A model for an integrated psychotherapy service

Jeremy Holmes and Sally Mitchison

A model psychotherapy service is proposed, integrated in the double sense of combining different psychotherapeutic modalities in a single psychological treatment service, and forging close links with general psychiatry. The four limbs of the service extend into supporting counsellors in general practice, providing psychotherapeutic input into the treatment of the severely mentally ill, managing patients with personality disorders, and supplying psychotherapeutic aspects of a liaison service. The advantages of this model in the current managerial climate are discussed.

> "Constant revolutionising of production, uninterrupted disturbance of all social conditions, everlasting uncertainty and agitation distinguish the [managerial] epoch from all earlier ones. All fixed, fast frozen relations, with their train of ancient and venerable prejudices and opinions, are swept away, all newly formed ones become antiquated before they can ossify. All that is solid melts into air, all that is holy is profaned, and man is at last compelled to face with sober senses his real conditions of life and his relations with his kind." (Marx & Engels, 1847).

Karl Marx's famous text can, by altering one word, well be applied to the present era in the NHS. In it Marx reveals his ambivalence towards a capitalism that is both destroyer and creator, a force sweeping away all that impedes progress, but also everything that is of value, forcing new ideas and adaptations. Psychiatric services, no less than other social institutions, adapt themselves – more or less successfully – to the prevailing economic, political and cultural environment. The 'reforms' which have swept through the health service in the past five years have thrown existing categories and groupings into disarray, and have led practitioners to search for new identities, roles and allegiances. Medical psychotherapists feel exposed to managerial attack, concerned that they will be seen as easy pickings, replaceable by cheaper and more tractable counsellors. General psychiatrists have seen their work increasingly hemmed in with statutory responsibilities, and worry that their role will be reduced to assigners of diagnoses and prescribers of medication.

These changes often lead to defensive rather than effective response. Psychotherapists adopt a paranoid position, feeling misunderstood and undervalued, or develop compensatory omnipotent fantasies of their special importance. General psychiatrists dream of escape – into the private sector, or early retirement, according to age.

All this is highly discouraging, and sets a poor example to younger psychiatrists. The aim of this article is to propose a model of a psychotherapy service that, while resisting the extremism of the economic imperative that is driving recent changes, is adapted to the new environment yet preserves the central contribution of psychotherapy to psychiatric culture.

The essence of our proposal rests on the need for a double integration: integration of psychotherapeutic work within general psychiatry and medicine, and integration of the different psychotherapeutic modalities.

Activity

We see four main foci of psychotherapeutic activity, each of which is associated with a particular client group (Fig. 1).

A cascade of support for psychotherapy and counselling in primary care

Increasing amounts of what was the traditional work of psychotherapy departments is now being done by counsellors in general practice and in community-based mental health resource centres. The majority of these patients are suffering from mild to moderate anxiety-based and depressive disorders, which respond well to validated brief therapies. Rather than feeling threatened by this, medical

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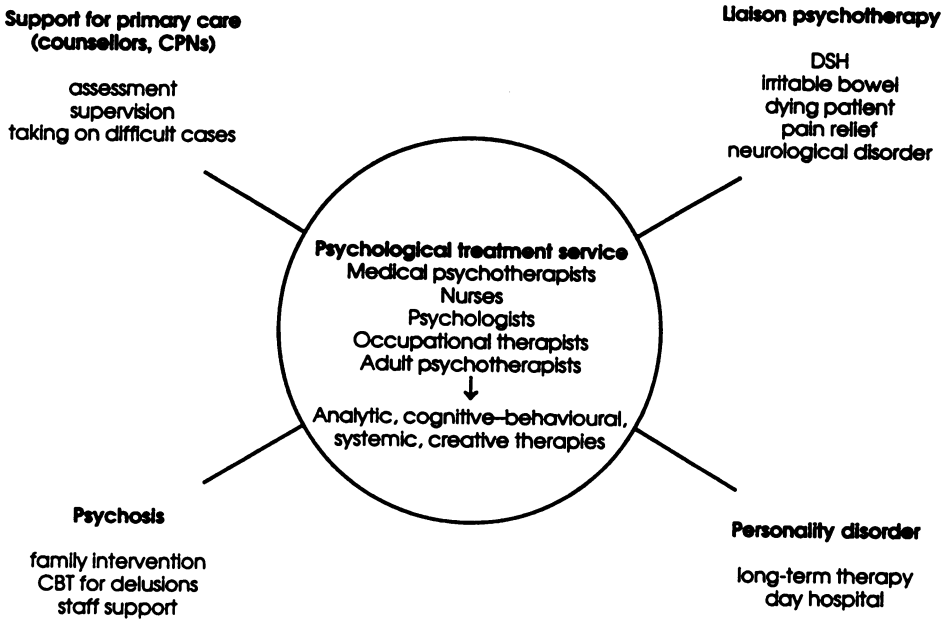

