



PSYCHOTHERAPY SERVICES A STRATEGY FOR IRELAND

Irish College of Psychiatrists

Submission to the Expert Group on Mental Health Policy

The Irish College of Psychiatrists
121 St Stephen's Green
Dublin 2
Tel: 01-4022346
Fax: 01-4022344
Email: icpsych@eircom.net

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Executive Summary

Modern mental health services espouse a balanced **bio-psychosocial** approach in the treatment and management of the mentally ill, the emotionally disordered individual and the dysfunctional family and society. However, unlike the well developed pharmacological therapies, psychological therapies are poorly developed, uncoordinated and relatively inaccessible.

A recent report on the state of in-patient psychiatric wards depicted an un-therapeutic environment in which staff felt beleaguered and patients dissatisfied and specifically called for more psychological treatments in inpatient setting. (Muijen M, 1999)

In this document **psychotherapy** and **psychological therapies** are synonymous and used interchangeably. Psychotherapy is recognised as “an interpersonal process designed to modify feelings, cognitions, attitudes and behaviour which have proved troublesome to the person (or society) seeking help from a trained professional” (Strupp HH, 1978). It is often termed a ‘talking treatment’.

In the community, primary care and community mental health team professionals will provide most psychological therapies, with support, training and supervision from psychological therapy specialists. A specialist (tertiary level) psychotherapy service is likely to require some centralisation, to ensure that standards of training, supervision, audit and evaluation are maintained.

The full range of psychotherapies should be provided and / or accessible at all levels of Primary and Mental Health Care Services.

Psychotherapy can improve therapeutic outcomes and treatment adherence. It can reduce the length of inpatient stay and readmission rates. It can also reduce the repeated demands of challenging patients on other parts of the health service for example, A&E, General practice and the medical specialities.

Psychotherapy training improves staff confidence and morale in dealing with difficult cases.

A comprehensive and accessible range of psychotherapy services cannot be provided without an increase in consultant psychotherapists, clinical psychologists and adult psychotherapists.

Mandatory basic specialist training in psychiatry cannot be delivered without the appointment of dedicated Consultant Psychotherapists or Consultant Psychiatrists with a special interest in Psychotherapy. It is envisaged that by late 2004 those doctors who are sitting basic specialist examinations in Psychiatry (MRCPPsych candidates) will not be permitted to receive their Higher Qualifications until they fulfil Psychotherapy training requirements. The Irish Training Schemes in psychiatry are at risk of losing accreditation by the Royal College of Psychiatrists. This represents a serious manpower issue for psychiatry.

The **academic infrastructure** (in the form of accredited university masters and certificate courses) needs to be developed resourced and supported so that it can provide the theoretical training needed for psychotherapies.

The **National Health Care Strategy 2001** mentions counselling. However, there is no reference to psychotherapy or any differentiation between the two methods of intervention. We envisage this document will help clarify the differing types of psychotherapeutic intervention from counselling to psychotherapy, assisting the optimum development of Psychological Services in Ireland

Introduction

- 1.1 Throughout the document, Psychological Therapy Services (PTS) and psychotherapy are synonyms and these terms are used interchangeably. **Counselling** is a type of Psychotherapy of the supportive and educative type.
- 1.2 Biological or pharmacological treatments have achieved a sophisticated and highly organised state of development in Ireland over the last fifty years. The same could not be said for psychological therapy services. These are under-developed and poorly resourced in Ireland, unlike Europe, the US and United Kingdom. The result is that psychiatric services lack the effectiveness, efficiency and balance that a comprehensive holistic approach brings.
- 1.3 The demand for the added value that superior psychological therapy skills can provide is emerging from many other sources;
 - a) The **Annual Report of the Inspector of Mental Hospitals December 2002** refers to “The continuing shortage, in some cases, complete absence of psychologists, social workers and occupational therapists is an intolerable restriction on the nature of the service delivered and makes multidisciplinary working impossible.’
 - b) **The National Health Care Strategy (Department of Health, 2001)** identifies key targets for development in mental health pending the report of the Mental Health Expert Group. They include:
 - Services for the Elderly
 - Child and Adolescent services
 - Specialist services for eating disorders
 - Suicide preventionKey to developing and improving our interventions in these areas should involve the development and resourcing of Psychotherapy services in an integrated fashion.
- 1.4 The following reports all contain in their recommendations direct implications for

increased strategic planning of Irish Psychological Therapy Services as outlined in this report.

