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Staffing a district psychotherapy service

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In 1975 the DHSS made psychotherapy one of the five psychiatric specialities. Since then, any comprehensive District mental health service has had to include a psychotherapy department.

The types of disorder that benefit from dynamic psychotherapy, for example neuroses and personality disorder, are well documented (Malan, 1979). Many of the patients with such conditions demand a lot of attention from primary care services, community services and general psychiatric teams. A District can reduce the strain on these services, and its need for day hospital places and hospital beds in the management of these patients, by establishing an out-patient psychotherapy department.

One of the main reasons why Districts have been slow to develop psychotherapy is that they have faced problems about what kind of staff they can safely employ.

The problems of staffing

The only formal career post in the NHS is that of consultant psychotherapist. A District could, therefore, proceed by establishing a department staffed only by consultant psychotherapists. In practice, this option is both unrealistic and undesirable. It is unrealistic because Districts have neither the will nor the finances to appoint a sufficient number of consultants to provide anything approaching a service. It is undesirable because non-medical psychotherapists, who are cheaper to employ, would be precluded from a career in the NHS, resulting in a waste of talent.

In practice then, Districts will want to appoint non-medical staff in addition to consultants. Unfortunately, the employment of non-medical psychotherapists in the NHS is problematic. There is no single profession of psychotherapy. There is no register of psychotherapists. There is no central council of psychotherapy regulating either training or standards of clinical practice. It is even debatable whether such structures are desirable. Instead, there is a mass of separate organisations offering various trainings, courses, degrees and diplomas. These problems are compounded when it is realised that many of the training organisations in the private sector are unfamiliar with the range and complexity of the work in the NHS, offer only a limited range of clinical experience to their trainees, and have little experience of the serious psychiatric disorders. Districts providing a psychotherapy service, therefore, face major problems. The first is what kind of staff they can safely employ in addition to consultant psychotherapists. The second is how to ensure quality control over their clinical practice.

Solution 1 – The multidisciplinary model

One solution to the problem is to establish multidisciplinary departments. In this model staff who have specialised in psychotherapy are drawn from all the major disciplines associated with the treatment of mental illness, e.g. social work, occupational therapy, art therapy, nursing and psychology. It is presupposed that professional regulation of clinical practice will be exercised by the base profession. The attraction of this model is that although team members have specialised, they retain links with their respective base professions, links that enable them to liaise on matters such as referral and training.

In working practice, however, the model proves to have a number of serious disadvantages. First the career prospects of non-medical psychotherapists employed in this way are poor. Professions such as nursing, occupational therapy and social work do not, as yet, sufficiently reward special clinical experience and responsibility with either status or money. Consequently, staff who wish to advance their careers must leave psychotherapy to take up senior positions of an administrative nature within their profession of origin. This makes it difficult for psychotherapy departments to retain the services of skilled and experienced non-medical practitioners. Furthermore, when other disciplines control posts, it is impossible to ensure the continuity of the psychotherapy service because there is always the risk that posts will be re-allocated to make good a short-fall elsewhere.

Perhaps the most serious disadvantage of the multidisciplinary model is that it does not adequately address the problem of quality control. Staff in such departments are often clinically and/or professionally accountable to seniors who do not work in the psychotherapy department, who have no training in psychotherapy, who are not familiar with or who may even be antipathetic to the needs of the psychotherapy services and who are in any case charged with the responsibility of meeting the priorities of their own discipline. Even with the best of will, such a management structure is bound to result in problems because it cannot rationally monitor the appropriateness and quality of the work being done. It may be a different matter in multidisciplinary teams that do multidisciplinary work. It is proper to argue, for instance, that a social worker in a community team doing social work needs to be managed by a senior social worker. But the unique feature of a psychotherapy team is that it does unidisciplinary work. That is to say, irrespective of the therapists' professional backgrounds, they all do the same work; they all do psychotherapy. This being so, quality control can only be achieved by ensuring that they are managed by senior psychotherapists.

