of recurrent depression. It is based on the observation that recurrence in people who have recovered from a depressive episode is more likely when patterns of negative thinking are triggered by low moods encountered in the course of everyday life. Negative thinking leads to lower mood and this pattern escalates to bring on a relapse of depression.

Techniques from Cognitive Behavior Therapy are incorporated into the program to promote greater awareness of these patterns and mindfulness practices are used to disengage from them. The focus is on changing one's relationship to unwanted thoughts, feelings and body sensations so that participants no longer try to avoid them or react to them automatically, but rather respond to them in an intentional and skillful manner.'

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