- **Report of the expert group on the structures and organisation of Prison Health Services September 2001:** This report states that developments are needed in relation to psychiatric services. This should include enhanced Psychological Services.
- **National Drugs Strategy 2001:** This report states that immediate access should be provided by Health Boards to drug misusers in the form of professional assessment and psychological interventions not later than one month after assessment.
- **Homelessness - An Integrated Strategy 2001:** This report states that preventative strategies targeting high risk groups are an essential requirement for those leaving custodial or health related care. This should include in our view access to a broad range of Psychological Interventions.

1.5 **The National Counselling Service** is a new service established in September 2000. While initially established to provide counselling for those abused in Institutional care in Ireland, this service has since its inception provided counselling for all adults presenting with abuse in childhood. In their first report (NCS, 2002) a number of recommendations are made. These include:

- providing an accessible and timely service
- providing out of hours services where necessary
- providing choice of service
- affording people the opportunity to attend group therapy
- providing opportunities for future research

1.6 **“Biological priority; psychological superiority”** is an aphorism or ideal for mature mental health services. Although expertise and urgency are prioritised in the physical and pharmacological treatment of mental disorder, mental health professionals are required to develop superior skills and expertise in the psychological therapies compared to their colleagues in other health care disciplines.

1.7 There is a growing evidence base underpinning the use of psychotherapy in the management of a wide variety of conditions including psychoses, eating disorders and severe personality disorders (Roth and Fonaghy, 1996).

For some disorders, psychological treatments are the treatment of choice for example; whilst in others they are an adjunct to medication.

1.8 Much of the recent literature outlining a modern psychiatry and psychotherapy service emphasises the effectiveness of a hub and spoke model, involving experts providing treatment and disseminating knowledge by training, supervision and consultation with others throughout the Mental Health System.

- a) This approach complements the need to widen the availability of psychotherapy and to co-ordinate services into a tiered system delivered by appropriately trained professionals.
- b) This model provides for prevention and early detection methods at one end of the spectrum and at the other end, specialist services to provide treatment of complex patients, training, research and evaluation.
- c) There is increasing evidence that mental health teams with good psychological therapy skills suffer less from stress and poor morale and have enhanced treatment outcomes
- d) At a societal level the lack of development of sophisticated psychological therapy services makes an important statement about the cultural evolution of that society. Abstract concepts such as conflict resolution, diversity, tolerance, compromise and ambivalence have their origins in the corpus of psychoanalytic, group analytic and systemic therapy. Although experts in these disciplines from abroad are of considerable benefit, it is time for this society to show that it is ready to invest and provide resources for indigenous experts to champion and develop local skills.

Background

2.1 Psychological therapies make up one of the two main classes of treatment for mental health problems (the other being physical treatments). Over the last 50 years there have been major advances in psychotherapeutic treatments and today various forms of psychological therapies are widely practised within the Health Service, in the voluntary sector and in private practice.

Public demand for psychologically informed treatments has also risen – partly due to increasing public dissatisfaction with medication only as a treatment for emotional disorders and partly due to the general trend of people becoming more open to the idea of working through their symptoms with a suitably trained professional in a therapeutic environment. There is also demand for the therapies from those front line professionals responsible for managing services.

Demand for all forms of psychotherapy outstrips supply.

Today a wide range of mental health problems, including those with severe and enduring mental illness can be appropriately treated by one or more of the many forms of psychological treatments. In general, treatments may be offered for relatively short periods or be open-ended. They may be offered to individuals, families or to groups. With some adaptations they can be provided for children and adolescents. The format of treatment can also differ in terms of intensity (e.g. five times a week or once a week or once a month), the setting (in-patient or community based) and the extent to which non-psychosocial treatments (such as medication) are offered adjunctively.