If the multidisciplinary model is to succeed, certain changes are necessary. First, all the professions represented in the department would have to have a career structure that rewarded specialised clinical expertise and responsibilities. Furthermore, there would need to be some mechanism to ensure comparability so that a nurse and a psychologist, for example, with equivalent experience and equivalent responsibility would be on an equivalent scale. Secondly, it is essential to have a management structure that is capable of ensuring that the needs, priorities and policies of the psychotherapy service are met. This can happen only if the managers of the service are senior psychotherapists charged with a primary responsibility to develop the service and ensure its quality. As these changes in career structure and management arrangements are unlikely to come into force the multidsciplinary model can never really be effective.

Solution 2 – The adult psychotherapist model

One solution that can effectively address these problems is the employment of a team of specifically designated psychotherapists. The expression 'adult psychotherapist' for such appointments is gaining currency mainly because there is already a Whitley Council scale for child psychotherapists. In this paper an adult psychotherapist is someone appointed to work specifically as a psychotherapist in the NHS but who is not, administratively speaking, a member of another professional group. Although adult psychotherapists will, in all probability, have a qualification in one of the professions involved in mental health work, e.g. psychology, social work, nursing, art therapy or even medicine, they will not in terms of their pay and conditions of service, belong to that profession. Neither will they be managed by that profession. They will be managed clinically, administratively and professionally by a senior psychotherapist who also works in the psychotherapy department.

There are significant advantages in this model for both the service and for the staff. First, the range of applicants, being no longer confined to one professional group, is considerably widened. Also the appointment being more explicitly based on the applicant's ability and experience in psychotherapy ensures that the quality of the service is maintained. In other words, it becomes possible to appoint a good psychotherapist rather than a good nurse or a good art therapist.

Secondly, a career structure that can rationally relate pay and status with experience and responsibility becomes possible. Recognition and equitable reward are essential for staff morale and are the

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vital incentives for staff to continue working in psychotherapy.

Thirdly, it provides the mechanism by which a psychotherapy department in the NHS can exercise professional regulation over the nature and quality of its work. A management structure in which adult psychotherapists are accountable clinically, administratively and professionally to senior psychotherapists in the department is capable of ensuring that work is conducted competently and in accordance with the policies and priorities of the psychotherapy service.

The adult psychotherapist model, therefore, overcomes the dangers inherent in a multidisciplinary department. The career structure and management arrangements that it makes possible are essential if a department is going to provide a safe and effective service with a sense of security, cohesion, and purpose.

Ensuring quality control

Whether Districts opt for the multidisciplinary or the adult psychotherapist model, they still have the problem that there is no single profession of psychotherapy that regulates standards of training and clinical practice. Health authorities are therefore faced with unusual difficulties in judging whether somebody is an adequately trained and competent practitioner. Before 1975, this was virtually an impossible task because health authorities had no way of assessing the conflicting claims of the many squabbling psychotherapy organisations, most of which are in the private sector and not primarily concerned with the practice of psychotherapy in the NHS. In 1975 the DHSS made psychotherapy a full medical speciality, and this provided a way out of the impasse. Since then it has been possible for Districts to appoint consultant psychotherapists knowing that they do so with all the safeguards that surround the appointment of consultants in any other speciality, and the safest and most straightforward way to safeguard the quality of the clinical service has been to ensure that the service is clinically and professionally managed by a consultant. The crucial issue is to make a consultant responsible for allocating duties and responsibilities to other members of the team in accordance with their training, ability and experience in psychotherapy and for ensuring that these duties are carried out in accordance with policies and priorities of the psychotherapy service. Although this safeguard is needed which ever model of staffing is adopted, in reality it is much easier to implement if a team of adult psychotherapists is employed.

Conclusion

A register of psychotherapy still seems a dim and distant vision. Its desirability, let alone its practicality, is far from certain. Yet the NHS needs to employ psychotherapists, needs to know that they have undergone a credible training and that they are competent practitioners and needs to be able to equate their pay and status to their experience and responsibilities. Until such time as there is a formal Whitley Council scale and conditions of service, the most cost-effective way of providing a District psychotherapy service is to establish a team of adult psychotherapists employed on personal variations orders, paid on the child psychotherapist scale and made administratively, clinically and professionally accountable to a consultant psychotherapist.

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