

Interface between the General Adult and Community Faculty and the Psychotherapy Faculty of the Royal College of Psychiatrists.

General Principles

The last few years have witnessed a widespread recognition of the importance of basic psychological skills in listening, understanding and communicating with patients of mental health services. In addition, formal psychological therapies are accepted as having a role in the management of all types of mental distress and illness, ranging from personality disorders to psychosis. Now it is necessary for the expertise of general adult psychiatrists and medical psychotherapists to be brought together. In effect, all psychiatrists should possess the core skills of a psychotherapist and medical psychotherapists should be experienced in treating those with severe mental illness and personality disorders. This interface document highlights some of the principles and methods through which this recognition can be realised in psychiatric practice. The two Faculties agree to work together to achieve these objectives.

Core Requirements:

All Psychiatrists currently in training, now have to achieve the required levels of knowledge and basic competence in a range of psychological therapies (see the Royal College document on psychotherapy training: Requirements for Psychotherapy Training as part of Basic Specialist Training). Additional training for Specialist Registrars and in the context of Continuous Profession Development at career level, should enable psychiatrists to support the appropriate development of core and specialist skills in psychological therapies by other members of the mental health team. Further defined training will enable the psychiatrist to offer specific sessional commitments to specialised teams (for example in the treatment of personality disorder, family therapy in psychosis or cognitive behaviour therapy). Such commitments could involve clinical sessions, supervision and/or training in psychological therapies.

Psychiatrists from both faculties should work together with their service commissioners to ensure the provision of adequate resources to deliver a safe service which guarantees a high clinical standard. No clinician should accept responsibility for running a service with inadequate resources that might undermine the level of care provided to patients and their carers.

It is incumbent on members of both faculties to work together and with colleagues of other disciplines to ensure that there is agreement on the basic principles of organising in-patient areas, specialist treatment facilities (e.g. day hospitals) and community teams, so that they are maximally therapeutic. This approach will require a close partnership with carers and user of the relevant services and a commitment to quality backed by meaningful supervision and clinical audit.

Training

The two faculties fully endorse the Royal College document of psychotherapy training for Senior House Officers: Requirements for Psychotherapy as part of Basic Specialist

Training. Knowledge and skills objectives for basic psychotherapy training are clearly outlined in the document. The objectives are achievable within a general psychiatric setting if supported by a robust psychotherapy service with a training remit and a local psychotherapy tutor. They can be appraised through the educational contract between the trainee and the educational supervisor by use of the log book and can be assessed through supervision, case formulation and other training exercises.

Basic specialist trainees must have adequate time and supervision programmed to enable them to meet these requirements. In addition there should be an opportunity to attend a weekly case discussion group. Although it is now policy that all SHOs acquire basic skills and knowledge prior to taking the MRCPsych, further supervised training will be necessary at SPR level to bring the psychological treatment skills up to a level necessary for Consultant Psychiatry practice.

It is especially important to increase knowledge of the indications for psychotherapeutic treatment and to improve skills in psychological assessment. In order to ensure that these processes runs smoothly, each SHO and SPR rotation should appoint a psychotherapy tutor to oversee these aspects of training. The tutor should have a CCST in psychotherapy and psychotherapy departments must be active in ensuring supervision of a high standard to trainees.

Effective implementation will require:

1. The appointment of a psychotherapy tutor who would normally be a psychotherapist. The post holder could offer practical advice and support to consultant psychiatrists wishing to acquire new psychotherapeutic skills.
2. Psychological treatment skills to form part of the educational contract.
3. Supervision by appropriately trained psychotherapists in conjunction with other specialist practitioners with whom formal arrangements have been agreed.
4. The use of the College Log book for basic specialist trainees.
5. Mandatory requirement to complete training in the psychotherapies before being awarded the MRCPsych.

Service Delivery

There is general agreement that patients with mental disorders, across a spectrum of severity, should have access to a range of psychological therapies. These should be made available in a manner which ensures equality of access and maintenance of high quality clinical standards, underpinned by regular audit and supervision. In order to achieve this goal it is necessary for the two Faculties to promote models of joint working.

