Psychiatric Bulletin (1991), **15**, 174–179

The College

The future of psychotherapy services

Background

Psychotherapy became a separate medical specialty within psychiatry 15 years ago. It is time to review the development of the service and plan for the future, taking into account current health care trends.

Shortfall in medical staffing

Guidelines for psychotherapy staffing were published in 1975[1]. The 'long-term' goal was to achieve one whole-time equivalent (WTE) consultant for a population of 200,000. An interim target (by 1986) was to be 0.5 WTE per 200,000 people (a total of 125.5 WTE consultants in England and Wales, and 13 in Scotland).

Although some progress has been made (Table I), this is patchy and many districts continue to have no medical psychotherapy input. There are 114 consultants currently in post and 13 vacant established posts. Nearly half of them are part-time, principally in the Thames regions. There are many more consultants in the London area than elsewhere in the country (Table II).

It had been hoped that the shortfall might be compensated for by "special responsibility" and "special interest" posts[2]. It is recognised that the consultant psychotherapist cannot alone provide the whole range of services. He or she has a major responsibility to develop and co-ordinate the service by providing consultation and supervision for other members of staff. It is symptomatic of the lack of clear planning and monitoring that there are no formal returns for special interest and special responsibility consultant

TABLE I

Numbers of consultant psychotherapists in England and Wales

Year	*Source of information*	*Number of consultants*	*Number of vacant posts*	*Annual increase*
1987	DOH	84	?	?
1988 (Sept)	DOH	92	?	8
1989 (June)	RCPsych	106	13	14
1990 (March)	RCPsych	114	13	8

These figures exclude people holding more than one post, and exclude special responsibility consultants.

TABLE II

Numbers of consultant psychotherapists (England and Wales) 1990

Region	*DOH Sept 1988*	*RCPsych June 1989 (+vacancies)*	*RCPsych March 1990 (+vacancies)*
Northern	3	3	3
Yorkshire	3	3	3
Trent	6	8	7+2
East Anglia	2	2	2
North West Thames	10	17+6	19+4
North East Thames	26	26+2	27+2
South East Thames	10	11+3	11+3
South West Thames	10	15	15
Wessex	2	4+1	5
Oxford	3	8	9
South Western	0	2	3+1
West Midlands	5	4+1	6
Mersey	1	3	4
North Western	3	6	6
LPGTHs	12	included in Thames Regions	
Spec Hospitals	2	included in Oxford Region	
Wales	1	2	2
Total	99	114+ 13 vac	122+ 12 vac

The totals are greater than in Table I because of the inclusion of Special Responsibility posts (6) and of the same person holding two part-time posts.

Number of consultant psychotherapists (Scotland) 1990	
Edinburgh	3
Glasgow	3+2 vacancies+1 Special Responsibility
Dundee	1 Special Responsibility
Aberdeen	1+1 vacancy
Dumfries	1 Special Responsibility
Total	7+3 vacancies+3 Special Responsibility

Northern Ireland – one consultant in Belfast 1990

posts. However, a survey by the Psychotherapy Specialist Section of the Royal College of Psychiatrists[3] revealed that only about 10% of consultants in the mental illness field state that they systematically practise psychotherapy. Only 2% have special interest or special responsibility posts. The actual designation of special interest consultant posts in psychotherapy has proved unsatisfactory, partly because it has been misused as an alternative to 'special responsibility' or full 'specialist' designation. Such consultants have often had to attempt to provide a range of services and teaching without having obtained the rigorous training required and without being allocated an adequate number of sessions. It is recommended that posts formally designated as special interest posts in psychotherapy do not continue to be developed. There are currently six "special responsibility" posts and clearer guidelines for training for such posts have been proposed[4].

The reasons for the failure to develop sufficient posts are complex. The speciality has developed at a time when expansion has slowed down. Any new proposed posts will have to compete with the need for posts in other neglected areas such as old age psychiatry, mental handicap, rehabilitation, etc. Despite the increasing emphasis on community care, most planning and allocation of resources still concentrates on in-patient services[5]. The recent recognition of the importance of psychotherapy in the training for community psychiatry[6] is to be welcomed. Two points are worthy of comment. First has been the tendency of most psychotherapists to concentrate on clinical work and teaching, with a failure to collect epidemiological and outcome data required to argue their case. Secondly, and possibly linked to this, is the widespread erroneous belief that psychotherapy is only appropriate for a few relatively healthy, intelligent individuals, from the upper social classes, who have minor neurotic complaints. Psychotherapy then becomes relegated to the status of a luxury and is often associated primarily with private practice. Such an attitude does a disservice to the many patients who can benefit from the wide range of psychotherapeutic treatments available.