2.2 Throughout this document **Psychotherapy** and **Psychological Therapies** are synonyms and used interchangeably. In **counselling** there is generally less emphasis on theory than on practice, and self awareness of a general sort is emphasised more than personal therapy. Strupp's well known definition describes psychotherapy as "an interpersonal process designed to modify feelings, cognitions, attitudes and behaviour which have proved troublesome to the person seeking help from a trained professional." A useful way to categorise psychotherapy according to theoretical basis and clinical technique is as follows:

- **Transference Therapies** namely psychoanalysis and psychoanalytic / psychodynamic psychotherapy. These are longer-term processes (can be a year or more) and allow unconscious conflicts in the patient the opportunity to be re-enacted and interpreted in the relationship with the therapist.
- **Cognitive and Behavioural Therapies** are structured treatment approaches derived from cognitive and behavioural theories. Cognitive techniques (such as challenging negative automatic thoughts) and behavioural techniques (such as activity scheduling and behavioural experiments) are used with the main aim of relieving symptoms by changing maladaptive thoughts and beliefs.
- **Group and Systemic Therapies** focus on the relational context and address patterns of interaction and meaning and aim to facilitate personal and interpersonal resources within a system as a whole.

Each approach or category has differences in the way in which the relationship between counsellor/therapist and client/patient is conducted. Counselling, unlike the psychotherapies, tends to be conducted **without** any exploration of the relationship between the patient and the therapist. In psychotherapy the therapeutic relationship is often a central focus and a route to the exploration of past and present relationships and personal difficulties in the patient.

2.3 In the training of transference and group psychotherapists, extensive theoretical learning and **formal personal therapy** are essential requirements. These trainings are demanding and time consuming and need to be nurtured and supported within the professions to realise their maximum benefits to the overall quality of health care provision.

2.4 **Roth and Fonaghy (1996)** differentiate therapies primarily in terms of the following major classes:

- Psychodynamic Psychotherapy
- Behavioural and Cognitive Behavioural
- Interpersonal Therapy
- Strategic or Systematic Psychotherapy
- Supportive and Experiential Psychotherapy
- Group Psychotherapy

2.5 Within a Mental Health Service there are three types of Psychotherapy expertise and delivery based on Cawleys (1977) developmental framework:-

Type A - Psychological treatment as an integral component of Mental Health Care. This refers to the psychotherapeutic skills required by all mental health and social care professionals.

Type B - Eclectic Psychological Therapy and Counselling. This refers to the Psychotherapeutic skills needed by a broadly trained mental health/social care professional (nurse, occupational therapist, social worker, clinical psychologist or psychiatrist) with a special interest in Psychotherapy who treats patients but does not act in a senior consultative or training capacity.

Type C - Formal Psychotherapies. This refers to the specialist therapeutic skills required by a professional working for the majority of his/her time in the speciality i.e. Consultant Psychotherapist level with a significant responsibility for teaching and supervising others.

Economics

3.1 The cost of psychotherapy involves more than determining the price of treatment. The cost of psychological ill health to the individual, his/her friends and family and society is immeasurable. Mental ill health produces other social costs in terms of A&E department visits, GP appointments, medication, medical and psychiatric inpatient hospital admissions.

The cost of psychotherapy, therefore, must not be calculated solely by the price of clinical sessions but by the impact of the treatment on reducing the human and social costs and the demand on other facilities within the health care system, for example, General Practice and the medical specialities.

3.2 Several studies provide evidence of the savings produced by psychotherapy. One study of patients with severe personality disorder suggested that inpatient psychoanalytic psychotherapy produced savings of £7,423 per patient in terms of reduced usage of health service resources (Chisea M, Lacoconi E & Morris M, 1996). An Irish study conducted in the Cluain Mhuire service under the auspices of the Order of St. John of God noted that a significant saving was achieved (Blennerhassett R, 2003).

3.3 (Gabbard, 1997) reviewed the impact of psychotherapy on costs of care, from published studies between 1984-94 and concluded that psychotherapy led to a reduction in costs for most severe psychiatric conditions, particularly in relation to reduced inpatient costs and employment related savings. Five randomly assigned trials indicated that family therapy produced statistically significant cost savings in the treatment of schizophrenia.

3.4 Three recent trials at the Institute of Psychiatry in London have considered how the addition of psychotherapy to usual treatments can effect the use of health and community-care services (Chisholm D,1998). Those patients who received psychotherapy used hospital and community services less than the control groups. Follow up studies show that the intervention groups' comparative lower use of other health and community services persisted over time. These results indicate that psychotherapy is cost effective in the treatment of mental illness.