Psychotherapy departments will continue to act as a focus for training and delivery of all forms of psychological therapies. This will ensure the establishment of a core level of clinical expertise and training within the psychotherapy team and will necessitate close partnerships with clinicians involved in the delivery of psychological treatments in other parts of the adult psychiatric service (both in-patient and community). The level of integration between the centralised psychotherapy department and adult mental health

teams will vary depending on local circumstances and should be agreed at all levels of organisation. Several models of partnership present themselves:

- A) **Liaison Model.** The centralised psychotherapy service provides outreach work to a variety of psychiatric teams with particular attention paid to development of reflective practice, clinical supervision, initial assessments, training and consultation. Such departments must work towards a full understanding of the needs of local primary care and specialised mental health teams with a view to developing a responsive and appropriate service.
- B) **Dual Attachment Model.** Staff involved in the delivery of psychological therapies spent part of their time working in a centralised psychotherapy service with the remainder devoted to clinical provision in adult mental health teams. This ensures that psychotherapists are appropriately integrated with the adult teams and understand the local circumstances including existing staff skills and allocation of clinical resources.
- C) **Specialised Team Model.** Specialised mental health teams, such as first onset psychosis, assertive outreach, crisis intervention or in-patient services may employ psychotherapists directly with part of their time devoted to training and supervision on a centralised basis. This model emphasises the need for full integration of all staff within the specialised multidisciplinary team. Retention of centralised supervision and training helps ensure maintenance of psychotherapy standards

The model chosen must ensure ready accessibility to clinical services depending on level of need. Therapeutic resources should be organised in a manner which avoids lengthy waiting lists, thereby preventing unwarranted distortion of clinical priorities. Therefore, it is necessary to engage in a process of prioritisation determined by the levels of available resources and examination of care pathways to ensure that the service model implemented does not inadvertently erect barriers to patient care. Treatment modalities should be chosen on the basis of their known effectiveness (using an evidence based approach), which is agreed at local level between commissioners and providers of mental health services.

Level of resources: The two faculties agree that the level of provision necessary to deliver the above service requires one whole time equivalent consultant psychotherapist for 4 whole time equivalent adult psychiatrists (or one medical psychotherapist for a population of 100,000).

Pathways of care: In each Primary Care Trust, there is a need to provide a wide variety of psychological therapies. Selection of patients for more specialised therapeutic input may take place within primary care or require a more detailed assessment within a secondary care mental health team such as a CMHT or in-patient facility. Either way, staff must be properly trained in the process of assessment and in concepts of risk minimisation. They should possess basic psychotherapeutic skills including the capacity to create good therapeutic alliances with a variety of mental disorders. In order to avoid duplication of

assessment, a centrally organised psychotherapy service should never be seen as a tertiary service as a matter of routine.

It will be necessary for local providers and commissioners of services at all levels to meet and clarify pathways of care for all major and minor psychiatric disorders.

Guidelines for referral to specialised psychological therapy.

The psychiatrist referrer should be knowledgeable and experienced enough to be able to make a full assessment of the suitability of the patient for the proposed psychological therapy. This will necessitate a thorough discussion of the nature of the treatment so that the patient can provide informed consent and play an active role in the process. A detailed referral letter with information on past history, current problems and known risk factors should be provided. Medical responsibility within the various mental health services should be established by local protocol. In this context, it is important to bear in mind the principle that ‘nominal medical responsibility’ has no practical value and may cause confusion in the mind of the patient and other staff groups. Consultant psychiatrists and primary care doctors are expected to assume responsibility only for clinical decisions taken in their name and the referrer must ensure proper communication with colleagues at the point of transfer of medical responsibility. In complex cases, particularly those involving the management of severe personality disorder and joint team working, it will be necessary to clarify issues of medical responsibility for the individual case.

Conclusion

This document addresses a need for a substantive shift in the overall knowledge base, skills and working relationships of adult psychiatrists and medical psychotherapist.

The success of these proposals will depend on good working relationships between members of the two faculties on a daily basis. To this end, the role of the faculty link persons should include responsibility for proactively dealing with specific interface issues as they arise, in addition to acting as conduits for information between the specialties.

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