The range of psychotherapeutic treatments

Psychotherapy as a main treatment method

Where significant intrapsychic disturbance or interpersonal dysfunction is playing a major role in the aetiology or maintenance of a disorder, skilled psychotherapy may be the most appropriate or preferred treatment. The main diagnostic categories include:

(i) personality disorder
(ii) non psychotic affective disorder
(iii) neurotic disorder
(iv) adjustment reaction including atypical grief
(v) some psychosomatic disorders
(vi) various behavioural disorders, including the eating disorders and addictions
(vii) psychosexual dysfunction and deviation
(viii) post traumatic conditions including the sequelae of rape, assault and sexual abuse and the impact of natural and man-made disasters.

Psychotherapy in conjunction with other treatments

(i) Psychotherapy used in conjunction with antidepressant medication has been demonstrated to be a particularly effective combination treatment for major depressive disorders.
(ii) Psychotherapy may be used as a component treatment for a wide range of conditions, including psychotic illnesses. The aim is to mitigate the secondary effects of the disorder or to influence factors that contribute to relapses.
(iii) Psychotherapy as an adjunct in the management of physical disorders, particularly when difficulties in adjustment aggravate the effects of the physical illness. Marital and family problems may be generated and require skilled counselling.
(iv) Psychotherapy as a contribution in the management of severely disadvantaged groups of patients such as the mentally handicapped, chronically mentally ill, and some elderly patients.
(v) Psychotherapy as a treatment model in the context of a larger therapeutic programme and supportive setting for the treatment of some severe personality disorders (for example borderline, narcissistic and psychopathic) who have shown themselves able to utilise a psychotherapeutic approach.

The role of the consultant psychotherapist

The consultant psychotherapist is trained to a high level of expertise in at least one specialised branch in psychotherapy. He or she also has a working knowledge of other fields[4].

A recent survey of consultant psychotherapists[7] yielded the following average figures for allocation of consultant psychotherapists' time:

(i) assessment 19.3%
(ii) individual treatment 15.6%
(iii) group treatment 8.3%
(iv) teaching/supervision 31.5%.

https://doi.org/10.1192/pb.15.3.174 Published online by Cambridge University Press

The remaining 25.3% covered management, administration, research and consultation to institutions, etc.

Clinical function

(i) Assessment of patients regarding suitability for various forms of psychotherapy.
(ii) Treating patients presenting special difficulties, and maintaining his/her own clinical skill to a level commensurate with supervision responsibilities.
(iii) Acting as a leader of therapeutic communities.

Teaching function

Medical students and non-psychotic doctors

There is growing recognition of the importance of teaching communication and interview skills to medical students and doctors in all fields. The 'Balint Group' remains an important model for developing psychotherapeutic skills in general practitioners[8].

Psychiatrists

A substantial basic training in psychotherapy is recommended for all psychiatrists and the Royal College of Psychiatrists has published guidelines on this matter[9]. The Association of University Teachers in Psychiatry has also produced guidelines on the teaching of dynamic psychopathology[10]. Any increase in general psychiatry trainees will place additional demands on psychotherapists. Extensive training and experience is further required by those who plan to work as future specialists[4].

Other disciplines

Consultant psychotherapists are increasingly asked to contribute to the teaching of psychotherapeutic skills to a wide range of professionals.

(i) Nurses (including health visitors, community psychiatric nurses and nurse specialists in psychotherapy).
(ii) Psychologists (especially those who wish to develop dynamic in addition to cognitive behavioural skills).
(iii) Social workers.
(iv) Occupational therapists.
(v) Music therapists (who require dynamic supervision of the processes that occur in their work).
(vi) Art therapists.

Voluntary agencies

A wide range of organisations provide counselling and support to those who are physically and mentally ill, or who are in situations of trauma or stress. Such groups rely heavily on teaching and supervision from recognised specialists, in particular from consultant psychotherapists.

Management function

While psychotherapy is a multidisciplinary activity, the consultant psychotherapist will take a lead in organising services. This management role is appropriate because of:

(i) the length of general and specialised training before consultant appointment
(ii) the breadth of training required before taking up a post under the formalised competitive system in the NHS
(iii) the consultant's familiarity with Health Service practice and organisation
(iv) the consultant's broad knowledge of severe psychiatric disorder and organic illness.

The consultant psychotherapist will therefore have a key role in representing psychotherapy to managers at unit, district and regional levels.

