Leadership and management

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How can psychiatrists offer psychotherapeutic leadership in the public sector?

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Abstract

Objective: This article reviews the forms that psychotherapeutic leadership can take for psychiatrists attempting to optimise outcomes for individuals receiving treatment in the public mental health sector. It explores a range of roles and functions that psychiatrists can take on as psychotherapy leaders, and how these can be applied in clinical, administrative and research contexts.

Conclusions: Psychiatrists need to play an increasing role in clinical, administrative and academic settings to advance service provision, resource allocation, training and research directed at psychotherapies in the public health sector.

Keywords: psychotherapy, leadership, psychiatry, public health

In the public mental health sector, psychiatrists are often confronted by underlying deficiencies in the quality of care. This is reflected in the commonly held view that longitudinal, consistent and psychologically informed care is often lacking for those requiring it; including coordinated, evidence-based psychotherapeutic management. As a result, clinical deterioration, iatrogenic harm and other adverse outcomes are frequently observed.[1]

This article will explore the psychotherapeutic leadership that psychiatrists can offer to counter these problems, and will assert that this leadership is not only desirable but is an essential feature of public health service provision.

Aspects of psychiatric psychotherapy leadership

Psychiatric psychotherapy expertise can reinforce general ideals such as reflective practice, patient-centred care, practitioner self-care, the benefits of supervision, social equity in access to services and the role of psychotherapeutically informed care overcoming difficulties such as iatrogenesis, polypharmacy, excessive medicalisation or excessively biological, 'decontextualised' formulation. Psychiatric psychotherapists give expert advice around boundary issues and violations, countertransference issues and team dynamic problems. These are arguably skills all psychiatrists could and should have. However there may be more refined and sophisticated psychotherapeutic skills and insights that a psychiatric psychotherapy expert can offer. These relate to advanced administrative, research or supervision skills, more extensive clinical experience, or higher level training in a certain specialised modality of psychotherapy.

As such, there is a spectrum of psychotherapy competencies among psychiatrists and trainees, from basic trainee, to advanced trainee to general fellow to subspecialist expert. Nevertheless, at all of these levels, the psychiatrist, or trainee, may be required to offer leadership regarding psychotherapeutic approaches.

Psychiatrists as leaders engaging with other psychotherapists

One dilemma relates to boundaries of inclusion and exclusion: can psychiatric psychotherapy experts relate well to and influence other professional disciplines that constitute the majority of psychotherapy practitioners

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in the public sector (e.g. psychologists, nurses, social workers, non-governmental organisation workers, GPs)? Often psychiatrists are perceived by these groups as ill equipped to provide psychotherapy, or are seen to deprioritise or be disinterested in psychotherapy treatments. Yet, community, legal, health service and often patient expectations are that the psychiatrist assumes a principal role in conceptualising and contextualising the role of psychotherapy treatments, as well as in applying them. As such, it could be seen that all psychiatrists are expected to offer psychotherapeutic leadership by overseeing or guiding psychotherapy treatments offered by other therapists, offering psychotherapy themselves to complex patients when first-line therapy is not progressing, or when the problems presented by the patient frustrate all other therapeutic professionals.

One example of this type of leadership has been demonstrated when Australian psychiatrists have led inspirational work in the field of infant mental health and perinatal psychiatry, developing and overseeing programmes to intervene early in attachment difficulties and emerging mood and anxiety problems; work that has become increasingly widespread, encompassing population level perinatal interventions such as universal home visiting programmes,[2] through to tertiary programmes such as those offered by Helen Mayo House in South Australia. Psychiatrists have also been involved in postgraduate training in this field. Their role in these programmes has been to embed, guide and oversee psychotherapeutically informed service provision.

Psychiatrists can also play a similar role in psychotherapeutically informed systemic care for high-risk families. High-risk families with older children (3–12 years) caught in intergenerational cycles of neglect and abuse pose challenges for the mental health system and the child protection system alike. Working effectively with these families requires skills in trauma focused work and work with attachment and relationship dynamics. One local initiative in South Australia has seen a university–clinical partnership develop to explore an experimental model of service delivery for these families called parallel parent and child therapy.[3–5] The introduction and development of the therapy in the child and adolescent mental health service has not only provided treatment for families for whom little else was available but supported clinicians in developing a range of skills in relationship-based, trauma focused therapy, highlighting the usefulness of specialised research in community mental health teams.