Strategic Context

4.1 In the setting up of a Psychotherapy Service according to the British Psychological Society and the Royal College of Psychiatrists (1995) the main recommendations were:

- a) The Service should provide a comprehensive, co-ordinated and integrated assessment, treatment and consultation service in all the major psychological therapies using all existing resources to full effect.
- b) The Service should ensure that a comprehensive range of psychological therapies is available to the population in need, wherever possible in accessible locations. In the community, primary care and community mental health practitioners will provide most psychological therapies with support, teaching and supervision from psychological therapy specialists. A specialist psychotherapy service is likely to require some centralisation.
- c) Ideally there should be at least one specialist in each of the major psychological therapies provided e.g. transference therapies, cognitive and behavioural therapies and systemic and group therapies.

4.2 Roth and Fonaghy (1996) in “**What Works for Whom?**” describes the evidence based context for developing comprehensive treatment services for specific disorders. The emphasis is on providing a wide range of treatments including:

- Psychodynamic (Psychoanalytic) Psychotherapy
- Behavioural and Cognitive Psychotherapy
- Interpersonal Psychotherapy
- Strategic or Systemic Psychotherapies (Family)
- Supportive and Experiential Psychotherapies
- Group Therapies

Roth and Fonaghy’s philosophy is that psychological treatments should be readily available to patients who would benefit from them, rather than in an ad-hoc and non-evidence based way.

4.3 In Ireland to date, there has been little strategic planning of the psychotherapy services. Services including the National Counselling Service have been resourced in response to crisis situations instead of part of a long term evidence based strategy for development of psychotherapeutic services. In **Planning for the Future** (1984) the importance of multidisciplinary team working was highlighted as part of an effective Mental Health Service. Efficacious multidisciplinary team working requires a co-ordinated resourced strategy for development of Psychotherapy services. In **The Future of Psychiatry in Ireland, January 1998** (a document prepared for Comhairle na nOspideal by the Irish Division of the Royal College of Psychiatrists) there are proposals for all specialties within psychiatry including the recommendation of proposals for strategic planning of psychotherapy services.

4.4 The Department of Health in England (February 2001) published “**Evidence Based Clinical Practice Guidelines on Treatment Choice in Psychological Therapies and Counselling**”. The guidelines include:

- Effectiveness of all types of therapy depends on the patient and the therapist forming a good working relationship.
- The patient’s age, sex, social class or ethnic group should not determine access to therapy.
- In considering psychological therapies, more severe or complex mental health problems should receive secondary, specialist assessment.
- Therapies of fewer than eight sessions are unlikely to be optimally effective for most moderate to severe mental health problems. Often 16 sessions are required for symptomatic relief, and more for lasting change.
- Counselling is not recommended as the main intervention for severe and complex mental health problems or personality disorders.
- A co-existing personality disorder may make treatment of most disorders more difficult and possibly less effective; indications of personality disorder include forensic history, severe relationship difficulties, and recurrent complex problems.
- Patient preference should inform treatment choice, particularly where the research evidence does not indicate a clear choice of therapy.
- The skill and experience of the therapist should also be taken into account. More complex problems, and those where patients are poorly motivated, require the more skilful therapist.

4.5 All these major documents which have been published over the past six years exhibit a continuity in approach to the development and delivery of psychological treatment services.

