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therapies) has been recognised in recent work on therapist competencies (Bennett & Parry, 2004) and future studies will also benefit from assessment of trainees' developing competencies independent of measurement of clinical outcomes.

In practice, trainees may acquire experience in integrative therapies such as CAT under the SHO guidelines in several ways and these will vary in their demands. Our findings suggest that training experiences that pay most attention to common, transferable psychotherapy skills, such as the BPT described here, are best provided before work with more derivative models is undertaken.

Declaration of interest

None.

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CERI EVANS AND PAUL REYNOLDS

Survey of the provision of psychological therapies for older people

AIMS AND METHOD

The aim of the present study was to assess the current state of provision of psychological therapies for older people in Wales. A postal questionnaire was sent to all consultant old age psychiatrists in Wales, requesting information regarding the consultant's community mental health team (CMHT) and access to psychological therapies.

RESULTS

A response rate of 85% was achieved: 45% of CMHTs had team members providing psychological therapy; 31% of CMHTs had access to psychological therapy via the team and also generic services. The estimated average wait for generic services was 29 weeks. There was no access to psychological therapies for 17% of CMHTs.

CLINICAL IMPLICATIONS

In some areas of Wales there is limited or no access to psychological therapies via mental health services for older people. This may represent an important unmet need. Long-term strategies, taking into account recruitment and retention, training and new ways of working, need to be implemented.

Psychological therapies are the first-line treatment of choice for a number of psychiatric disorders and are useful adjuncts to pharmacotherapy. The evidence base is growing and this includes effectiveness data for older people, with a recent report concluding that a 'patient's age... should not determine access to therapies' (Department of Health, 2002). Surveys have shown that older people want greater access to 'talking therapies' (Evans, 2000) and there is increasing emphasis on this treatment modality in the National Institute for Clinical Excellence (NICE) clinical management guidelines for depression (NICE, 2004a), anxiety (NICE, 2004b) and schizophrenia (NICE, 2002).

It is therefore clear that mental health services for older people need to be able to provide psychological therapies as a front-line treatment. Murphy's (2000) survey of UK psychotherapy departments revealed that only 13% of respondents felt that the needs of older persons in their catchment area were being met. Benbow & Turner (2000) pointed out that Murphy's study did not address the provision of psychological therapies within old age psychiatry departments. Evans (2004) addressed this issue by surveying old age psychiatrists in the UK and found that anxiety management was widely available (95% of mental health teams) as was cognitive-behavioural therapy (CBT; 76% of teams).

**Table 1. Psychological therapies available via community mental health teams**

Number ¹	Practitioner	Therapy 1	Therapy 2 (if applicable)
4	Psychologist	CBT	
3	CPN	CBT	
2	Psychologist	CBT	Brief solution-based
2	Psychologist	CBT	Systemic psychotherapy
1	Psychologist	CBT	CAT
1	Psychologist	CBT	Integrative psychotherapy
1	Psychologist	Group CBT	
1	CPN	CBT	Psychodynamic psychotherapy
1	Psychologist	CBT	Systemic family therapy
1	Consultant psychiatrist	Supportive	
1	Consultant psychiatrist	CBT	Psychodynamic psychotherapy

CPN, community psychiatric nurse; CBT, cognitive-behavioural therapy; CAT, cognitive-analytic therapy.

1. Total=18.

Table 2. Availability of psychological therapies via CMHTs or generic services

	Therapies available via CMHT <i>n</i> (%)	Therapies not available via CMHT <i>n</i> (%)	Total <i>n</i> (%)
Generic services available	9 (31)	11 (38)	20 (69)
Generic services not available	4 (14)	5 (17)	9 (31)
Total	13 (45)	16 (55)	29 (100)

CMHT, community mental health team.

However, Evans' (2004) survey may not accurately represent the level of provision in Wales, which has relatively few old age psychiatrists compared with the rest of the UK. In addition, Wales now has its own mental health policy and National Service Framework necessitating surveys of current resources and practice at a Welsh national level.

The aim of the present study was to assess the current state of provision of psychological therapies for older people in Wales. Specifically, we were interested in what was being provided directly by multidisciplinary staff of the community mental health team (CMHT), as well as what was available from generic psychology and psychotherapy services.