Psychiatrists as leaders in applying specialised psychotherapies in the public sector

Psychotherapies are often perceived to be too specialised, 'high end', hard to train and apply. Conversely, if psychotherapies are applied and adapted, they can be seen to be too easily diluted or bastardised from their more pure, manualised, evidence-based form. Leading on from this are questions about the optimal manner in which specialised psychotherapies can be applied, informed or translated in a pragmatic way in the public sector, paying attention to quality, as defined by research-based outcomes. Questions remain as to whether these applications should occur in local, innovative centres of excellence or universal, systematised approaches involving regional or national guidelines and pathways that are uniformly adhered to.

These issues are well demonstrated in the domain of public service provision to individuals suffering borderline personality disorder. In Australia in the past decade, this clinical domain has been increasingly emphasised, including recently published National Health and Medical Research Council (NHMRC) guidelines, and federal and state government policies,[6] but there continues to be great difficulty in achieving universal and systematised services for this clinical population. The fundamental issue relates to the resource-rich nature of quality evidence-based care, which needs to be phase specific, multimodal, individually tailored, multisite, with the longer term and relatively intensive involvement of dedicated psychotherapists (e.g. NHMRC and National Institute for Health and Care Excellence guidelines). All of these factors make this domain of service provision especially challenging in the public sector.

Certain regions and leaders have developed psychiatrist-led centres of excellence with local and national impacts in training, research and limited service provision, for example: the Westmead Psychotherapy Unit has produced quality training and research in the conversational model of psychotherapy, offering local services and establishing a growing network of expert practitioners;[7] Spectrum in Victoria is a state-wide, government sponsored 'hub and spoke' model delivering limited services and wider education, training and consultation;[8] and the Hype Service at Orygen, the youth national centre of excellence, directs its training and research agenda towards models of care for youth borderline problems, with further consultative and training input and service input via headspace centres.[9] Another service, Project Air, has attempted to instill therapeutic principles into generalist public mental health service provision without a dedicated or comprehensive specialised clinical service.[10] These centres, in different ways, address issues of training, research, consultation and service provision in innovative ways in comparison to the majority of regions that subsist with a few isolated practitioners or interest groups, some isolated dialectical behaviour therapy services, but no coordinated regional approach. In some regions, such centres only exist as an aspiration.[11]

Psychiatrists, in this context, with expert psychotherapeutic, research and administrative skills can potentially further advance the field through such models, exploring their broader application to form state-wide and even national initiatives, further collaborations with international centres of excellence (for example the

Personality Disorders Institute, New York, USA; the Anna Freud Centre, University College London; or Professor Marsha Linehan's Behavioral Tech).

Psychiatrists as leaders in treating high prevalence disorders

High prevalence disorders include depression, anxiety disorders and, arguably, substance use disorders. Systematic reviews conclude that therapies such as those loosely falling under the rubric of cognitive behavioural therapy (CBT) and interpersonal therapy should underpin the treatment of major depression and CBT is the first choice for the anxiety disorders.[12] Because of the frequency at which these disorders present, public sector mental health services in Australia often deflect them, unless they are severe or associated with risk. Broader national approaches that have sought to improve access to psychotherapy, such as the Better Access programmes, have yielded equivocal results with criticisms of inequity of access and treatment fidelity issues.[13,14]

Patients who do not respond, who are not going to respond or who want CBT for symptoms that are actually trait related, defeat many that offer only one model of therapy. Psychiatrists lead through adopting a broader perspective, helping other practitioners to formulate, and by considering other diagnoses that confound enthusiastic application of first-line evidence-based therapies. The National Review of Mental Health Programmes and Services recommends significant reform in our system in which a new model in 'stepped care' is implemented. Less severe problems are dealt with by less trained, less intense therapies with safeguards and supervision, and the ability to move the patient on to a more intense treatment if needed. Low intensity psychological interventions have demonstrated benefit in the UK[15] and beyondblue's NewAccess programme, a multi-site Australian adaption, having undergone 4 years of development, application in a demonstration site and economic evaluation, is proving very hopeful indeed for Australian settings. Psychiatrists have had the privileged position granted by leadership and oversight to identify places for such new models of care. Another example is in the IAPT@Flinders[16] where low intensity CBT has been customised to acute mental health presentations.