The consultative function

In view of his or her specialist knowledge of individual and group dynamics, the psychotherapist is asked to respond to a wide range of requests from professional colleagues. He or she may be asked to explore complex aspects of the work setting as it affects individuals, staff teams and the organisation as a whole. Help may be sought at times of crisis (e.g. a high level of staff illness) or as a continuing contribution to the delivery and self-monitoring of effective services. The conflict and rivalry engendered by working in a multidisciplinary setting (for example in community mental health teams) may benefit from external consultation of this sort.

Proposals for psychotherapy services

District services

A psychotherapy service should be an integral part of each district's development plans.

(i) It should meet a wide range of clinical needs and be provided in a variety of clinical settings.
(ii) The range of treatments should include individual short and long-term therapy, group family and marital therapy, and behavioural and cognitive therapies. Close liaison will be required with psychology departments to ensure appropriate integration and differentiation of services according to staff resources and patient needs.

(iii) The staff should include personnel of various levels of training from the relevant core disciplines. The teaching function should be an integral part of the service with trainees contributing considerably to the resources available for patients.

(iv) There must be effective links with other medical and psychiatric colleagues including academic departments in order to encourage clinical research.

(v) Adequate supporting services should be provided for teaching as well as clinical work.

(vi) The specialised service should be planned as part of a coherent strategy at district and regional levels in the light of the different circumstances in different parts of the country.

(vii) A 'core team' should be built up to promote the planning and delivery of psychotherapy services in each district. A minimum of three WTE specialist colleagues who meet on a regular basis should be aimed for. This 'core team' will work with other less specialised staff to co-ordinate the comprehensive services to the district. As in other settings in the health service the consultant will be the team leader.

Regional services

In addition to these district services most regions will continue to provide regional or sub-regional specialty centres, each serving a population in excess of 1 million. Such regional centres, or districts identified as carrying certain regional responsibilities, may also need to provide intensive milieu therapy or therapeutic community facilities. They will have an important undergraduate and postgraduate teaching role.

National services

These regional centres will be further complemented by national training resources such as the Tavistock and Portman Clinics[11].

Medical staffing requirements

From the above, it is clear that even the present envisaged target of one consultant psychotherapist per 200,000 population is considered inadequate. The development of such posts should be considered an urgent priority and be linked to specific longer term planning to build up a core team. The staffing requirements in each district will be affected by local resources in the private and voluntary sectors and will also be affected by local authority provision. It is likely that the core team within the NHS will require an additional two WTE posts at non-training grades in order to provide a comprehensive service. These posts may be non-consultant medical posts or non-medical specialist posts. As psychotherapists provide mainly out-patient services on a regular timetabled basis, the field is particularly appropriate for those wishing to work part-time.

The 1987 allocation by JPAC of 16 additional senior registrar posts was a welcome step towards improving the situation[12]. An additional four posts were further granted in 1990.

Management and administrative issues

Because of its wide application, psychotherapy differs from other specialties in having no exclusive population to define age or diagnosis. The term 'psychotherapy' is sometimes used to refer to a specialty within psychiatry and at other times to refer to a general approach in psychiatry which stresses psychological rather than physical factors. Consequently the staff of many departments of psychotherapy work in close co-operation with general psychiatric colleagues. Psychotherapy teams also tend to function with a marked multidisplininary emphasis and with considerable overlap of roles. The drawback to both of these features of the specialty is the difficulty in providing managers with precise information about populations to be served, levels of immediate need and national staffing levels.

Clinical information systems and performance indicators

Clinical information systems utilised for recording psychotherapy activity should be sensitive to the nature of such work, including the requirement at times for intensive and long-term treatments. The recommendations of the Korner Committee[13] have been criticised as inappropriate for out-patient services and many aspects of psychiatry. Psychotherapy itself was only mentioned in passing, bracketed with audiological and optical services. The selection of appropriate performance indiators for psychotherapy poses a number of problems, some of them shared with the field of child and adolescent psychiatry. Performance indicators which measure activity are of less value than a more extensive clinical audit which includes out-come measures. Outcome in psychotherapy should not be viewed simplistically in terms of symptom relief only but include such items as social functioning, utilisation of other services and prevention of deterioration. It is agreed that there should be a 'model minimum data set' for service evaluation geared to psychotherapy practice. This should be standardised where possible. However, it would be inefficient and costly to assume that

every small psychotherapy department can collect more sophisticated information. Such projects should be undertaken to answer specific research questions, or in larger regional centres with access to university facilities.