Method

A postal questionnaire and a post-paid reply envelope were sent to all consultant old age psychiatrists in Wales. Names and addresses were obtained by contacting the relevant National Health Service (NHS) trusts. The questionnaire requested information regarding the nature of the catchment area; details of any CMHT members practising psychological therapies, qualifications and approximate case-load; details of local specialist psychology and/or psychotherapy services and waiting list time. There was also a space for general comments, such as how they would like psychological therapy services for

older people to develop. A reminder letter was sent to non-respondents after 6 weeks.

Results

Of 34 questionnaires sent, 29 were returned – a response rate of 85% – with all NHS mental health trusts in Wales represented at least once. The average catchment area size was 14 090 (range 7000–28 500). The majority (48%) of catchment areas were mixed urban/rural; 3% were suburban; 21% were urban and 21% were rural; 7% did not specify.

Of 29 CMHTs, 13 (45%) had at least one team member offering a form of psychological therapy. Of these CMHTs, every one had at least one psychologist practising CBT. The psychologist often practised other types of therapy as well (Table 1). Four CMHTs had community psychiatric nurses practising CBT (one of whom also practised psychodynamic psychotherapy). Two CMHTs had consultants practising psychotherapy (one CBT and psychodynamic psychotherapy and one supportive psychotherapy). One other consultant was undergoing training in cognitive-analytic therapy (CAT). Where figures were available, psychologists had seen on average 12 clients for psychological therapy in the last 6 months, and community psychiatric nurses had seen on average 6 over 6 months.

Of the 29 CMHTs, 9 (31%) had psychological therapy available via the team and also had access to generic

original
papers

psychotherapy or psychology services. The average waiting time for these services was 29 weeks (range 4–64). The therapies available were CBT, psychodynamic psychotherapy, integrative psychotherapy and CAT.

Of the 29 CMHTs, 11 (38%) had access to psychological therapies only via generic services. The waiting time was on average 23 weeks (range 8–38). The therapies available were CBT, family therapy and CAT. Two CMHTs stated that they had 'very limited access' and 'no new referrals' accepted.

Of the 29 CMHTs with no team members practising psychotherapy, 5 also stated that they had no access to generic psychotherapy or psychology services; that is, 17% of all CMHTs for older people in Wales had no access to psychological therapies for their clients (Table 2).

Analysis of the general comments sections of the questionnaires revealed that the most frequently made comment indicated the need to recruit more staff trained to provide psychological therapies. The majority of comments emphasised dissatisfaction with the current quality of the psychological therapy services available and suggested that existing staff should have opportunities to train in this specialty. A less frequent comment was that psychological therapies for older people were not seen as a priority within the mental health services. However, one consultant commented that they were satisfied with the availability of psychological therapies.

Discussion

This study shows that in some areas of Wales there is limited or no access to psychological therapies via mental health services for older people. More than one in six CMHTs for older people in Wales have no access to psychological therapies whatsoever. Unless the need for psychological therapy in the geographical areas covered by these CMHTs is being met by primary care or by voluntary services, this may represent a significant unmet need. Psychological therapies are being provided from within individual CMHTs – mainly by psychologists, but also by community psychiatric nurses. A very small minority of consultant old age psychiatrists in Wales provide psychological therapy. Cognitive-behavioural therapy is the most widely available psychological therapy, and the availability of other approaches, such as CAT, systemic and psychodynamic psychotherapy, is limited. Where generic psychotherapy and psychology services are available for older adults, the average waiting time approaches 6 months.

Psychological therapies are an important treatment option that are effective for many psychiatric disorders. This is true irrespective of the age of the client group. The proportion of the population aged 65 or over is increasing and a parallel increase in demand for psychotherapy is likely. Publication of the NICE guidelines on the treatment of anxiety (NICE, 2004b) and depression (NICE, 2004a) is likely to increase public awareness of psychotherapy, and particularly CBT, and recent adverse publicity and concerns regarding selective serotonin reuptake inhibitors (e.g. Bosley, 2004; Hope,

2004) may make non-pharmacological treatments appear more attractive to service users.

In addition, future generations of older people may be more psychologically aware, and have different expectations from mental health services. This may lead them to seek the appropriate psychological treatments, rather than medications, for their problems, thus increasing demand further.