Assessment of Need

- 5.1 **The Health Care Strategy 2001** identified four priority areas for the development of Mental Health Services; services for the elderly, child and adolescent services, eating disorder services and suicide prevention. Improving quality of care in all these areas requires increased resources in Psychotherapy.
- 5.2 The **Annual Report of the Inspector of Mental Hospitals December 2002** has referred to the shortage of specialists with Psychotherapeutic skills as essential participants in the multidisciplinary team nationally.
- 5.3 **The Stark Facts: The Need for a National Health Strategy** (V. O' Keane, A. Jeffers, E. Moloney, S. Barry. March 2003) The results of this survey indicate that clinical resources are overstretched and the lack of a national mental health strategy has led to limited availability of specialist services. With regard to non medical staffing, the survey of psychiatric services found that psychology services were not available for 23% of the services.
- 5.4 The **National Counselling Service of Ireland's Annual Report 2002** clearly outlines the need for Psychotherapy services. In their first report they state 'Between September 2000 and September 2001 almost 2000 adults who experienced abuse in childhood sought counselling from the National Counselling Service. Of these almost 700 (33%) identified that they were abused as children in Institutional settings'. In Ireland to date we have no accurate estimate of need in other settings.
- 5.5 **Amnesty International Report of Mental Health:** In Chapter 3, Amnesty International report that under *Planning for the Future* (1984), Ireland is obliged to equitably secure the provision of a sufficient number of hospitals, clinics and other health facilities and the promotion and support of the establishment of institutions providing counselling and mental health services. In Chapter 5, they recommend that a comprehensive range of therapies, in addition to pharmacotherapy, is available to everyone with mental illness and cites an over reliance on medication.
- 5.6 **Primary Care Strategy:** This document did not refer specifically to strategic development of Irish Psychotherapy services. We hope our document will be of

assistance in initiating the development of a co-ordinated strategy at primary , secondary and tertiary levels of care.

- 5.7 Psychological therapy interventions in several major psychiatric diagnoses have been shown to cost no more than standard care (owing to reduced offset costs), while producing consistently better outcomes (Gabbard, 1997)
- 5.8 The need for psychological therapies is emphasised by both professionals and consumers:
- a) Psychiatrists feel they lack the time and adequate setting in which to practice their therapeutic skills (Deahl & Turner, 1998) with a consequent lowering of morale and difficulty in recruitment.
 - b) Users of psychiatric services consistently call for more 'talking treatments' (Wood D, 1993) and complain that psychiatrists rely excessively on physical methods of treatment.
 - c) A recent report on the state of in-patient psychiatric wards depicted an un-therapeutic environment in which staff felt beleaguered and patients dissatisfied (Muijen, 1999) and specifically called for more psychological treatments in inpatient settings.
 - d) Users and providers experience an unmet need for psychological therapies, and this is a crisis that affects mental health professionals. If nothing is done to tackle this problem there is a risk that an increasingly limited biological model will dominate policy-makers' view of psychiatry, pushing psychiatrists further towards a role of social control rather of therapeutic intervention.

Current Provision

6.1 Access to psychological therapy services in Ireland is limited. This is underlined by the number of Psychologists registered with the Psychological Society of Ireland. The Annual Report on Irish Mental Health Services (2001) has highlighted this unmet need. In addition **The Stark Facts: The Need for a National Health Strategy** (V. O'Keane, A. Jeffers, E. Moloney, S. Barry. March 2003) indicates that clinical resources are overstretched and the lack of a national mental health strategy has led to limited availability of specialist services. With regard to non medical staffing the survey of psychiatric services found that psychology services were not available for 23% of the services.

This results in services being unevenly distributed, uncoordinated and inadequately resourced to meet present demands. Patients do not have ready access to these services and there are unacceptably long waiting lists for assessment and treatment in most services.

6.2 Clinical psychology services provide some of the range of psychological treatments often at both primary and secondary care levels. As a result invariably they have long waiting lists for assessment and treatment.

6.3 In mental health services, Community Psychiatric Nurses, Social Workers and Occupational Therapists may have training in counselling or psychotherapy and could provide this service to a small number of patients on their caseload. However, these overloaded professionals have great difficulty in setting aside time to provide these treatments in the face of constant demands on them to provide acute care and crisis management.

6.4 There are no Consultant Psychotherapists in Ireland. According to the recommendations of The Royal College of Psychiatrists (1999) a minimum staffing level should be one WTE Consultant Psychotherapist per 200,000 of the population. Given these figures Ireland should have a minimum of 20 WTE Consultant Psychotherapists, providing leadership of services, training and supervision.

- 6.5 A number of mental health professionals in Ireland currently have training in a variety of Psychotherapies. However the current lack of organisation of services is highly inefficient and does not permit these highly trained professionals to provide expert treatment to the patient population. This waste of a valuable resource is regrettable.
- 6.6 Within the voluntary sector, services in psychological therapy and counselling exist but access to these services, as with other services suffer from long waiting lists and limited resources. There is much to be gained from a partnership with well organised, statutory psychological services.