Fig. 1. An integrated psychotherapy service.

psychotherapists should welcome the diffusion of psychotherapeutic skills within the multidisciplinary team. Their role as secondary/tertiary providers is to offer supervision and training for community workers whose interventions may otherwise be ineffective (Andrews & Teeson, 1994). Psychotherapy units will also continue to be a referral point for assessment, consultation and treatment for the more difficult cases. They can help with setting up therapeutic groups in the community targeting vulnerable people such as the bereaved, victims of sexual abuse, and those involved in marital violence.

Psychotherapeutic contribution to the management of the severely mentally ill

The current climate has rightly seen an increasing managerial emphasis on the treatment of patients with long-term mental illness, especially schizophrenia. These patients are generally looked after by both in-patient and community staff who have little specific training in therapies relevant to psychosis. This may explain the well-documented drift among community staff away from the long-term mentally ill towards neurotic disorders (Goldberg & Jackson, 1992). Psychotherapists can make two important contributions here. First, the deliverers of care need to be trained by cognitive and family therapists in the new 'interpersonal technologies' needed to reduce the intensity of psychotic experience, and to prevent relapse. Cognitive interventions in schizophrenia can make hallucinations more bearable and decrease their frequency (Chadwick & Birchwood, 1994). Despite more than a decade of research showing that family interventions can reduce relapse rate in schizophrenia, the traditional divide between general psychiatrists (who look after the patients) and family therapists (who possess many of the necessary techniques) has meant that these findings have yet to be incorporated into routine clinical practice (Leff, 1994). Second, psychodynamic understanding of the mental mechanisms prevalent in psychosis – splitting, omnipotence, autism, projective identification (Gabbard, 1990) – while rarely applicable to the direct treatment of these patients, can be highly relevant to the psychiatric environment that contains them, whether this is in-patient ward, hostel, day centre, or home-based treatment. Staff

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support groups, often facilitated by psychotherapists, can help combat the alienation that contributes to in-patient suicides (Morgan, 1994), and reduce burnout in community workers.

The management of severe personality disorder, especially borderline personality disorder

Although relatively small in numbers, these highly disabled patients consume an inordinate amount of NHS resources and staff time, often without obvious long-term benefit. There is evidence that well-planned psychotherapeutic interventions can be cost-effective in some patients with personality disorders (Stevenson & Meares, 1992; Higgitt & Fonagy, 1992). Gunderson (Gunderson & Sabo, 1993), a leading authority on borderline personality disorder, considers that the single most effective strategy for maintaining these patients out of hospital is long-term individual psychotherapy. This is likely to be supportive-directive for the most disturbed individuals, supportive-expressive for the better functioning group (Winston *et al*, 1986; Wallerstein, 1986; Holmes, 1992). It should be a key task for a psychotherapy service to insist on a long-term perspective in the management of these patients, and often, in larger centres, to provide a psychotherapeutic day hospital or small in-patient unit where they can be treated. This work will overlap with providing a service for other patients who require long-term psychotherapy, including those with eating disorders, those who have been sexually or physically abused, or who recurrently injure themselves.

A psychotherapeutic liaison service

The district general hospital has been described as "America's second mental health service" (Fahy & Wessely, 1993), and the same is likely to be true in the UK. The key skills of liaison work are essentially psychotherapeutic. Guthrie *et al*'s (1991) study of successful psychodynamic treatment of irritable bowel syndrome is a recent impressive example. Psychotherapists have important contributions to make among others, in pain management, to the care of the dying patient, in coronary rehabilitation, in neurological services, and in genito-urinary medicine. Many patients who have deliberately harmed themselves can benefit from brief psychotherapeutic interventions, which may have a prophylactic effect (Morgan, 1994), and this need is highlighted by the *Health of the Nation* requirement to reduce suicide rates by 15% by the year 2000 (Department of Health, 1992).

