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The future of psychotherapy in the NHS*

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Mental health services in general are at present receiving a bad press. Recent complaints focus on two main areas: the widespread prescription of tranquillising drugs, and the social consequences of the policy of community care. There is now serious concern, both among the public and in the profession, about the over-prescription of tranquillisers. The legal implications are serious. An article in the *Journal of the Medical Defence Union* was recently quoted in the *Bulletin:* "Dr Ashton's article is a timely reminder that the prescription of benzodiazepines is now a high profile activity for the psychiatrist that has been scrutinised much more closely than many of our other functions. It is well to be aware that one of the potential onlookers is a lawyer" (Tyrer, 1988).

For most psychiatrists the prescription of tranquillising drugs has been a mainstay of professional practice. The time is now overdue to review prescribing policy, the training of medical students and of psychiatrists, and the weakness of psychotherapy in this training. The other mainstay of traditional psychiatric services was hospitalisation under the control of the consultant psychiatrist. Treatment depended on teamwork, done by nursing staff in conjunction with psychologists, social workers, occupational therapists, etc. Many psychiatrists viewed their role only as 'consultants' in the narrow sense, that is as experts on the medical/mental state of the patient. Regrettably few were trained in multidisciplinary teamwork and the application of group and institutional processes to that work.

With the move towards community mental health care, these skills are now increasingly required. Services are often no longer controlled by psychiatrists. The recent Griffiths Report on community care, for example, proposes the appointment of 'care managers'. Because psychiatrists are, in the public view, held responsible for the provision of mental health services, any shortcomings in the service are placed at our doorstep and give us a bad name. It is therefore essential that we participate competently. The workers' main need will therefore be for greater understanding of the process of rehabilitation as it affects both the patients and the work of the staff group and its morale. To meet this, we need to improve our understanding of group and institutional processes and of management skills. NHS psychotherapists, with their training in dealing with unconscious defensive processes both in individuals and in groups, have an important contribution to make here, in the field of training and in institutional consultancy.

Child psychiatry is also increasingly caught up in intra-institutional and inter-disciplinary disputes – areas in which authority structures are very unclear, and where there is a lack of staff training and the study of institutional management. Here, too, the application of psychoanalytic principles to group-work and institutional processes is necessary.

There have been other shifts in practice and in public opinion. The overall climate has changed over the past years from one of trusting, or at least passive, dependency towards distrust of authority and greater dependence on self. We are now in the era of failed dependency. This is reflected in government, in industry, and also in the 'national' state of mind (Miller, 1986). Applied to our field, it means that the attitude of 'leaving it to the experts' no longer goes down so well with the public.

The climate is veering in the direction of people taking more responsibility for themselves, and towards a 'self-help' state of mind (individually and in groups and organisations) rather than dependency on experts who impose diagnoses and prescribe treatments in which the patient is only a passive consumer.

This phenomenon manifests itself in the general medical field with self-help groups in every field from congenital disorders to cystitis, as well as in the field of psychological disorder and distress. Training and experience may help us psychiatrists to harness this greater preparedness on the part of patients to take responsibility for themselves. To do this, we need to alter some of our training priorities and move towards fostering greater independence of thought and action in our patients. I believe that contributions coming from that end of the psychotherapy spectrum concerned with group-relations and consultancy to institutions would help in preparing us for this change of stance.

*(Based on the 1st Annual Public Lecture of the Association for Psychoanalytic Psychotherapy in the NHS).

Planning the future – the role of psychotherapists in the Health Service

So, what should our priorities be? It is the Government's avowed policy to "give the consumer a choice", as well as developing the percentage of health care delivered by the private sector. Relatively little attention is given to the general area of public education in mental health matters, and in particular to the areas of staff support and of institutional morale.

Taking into account this difference of emphasis in the private and public sector, I believe that NHS psychotherapists can make a great contribution in fostering good human relations in the National Health and associated services, such as education and social services, as well as in the training of staff and the provision of psychotherapy where the emphasis is on breaking the generational pattern of deprivation and the fostering of good community mental health policies.

Although it is not yet standard for all NHS psychoanalytic psychotherapists to have training in institutional processes and in consultancy, the need for it is increasingly realised and fits well with their basic training. In the Health Service, there is growing awareness of the pressures on staff, and how costly poor staff management is in terms of absenteeism, burnout and staff loss. And the pressures on the Health Service mount!

Apart from the foregoing, at least two other roles are essential for the NHS psychotherapist. The first is training members of other NHS disciplines in the basic principles of psychoanalytic understanding to achieve a better emotional deal for the patient in general hospitals, better staff morale, and improved community mental health. Translated into 'Griffiths' terminology this means better preventive services and more cost-effective use of staff resources.