General Principles of Service Provision

7.1 In the documents published on the provision of psychological therapy services and training there are some agreed key elements:

- The **development** of psychological treatment services should build on existing resources wherever possible, rather than disrupting, dismantling or replacing established services in order to create an "ideal" model.
- **Essential clinical components** of a service are assessment, treatment and a consultative service to other treatment providers and potential referring agents.
- A service should be **comprehensive** (from the 3 categories of Psychotherapy). It should offer a range of treatments and provision should be made for the introduction of additional models of treatment.
- The clinical service should be **integrated** across all levels of health care and provide treatment at different levels of expertise. (McCarthy and Dodd, 2001)
- There should be **collaboration** between the various providers to ensure clear referral channels, comprehensive assessment and flexibility in treatment approach. Partnership with the voluntary sector is an important aspect of this collaboration.
- Services should be **efficient and effective**. The services should provide treatments, that meet assessed need and the treatments provided should be clinically effective.
- Services should be **accessible** to the whole community.
- All practitioners of psychological therapies should be **proficient** in the treatments they deliver. This has implications for training and three levels of training within each model of therapy are recommended.
- The preferred model arising out of the recent literature is a "**consortium of psychological therapy providers**". This means that a number of professional groupings with training in different types of the psychological therapies and at different levels of expertise would link together to offer a comprehensive psychological assessment and treatment service at different levels within the service.

Models for Service Provision in Ireland

8.1 A number of dimensions can be identified when considering the need for psychological therapy services. A comprehensive range of psychological therapies should be provided at primary, secondary and tertiary levels. The range of therapies should include Psychoanalytic/Psychodynamic, Cognitive Behavioural, Group Analytic and Systemic Family Therapy.

1. Location and Range of Services

Tier One: *Primary* - general practice setting;

Tier Two: *Secondary* - community mental health team;

Tier Three: *Tertiary* - specialised district or supra-district services;

- out-patient, day patient, in-patient services
- generic / specialist services
- services for specific populations (e.g. personality disordered patients or those who have been abused or traumatised) compared with general services

2. Model of Therapy

Essentially transference, cognitive and behavioural and groups and systems therapies.

3. Levels of Training and Clinical Experience

The degree of specialisation required of practitioners at different tiers of the Psychological Therapy Services.

4. Research

Research will need to be undertaken to evaluate outcomes.

8.2 This is an integrated model providing a range of effective psychological treatments appropriate to a range of disorders. In this tiered model of care as stated there are three tiers.

Tier 1 – Primary Care Level: Self-help materials and self-help groups. Counselling and time limited treatment programmes. These interventions are appropriate for common transient or mild to moderate mental health problems.

Tier 2 – Secondary Care Level (Community Mental Health Teams): Specific evidence-based psychological treatments. Short- to medium-term interventions e.g. cognitive and behavioural, psychodynamic and family therapies. Appropriate for moderate mental health problems e.g. moderate depressive and anxiety disorders.

Tier 3 – Complex Mental Health Problems: This refers to Specialist Consultant Psychiatrist Psychotherapist led services. The disorders are usually long-term and recurrent. Often require long term care from a range of agencies. If not treatable, advice on management and support to primary care and secondary care is needed.

8.3 It is vital that the right treatment is provided for the right patient at the right time. Expert assessment in a consortium of psychological therapy services is an essential stage in patients being allocated to appropriate treatment. Currently patients with complex mental health problems often have multiple assessments from a range of services. This is inefficient and often frustrating for patients who are psychologically vulnerable. They may spend long periods of time on assessment and treatment waiting lists and receive little in the way of appropriate treatment.

8.4 **Pathways of Care** can be devised for each disorder with pathways from primary care through to specialist services. However, the delivery of these services requires:

1. The provision of adequate services at all levels.
2. Integration of services across all levels
3. Access to a range of effective psychological treatment interventions
4. Evaluation of the service
5. Appropriate training and supervision of staff

Needs of Specific Patient Diagnostic Groups

9.1 Determined efforts to widen the availability of psychotherapy to those on low incomes, males with personality disorders and the seriously mentally ill must be in the forefront of any modern Psychological Therapy Service. There has in the past been pressure to restrict mental health service psychiatric treatments, including psychological therapies, to the 'seriously mentally ill', a term which sometimes excludes chronic psycho-neurotic disorders, severe personality disorders, and other disabling psychiatric disorders.