Staffing

It is clear from this list that no single psychotherapeutic modality is sufficient, and that psychotherapy units will need to offer the full range of treatments including psychodynamic, cognitive-behavioural, systemic, and creative therapies (Holmes, 1991). Since few psychotherapists are highly trained in more than one type of therapy, this means in practice a multidisciplinary psychological treatment service, along the lines advocated by the British Psychological Society and the Psychotherapy Section of the Royal College of Psychiatrists joint working party (Binns *et al*, 1994), staffed by medical psychotherapists, psychologists, nurses, occupational therapists, and adult psychotherapists. A 'hub-and-spokes' model is needed in which workers come into a central psychotherapy unit for training and supervision and then return to their district base.

Training

Training will be an integral part of this psychiatrically focused psychotherapeutic work. Senior members of the psychological treatment service will all have undergone specialist training in their particular discipline, equivalent to the four-year training for senior registrars in psychotherapy (Cawley's 'levels 3 and 4', Brown & Pedder, 1993). A central task will be to impart relevant 'level 1 and 2' psychotherapeutic skills to all mental health workers. The mandatory guidelines on psychotherapy training as part of general professional training (Grant *et al*, 1993) place this at the heart of psychiatric education, and should ensure that all psychiatrists are able to undertake appropriate psychotherapeutic work. A basic requirement is the need for small intimate weekly supervision groups which provide a space for reflection (as opposed to action), to which all psychiatrists in training can regularly retreat from the hurly-burly.

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Conclusions

The integrated model of psychotherapy services we propose has many advantages, including the following.

(a) The Psychotherapy Section of the Royal College of Psychiatrists has consistently argued that there is a significant underprovision of medical psychotherapists within the NHS (Grant *et al*, 1991). However this shortfall in itself has so far failed to impress purchasers of psychiatric care. It needs strongly to be argued that without adequate psychotherapy provision it will be impossible to meet quality standards for mental illness – a theme far more likely to speak to managers than the need for more jobs for psychotherapists (although these will inevitably be required).

(b) Integration of psychotherapeutic with general psychiatric work makes the College psychotherapy training guidelines far more likely to be successfully implemented than if psychotherapy remains hived off as a sequestered and rather precious speciality. Trainees should be learning to work with families of schizophrenic patients, taking on patients with long-term depression or neurotic disorders (and sometimes the 'easier' borderline patients) for individual therapy, and using cognitive-behavioural skills in their out-patient clinics as part of their routine psychiatric work, not as a luxury to be pursued in spare time by a few enthusiasts.

(c) Through its impact on quality standards for the long-term mentally ill and its contribution to suicide prevention, psychotherapy becomes central to the implementation of the *Health of the Nation* guidelines.

(d) Integration can lead to the development of consultant posts that combine psychotherapy with providing a service to a particular patient group, e.g. those with eating disorders, recurrent deliberate self-harm, or severe personality disorder. This will militate against the impossible demands of combined general psychiatry/psychotherapy posts, and, by being needs-focused, appeal to purchasers.

(e) It leads to cross-fertilisation between the different psychotherapeutic modalities and between psychotherapists and general psychiatrists, with potential for enhancing relevance and job satisfaction for both groups.

The main problems with our suggestions centre around the difficulties in altering well-established working practices, and the feelings of loss of identity and suspicion that inevitably accompany organisational upheaval. Unlike Marx's, our proposals are evolutionary not revolutionary, and many such changes are already under way. The purpose of this model is to stimulate debate, to call for systematic evaluation of psychotherapy services as they respond to change, and to encourage practitioners to fight to preserve what is good, while mourning with appropriate sadness and anger what must inevitably be lost.

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Animals, humans and Martians: the concept of persons

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This paper examines the concept of the person as distinct from the concept of the human being. It argues that the criteria which some contemporary philosophers propose for making this distinction are likely to have adverse effects for the moral status of people with learning disability and psychiatric disorders respectively.

The concept of the person as distinct from the concept of the human being has emerged from the moral problems posed to clinicians and moral philosophers by dilemmas in at least three separate areas, namely abortion, withdrawal of life-saving or sustaining treatments, and the attempt by some philosophers to forge a description of what animal rights consists of. In addition, there is the task as some philosophers see it, of providing a framework that would in principle enable us to answer the question "are there other people in the universe?" (Harris, 1985). Much of this literature is concerned with the exploration of criteria that determine personhood and by implication moral value. In this paper I will examine the arguments put forward for adopting particular criteria for assigning the status of person to some humans and not to others and then go on to argue that there is no compelling reason to make such a distinction between 'persons' and 'human beings'. Indeed, such a distinction is likely to have deleterious effects upon the moral status of people with learning disability and psychiatric disorders respectively.

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