Conclusions

Psychotherapeutic psychiatrists can offer leadership in the public system through academic (training, research), clinical (general and specialised) and administrative or managerial roles; advocating for high quality service provision (specialised psychotherapies and broader services infused with psychotherapeutic principles). As we know, it is exceptional to find dedicated, psychiatry-led specialist psychotherapy programmes in the public sector, or psychotherapy research in medical departments although we have disorders in which psychotherapy is a primary modality of treatment. This really places psychiatrists at the centre of an imperative to advance psychotherapy further in public service provision and university sector research, and some promising examples of this have been described. Further advancing this would arguably address issues such as concerns that training psychiatrists who work exclusively in the public health system do not have enough training and supervision in longitudinal, psychotherapeutic forms of management.[17] It could also improve connectedness with private sector practitioners and services that offer psychological treatments. Most importantly, though, it would further address the neglect of and inadequate service provision to many groups of patients, often the most unwell and socially disadvantaged.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

References

1. Harvey A and Gumport N. Evidence-based psychological treatments for mental disorders: modifiable barriers to access and possible solutions. *Behav Res Ther* 2015; 68: 1–12.
2. Government of South Australia. *CYWHS Family home visiting service outline*, 2005. http://www.cyh.com/library/CYWHS_FHV_Service_Outline.pdf.
3. Chambers H, Amos J, Allison S, et al. Parent and child therapy: an attachment-based intervention for children with challenging problems. *Aust N Z J Family Ther* 2007; 27: 68–74.
4. Amos J, Segal L and Furber G. Understanding maltreating mothers; a synthesis of relational trauma, attachment disorganisation, structural dissociation of the personality and experiential avoidance. *J Trauma Dissoc* 2011; 12: 495–509.
5. Furber G, Segal L, Amos J, et al. Outcomes of therapy in high risk mother–child dyads in which there is active maltreatment and severely disturbed child behaviors. *J Infant, Child, Adolesc Psychother* 2013; 12: 84–99.
6. National Health and Medical Research Council. *Clinical Practice Guideline for the Management of Borderline Personality Disorder*. Canberra: NHMRC, 2012.
7. Meares R. The conversational model: an outline. *Am J Psychother* 2004; 51–65.
8. Beatson J and Rao S. Psychotherapy for borderline personality disorder. *Australas Psychiatry* 2014; 22: 529–532.
9. Chanen A, McCutcheon L, Germano D, et al. The HYPE Clinic: an early intervention service for borderline personality disorder. *J Psychiatr Pract* 2009; 15: 163–172.
10. Grenyer B. Improved prognosis for borderline personality disorder: new treatment guidelines outline specific communication strategies that work. *Med J Aust* 2013; 198: 464–465.
11. Kent M, Cammell P and McMahon J. *Borderline Personality Disorder: An Overview of Current Delivery of Borderline Personality Disorder Services in the Public Sector across South Australia and a Proposed Way Forward*. Government of South Australia (SA Health), 2012.
12. National Collaborating Centre for Mental Health. *Social Anxiety Disorder: Recognition, Assessment and Treatment*. National Clinical Guideline number 159. London: NCCMH, 2013.
13. Meadows G, Enticott J, Inder B, et al. Better access to mental health care and the failure of the Medicare principle of universality. *Med J Aust* 2015; 202: 190–194.
14. Jorm A. Australia's better access initiative: do the evaluation data support the critics? *Aust N Z J Psychiatry* 2011; 45: 726–739.
15. Clark DM, Layard R, Smithies R, et al. Improving access to psychological therapy: initial evaluation of two UK demonstration sites. *Behav Res Ther* 2009; 47: 910–920.
16. Bastiampillai T, Jones GM, Furber G, et al. The IAPT@Flinders Service: adapting the improving access to psychological therapies model to the emergency department setting in Australia. *Australas Psychiatry* 2014; 22: 277–280.
17. Weissman M, Verdeli H, Gameroff M, et al. National survey of psychotherapy training in psychiatry, psychology, and social work. *Arch Gen Psychiatry* 2006; 63: 925–934.