9.2 Restricting psychiatric treatments to patients with psychotic illness would exclude treatment for both highly dysfunctional but readily treatable psycho-neurotic disorders (e.g. panic disorder, agoraphobia), and for patients with complex personality and behavioural problems who make heavy demands on both GPs and mental health services.

Where these restrictions have been introduced, they have not found favour with patients or their GPs.

9.3 Small therapeutic changes in patients with personality disorders may be critical in terms of improved life adjustment and expectancy, particularly for patients who make large and chaotic demands on primary care and mental health services. Effective treatment may require a prolonged psychotherapeutic input. Clinical evidence indicates that this is productive in terms of reduced behavioural disturbance and demand on services. Further research is required to establish a systematic evidence-base for psychological treatments of patients with personality disorders (Menzies ,1993).

Need for Co-ordination of Services

10.1 This will result in a range of psychological therapies being provided in a range of settings. Co-ordination is essential in order to ensure efficiency and accessibility of services and is required between practitioners of therapies in primary, secondary and tertiary level services.

There can be no single blueprint for co-ordination, but a working relationship between psychological therapists in the different settings is crucial. Co-ordination might involve:

- case allocation meetings
- a central referral system
- joint clinical services for specific patient populations (e.g. abuse survivors)
- a 'brokerage' system for assessment

10.2 Specialist Consultant Clinical Leadership championing psychotherapy training and services is needed to realise the full potential of a balanced bio-psychosocial approach, for patients, services and all professional disciplines. These **specialist consultant psychotherapists** will have the expertise to:

- Assess and treat complex cases where medication and psychological therapies are both often needed.
- Establish services for people with personality disorders, on an out-patient, Day Hospital or inpatient basis including the development of Therapeutic Communities.
- Share on-call responsibilities with colleagues.
- Co-ordinate and deliver training in psychotherapy for psychiatric trainees and other colleagues.

10.3 In summary, Consultant Psychotherapists support general adult mental health services by managing difficult cases and by providing support and supervision as appropriate both to colleagues and their teams.

In all these roles, like their general psychiatric colleagues, Consultant Psychiatrists in Psychotherapy work alongside other mental health professionals in multidisciplinary teams including clinical psychologists, nurse specialists in psychotherapy, adult non-medical psychotherapists and art therapists.

Models for Staff Training

- 11.1 To deliver a tiered psychological treatment model staff must be trained to appropriate levels.
- 11.2 Within Ireland a number of post-qualification training courses have developed over the past decade which provide training in a large range of treatment modalities ranging from the individual psychotherapies to group and family treatments. These courses are usually university based and the majority offers both theoretical and clinical training to Diploma or Masters level. Places on these courses are limited and demand usually exceeds supply.
- 11.3 These trainings are important in the Irish context for two reasons – first of all to build up a critical mass of people who can, with further experience, supervision and training become accredited specialists (for example with UKCP, BCP and Royal College Accreditation) and secondly to provide future trainers.

The current numbers of graduates from these courses cannot, however, meet the increasing demand for the psychological therapies within the Department of Health & Children. They are isolated and overwhelmed by demand and disadvantaged by the lack of an organised and integrated service.

- 11.4 Training, therefore, needs to develop towards a model that can produce a larger workforce providing treatment to meet the needs of client groups at different levels of the health service.
- 11.5 The Royal College of Psychiatrists has now deemed psychotherapy training as mandatory for junior doctors undertaking the final part of the Membership examination in Psychiatry (MRCPsych). These requirements are comprehensive and state that there should be approved training in theory and a number of treatment modalities. This programme of training will take 2½ - 3 years to complete by each trainee. From 2004, entrants will have to have completed this training to become eligible to apply for the MRCPsych Part II. If this training is not delivered in Ireland, it is likely that accreditation for the Psychiatry training schemes will be lost.
- 11.6 Implementation of this training will require expertise, man-power, co-ordination, time, training and finances.