The second element is to provide psychotherapy to those that most need it and can least afford it. It may seem somewhat odd to put this lower down in the job description of an NHS psychotherapist. My reason is the belief that raising awareness of the factors that generate psychological disturbance is a better use of our resources than concentration solely on the provision of psychotherapy services. The medical model surely includes prevention as well as cure. Of course the provision of psychotherapy services to children, adolescents and young adults, whether it be individual, family, marital or group therapy, is simultaneously one of the few effective ways we have of breaking the cycle of emotional disturbance and deprivation, for here treatment is prevention – essential if we are to make inroads into a self-perpetuating cycle. And, by definition, this is an area of need that will never be covered sufficiently, if at all, by the private sector.

On the creation of better services

All agree that the development of a national network of psychotherapists and psychotherapy centres within the NHS should have high priority.

At the Tavistock Clinic we are now working to implement the recommendations of the Seymour Report. This Report, completed in 1985, and accepted by the Minister for Health in 1987, designated the Clinic as a national training centre, and recommends expansion of its national role. In line with this, we are developing child psychotherapy projects in Manchester, Birmingham and Edinburgh, and these will in time, we hope, lead to courses that will qualify child psychotherapists.

We are also instituting a national programme for regional associates in adult psychotherapy. This will give colleagues in the provinces some involvement with the range of courses, research groups and other developments going on at the Clinic. Several such projects are under consideration.

The Association of Child Psychotherapists, whose principal training base is at the Tavistock Clinic, has a working party concerned with these matters. An increasing number of child psychotherapists have trained in London and moved out, and are now responsible for local developments that will lead to new services and, eventually, to new local training.

The Institute of Psycho-Analysis too, at a meeting held in February 1988, decided unanimously to engage in a project that would train psychoanalysts for Scotland and the North of England. The Association for Psychoanalytic Psychotherapy in the NHS also has been very active in fostering a climate of development.

The Royal College of Psychiatrists have achieved the creation of 16 new senior registrar posts in the Regions – no mean feat in this time of NHS austerity.

Issues to be addressed

We therefore have the national climate for growth; we have a fair number of firmly based clusters and the makings of many more. We have an appropriate debate about resources and about standards. Where do we go from here?

Correlation and co-ordination of projects

At present there is no centre or organisation that knows of developments in the field, and no system for correlating information or putting projects in touch with each other. There is no statutory body responsible for this, nor is there likely to be one.

The only one body on the horizon may arise from the Rugby Conference, but that will address itself essentially to the registration of a wide spectrum of psychotherapy training organisations inside and outside the NHS.

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Those of us in the field should therefore make a concerted effort to inform each other of developments and projects.

The creation of a profession of adult psychotherapist

It is our habit to hold on to our original profession, while also being psychotherapists; I think the time has come for us to put our weight behind the creation of an adult psychotherapist category of employment in the Health Service. The precedent is there, as is indeed the salary structure, child psychotherapists being employed on the same terms and conditions as clinical psychologists. At the latest count over 20 such posts already exist, all supposedly 'anomalous'. The profession therefore already exists *de facto*.

The confirmation of adult psychotherapy as a profession would provide a firm base for these individuals already employed in the Health Service under a variety of other odd titles and categories, and prevent their eventual loss to the Health Service; it would also provide the coherency for a national network that is at present divided, to the detriment of psychotherapy, between psychiatrists, psychologists, social workers and others who have a dual allegiance to their professions and to psychotherapy.

Public relations

I think as a profession we psychotherapists are not good at public relations. Our anxiety about publicly exhibiting ourselves, which can degrade our professional standards, as well as creating transference problems with our patients, is possibly exaggerated by lack of experience and training in work with the media, and fear of what our colleagues will say if we do appear. Our working traditions are peculiarly private and therefore an obstacle to developing public skills.

In the post-dependency national culture, there is now a greatly increased interest in all matters psychological, and informative radio and television programmes undreamed of ten years ago are now commonplace. There is greatly increased demand by the public and the media for information about psychological aspects of everyday life. We should make ourselves available for this work. Television, radio and the press are important educational tools in the field of personal and community mental health, and should be used wholeheartedly.

Comment

We have a choice – to continue in our "comfortable" settled ways of fighting each other as biological psychiatrists or psychotherapists, or else to cooperate in a new mental health venture. I hope that this contribution will contribute to the latter outcome.

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The group at work

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Experience in group therapy is recommended by The Royal College of Psychiatrists (1986) as an important aspect of training in psychiatry. However direct experience is unusual. It was reported in the *Bulletin* that a group formed by trainees in psychiatry to study the group process found a demand for personal therapy for its members (Whewell, 1987). In this paper a group is described which attempted to meet both needs.