Budget holding

One of the many proposals for the NHS is that there be a system of clinical budget holders who can 'buy' clinical and supporting services. In this context, the consultant psychotherapist needs to have a defined role as a primary clinician. The alternative would be to be placed in a position where psychotherapy services were 'bought' in the same way as laboratory services.

Relations with other professional groups

It is vital that psychotherapy departments do not become too separated from main stream psychiatric services. In addition to working closely with psychiatric colleagues the consultant psychotherapist needs to define responsibilities in relation to a number of other professionals potentially providing psychotherapy.

Child psychotherapists

The Section of Child and Adolescent Psychiatry have reviewed this development[14]. There is now a career structure for experienced non-medical child psychotherapists who have undergone a formal training. They contribute to the work of psychiatric departments and may work autonomously. Such posts are not usually associated with adult departments of psychotherapy.

Adult psychotherapists

At present there is no equivalent formal training or career structure for non-medical psychotherapists working with adults in the NHS. Some such posts have been designated on a person to holder basis. Other staff who have undertaken psychotherapy training may function as psychotherapists but remain within the line management structure of their core profession. The development of a formal training and career structure, similar to that for psychiatric consultant psychotherapists, is under continuing discussion[15]. The role of such staff relative to the consultant psychotherapist needs to be clearly defined.

Clinical psychologists

Another professional discipline which works psychotherapeutically is that of clinical psychology. Since the Trethowan Committee Report clinical psychologists have become relatively autonomous. Historically psychology and psychotherapy services have usually developed separately. Some degree of co-ordination is required to ensure that patients have access to the range of treatments available. This is recognised by the British Psychological Society[16]. The suggestion that psychologists assume the leadership role is considerably more contentious.

General practitioners

With the publication of the Griffiths Report on Community Care[17] and the increasing pressure on psychiatrists to adopt community methods of working, psychotherapists will have to consider a closer working relationship with general practitioners. The consultant psychotherapist should remain a specialist, rather than a counsellor attached to a general practice unless this is a particular area he or she wishes to develop and research. Discussion is required to see how the psychotherapist may be involved in monitoring or supervising such counselling activities.

The voluntary and private sector

The relationship between the NHS and the voluntary or private sector is a reciprocal one. Most NHS psychotherapy trainings require supplementary input from other settings, especially in the provision of personal therapy for the trainee therapist, in turn it is a legitimate and important role for an NHS psychotherapist to provide some training and staff support for voluntary organisations which are providing such valuable services.

Planning

The following stages are required:

(i) Department of Health directives and policy regarding future staffing norms, required levels of service and methods of data collection.

(ii) Regional Planning Groups for Psychotherapy utilising information and advice from the Royal College of Psychiatrists Regional Psychotherapy Representatives.

(iii) District Planning Groups with input from the local specialist psychotherapy team.

(iv) Regional Planning Groups should collate and monitor District Planning Group proposals for psychotherapy developments.

(v) District Psychotherapy Teams should offer local services and liaise with Regional and sub-regional services where appropriate.

Conclusion

A substantial increase in the numbers of consultant psychotherapists is still required. The 15-year-old target of one WTE per 200,000 population should be

vigorously pursued as part of planned policy at district and regional levels. This is urgently required in view of the unmet patient needs, increased teaching demands and the move to community care.

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Approved by Council
June 1990

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Special (Career Counselling) Committee

Council has approved the establishment of a Special Committee with the following remit:

> "To provide counselling to any individual pursuing a psychiatric career in the British Isles who believes that his/her career is being impeded by discrimination or disadvantage. It is anticipated that the individual will normally have made full use of counselling and advice resources available at a local level, including those provided by the Regional Postgraduate Dean. It is not intended to deal with issues connected with the Membership Examination".

The intention is to assist individuals in making rational choices about their future careers in their particular circumstances and to advise appropriate authorities where there is evidence of discrimination or handicap.

In future, all units will have a Clinical Tutor and each psychiatric training scheme has a Psychiatric Tutor who may be consulted for career advice. All staff in training should receive regular career counselling. The College Regional Adviser and the Regional Postgraduate Dean are also available to offer advice.

Anyone whose problems are not resolved by full use of these facilities may approach the Special Committee. In this case the individual should write to the President, setting out a brief account of the nature of his/her difficulties. Should the President decide that this is a proper matter for the Special Committee, the secretary will request a more detailed statement, including the names of those whose advice has already been sought.

The matter will then be considered by two members of the Committee who may arrange to interview the individual and agree appropriate further action.