Recommendations

- 12.1 A comprehensive range of psychological therapies should be provided at primary, secondary and tertiary levels. The range of therapies should include Psychoanalytic/Psychodynamic, Cognitive Behavioural, Group Analytic and Systemic Family Therapy.
- 12.2 Users should have equitable access to a range of comprehensive psychological services to meet their clinical needs.
- 12.3 Mental Health providers have a duty to provide patients with a full range of psychological therapies from the three main categories, namely transference, cognitive and behavioural and family/group therapies.
- 12.4 Mental Health providers have a duty to resource and actively support and promote staff training in the full range of psychotherapies.
- 12.5 Where individual professionals have acquired specialist expertise in the psychotherapies, providers and managers have a duty to ensure that this is brought to the benefit of the patient population.
- 12.6 As recommended by the Royal College of Psychiatrists there should be a minimum of 20 WTE Consultant Psychotherapists, to provide treatment and lead specialist services, training, research and supervision throughout the province. To initiate this process as recommended by the Hanly Report, an initial provision of three Consultant Psychiatrist Psychotherapists is essential.
- 12.7 There must be development of Senior Registrar training posts to support the proposed expansion in Consultant Psychotherapists.
- 12.8 Adequate training in the Psychotherapies must be provided to prevent the schemes for General Professional training in psychiatry from losing their accreditation by 2004. Unless sufficient specialists are appointed to lead, provide and co-ordinate training, Part II MRCPsych trainees will not be permitted to sit their professional membership exams if they do not fulfil the psychotherapy training requirements.

- 12.9 Within Ireland there should be a consortium of mental health professionals identified with the remit to organise, co-ordinate and implement clinical and professional training in the psychotherapies. Telecommunication should be encouraged to maximise dissemination of expertise.
- 12.10 Within teams there should be clearly identified members trained to national standards in the provision of the above therapies. Other team members should be encouraged and supported in training to certificate and diploma level in the psychotherapies.
- 12.11 The academic infrastructure in the form of the university training courses must be readily accessible to mental health professionals.
- 12.12 Experts in the psychotherapies should be readily available for consultation with other health professionals and organisations, where difficulties with team and organisational dynamics arise.

Appendix One – Definitions

Psychoanalytic therapies - A number of different therapies draw on psychoanalytic theories. Focal psychodynamic therapy identifies a central conflict arising from early experience that is being re-enacted in adult life producing mental health problems. It aims to resolve this through the vehicle of the relationship with the therapist giving new opportunities for emotional assimilation and insight. Psychoanalytic psychotherapy is a longer-term process (usually a year or more) of allowing unconscious conflicts opportunity to be re-enacted and interpreted in the relationship with the therapist.

Cognitive therapy - A structured treatment approach derived from cognitive theories. Cognitive techniques (such as challenging negative automatic thoughts) and behavioural techniques (such as activity scheduling and behavioural experiments) are used with the main aim of relieving symptoms by changing maladaptive thoughts and beliefs.

Cognitive behaviour therapy (CBT)- Refers to the pragmatic combination of concepts and techniques from cognitive and behaviour therapies , common in clinical practice.

Interpersonal therapy (IPT) - A structured, supportive therapy linking recent interpersonal events to mood or other problems, paying systematic attention to current personal relationships, life transitions, role conflicts and losses.

Systemic and family therapy (whether treating individuals, couples or families) focuses on the relational context, addresses patterns of interaction and meaning, and aims to facilitate personal and interpersonal resources within a system as a whole. Therapeutic work may include consultation to wider networks such as other professionals working with the individual or the family.

Supportive therapy - Refers to any psychotherapeutic approach that supports existing ways of coping with problems rather than challenges and attempts to change ways of thinking and responding.

Counselling - A type of Psychotherapy of the supportive and educative variety.

Appendix Two

This report has been produced by the Psychotherapy Executive Strategic Group which is a sub-committee of the Psychotherapy Section, Irish College of Psychiatrists.

Dr. Doreen O'Rourke (Chair)

Dr. Maeve Moran (Secretary)

Dr. Richard Blennerhassett

Dr. Philip Dodd

Dr. Anne Jackson

Dr. Aideen Moran

Dr. Evelyn McCabe

Dr. Anthony McCarthy

Dr. Siobhan Rooney

Dr. Pauline Twomey

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