If psychological therapies are to be provided as first-line treatment for certain disorders and as an important alternative or adjunct for other disorders, clearly the situation in Wales needs to improve. The recruitment and retention of staff is a key issue and this has been highlighted in the National Service Framework for adult mental health in Wales (Welsh Assembly Government, 2002). There is an obvious need for more mental health workers to provide a wide range of interventions, including psychological therapies. The National Service Framework states that all staff should be supported and provided with dedicated time and resources to develop skills that could include psychological therapies.

Another key issue is entrenchment in traditional roles by members of the CMHTs. It is important to devise new and more flexible ways of working for psychiatrists and other multidisciplinary staff (Department of Health, 2004). Although some skills are unique to staff groups, others (such as psychological therapies) can be shared across several groups. However, staff will require dedicated time and resources for continuing professional development.

In essence, as well as recruiting new staff, existing CMHT members of all disciplines need opportunities to develop skills and qualifications in psychological therapy. This sentiment is echoed in the general comments made on the questionnaires. The Royal College of Psychiatrists (2004) has increased the emphasis on training in psychological therapy as part of the basic specialist psychiatric training. Trainees are required to complete a minimum number of psychological therapy cases before they can apply for the MRCPsych Part II examination. This may have the effect of inspiring trainees to develop these skills further and the 'special interest' sessions at specialist registrar level are an excellent opportunity to do so. Specialist registrars should be encouraged to pursue psychological therapy qualifications and funding should be made available.

This survey has focused on the provision of psychological therapies at the secondary care level. Increasingly psychological interventions are being offered at the primary care level. It is the norm for general practices to employ a counsellor, and CBT practitioners are often available. This may be particularly valuable in rural areas. As these types of services develop, the burden on the corresponding local community mental health services for older people as well as generic psychological therapy services will be reduced.

Declaration of interest

None.



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RICHARD LAW-MIN AND JOHN PATRICK STEPHENS

Capacity, compliance and electroconvulsive therapy (ECT): the practice of ECT among consultant psychiatrists

AIMS AND METHOD

The aim of this study was to seek the views of consultant psychiatrists on the legal framework they would use when considering treatment with electroconvulsive therapy (ECT). A questionnaire, consisting of three clinical vignettes, was sent to 70 consultants in the Wessex rotation (East Dorset/Hampshire region).

RESULTS

A total of 56 questionnaires were returned; a response rate of 80%.

Despite good evidence of efficacy in depressive disorders (UK ECT Review Group, 2003), electroconvulsive therapy (ECT) remains controversial (Rose *et al*, 2003). This is highlighted in the NICE guidance (National Institute for Clinical Excellence, 2003). The use of ECT in incapacitated patients is probably an even more contentious issue. It is reported that the practice of detaining mentally incapable

Most consultant psychiatrists agree when giving ECT to incapacitated and non-consenting patients. However, there was a lack of consensus when dealing with seemingly incapacitated but compliant patients.

CLINICAL IMPLICATIONS

More clarification in this area is needed. Trusts can assist clinicians by devising their own policies based on nationally agreed standards of best practice. The treatment of mentally

incapacitated but compliant patients is an area of practice where uncertainty exists. If proceeding under common law in such cases, it is good practice to discuss with relatives/carers and obtain a second opinion from a consultant colleague. The most recent Bournemouth judgement and the new Mental Health Bill will have further implications for clinical practice.

and compliant patients for treatment of their mental disorder is widespread (Jones, 2004). Many clinicians may choose statutory rather than common law because of a

Vignette 1

A 30-year-old lady with resistant depression was admitted informally because of a high suicide risk. In the past, she has made several suicide attempts and has ended up on the intensive care unit after a serious overdose. Various pharmacological treatments have all been ineffective so far, but she has responded well to ECT previously. You judge that ECT is the only realistic option. She understands your rationale for recommending ECT but nevertheless refuses to have it.

Vignette 2

A 68-year-old man was admitted informally following the death of his wife 2 months ago. He has become severely depressed and withdrawn, with significant weight loss. He is barely communicative, refusing to eat or drink and take his antidepressant despite encouragement from staff. You have decided to proceed with ECT as you consider his condition to be critical. The next-of-kin is in agreement with the treatment plan. He does not appear to object to a pre-ECT work-up, i.e. he has allowed staff to take his blood, has had an ECG and a chest X-ray. He appears to passively accept whatever treatment is proposed. However, you believe that despite discussions, he does not understand what ECT really entails.