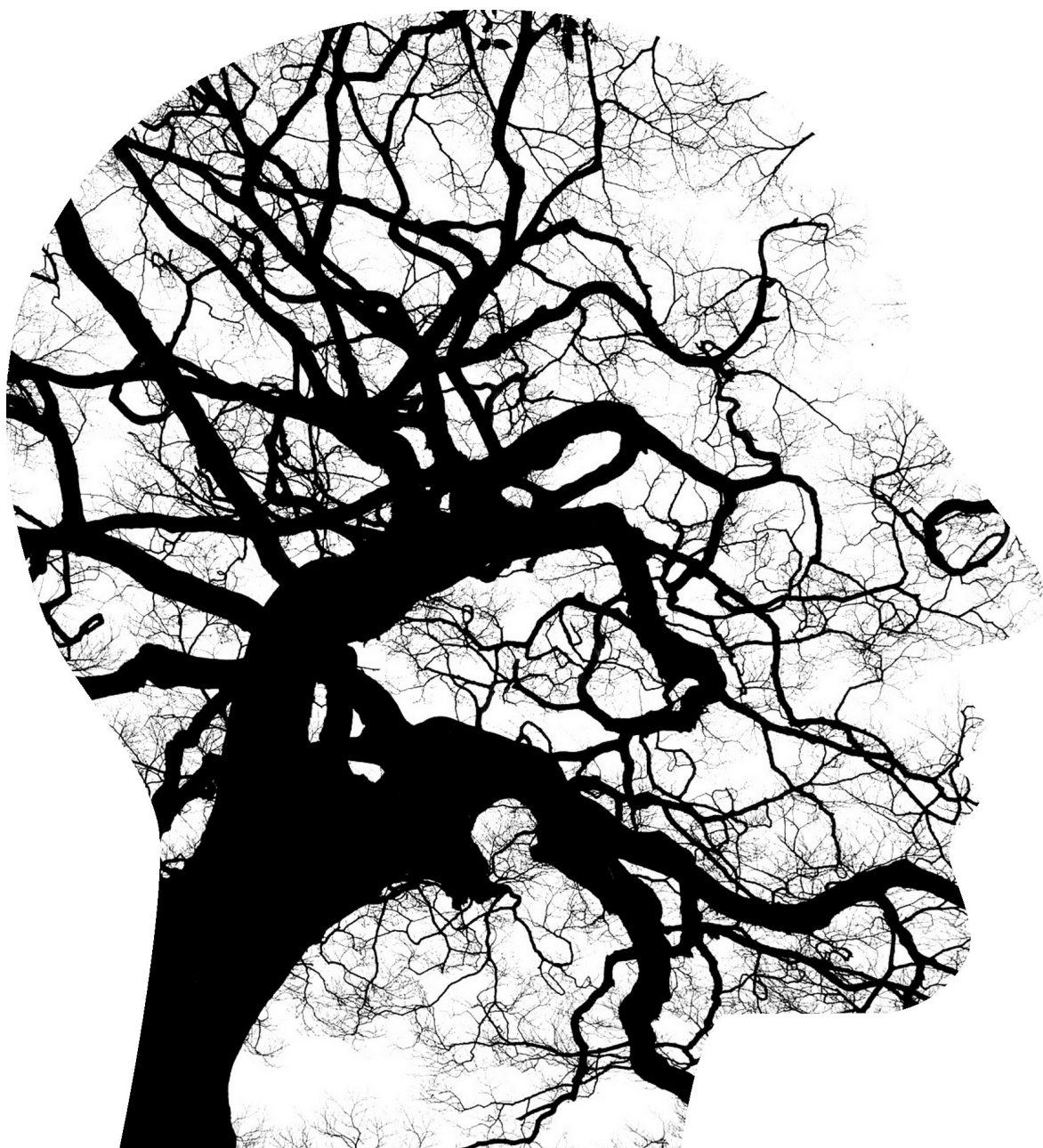


RCPsych

Psychotherapy survey

2018 training report on 2016 survey data



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| Authors

Dr William Burbridge-James, Chair of the Medical Psychotherapy Specialty Advisory Committee

Mr Adrian Husbands, Research Consultant

Foreword

“

It was Sigmund Freud who wrote ‘Being entirely honest with oneself is a good exercise’. In this extensive review of psychotherapy training for psychiatrists in the UK, the authors have left no stone unturned in holding a reflective mirror up to our training schemes. The therapeutic alliance forms the cornerstone of our practice as psychiatrists. Providing a successful educational environment in which to develop well trained, skilled and thoughtful practitioners able to work in a psychotherapeutically-informed way is the responsibility of us all. There is much in this report to be celebrated and we should take heart that in psychiatry across the UK, we have largely established a strong training foundation on which to build excellence. It will be important for us to avoid complacency in an ever-changing NHS that is under pressure, and we should remain vigilant to any threats to dilute psychotherapy training. This report highlights practical areas for widening training opportunities. Its findings will be of interest to trainees, trainers and educational commissioners.

”

Kate P. Lovett

Dr Kate Lovett
Dean, RCPSych

January 2018

Executive summary

Introduction

Psychotherapeutically-trained psychiatrists have a pivotal role in meeting society's demand for high quality mental health care. Their enhanced reflective capacity can increase the effectiveness of psychiatric interventions, enabling them to manage a patient's therapeutic journey skilfully, thereby reducing pressures on the NHS.

Achieving this requires high quality psychotherapy training which is embedded in the curricula for core and higher training in psychiatry.

The College therefore conducts routine quality assurance audits of psychotherapy training to identify challenges to effective training delivery and promote solutions. We conducted our first psychotherapy survey in 2012. It was well received, and the GMC requested a follow-up survey.

We were interested in three main areas for 2016's survey: core psychotherapy training, specialist medical psychotherapy training, and higher specialty psychiatric training.

Method and demographics

We distributed the survey between January and June 2016, with good representation from training schemes across the UK. Of the 46 training schemes, 41 (89%) responded. Psychotherapy tutors were the largest respondent group (48%), followed by 'other' (21%), training programme directors (17%), and 'both TPD and psychotherapy tutor' (14%).

Results

Core psychotherapy training

- The numbers of core psychiatry trainees in 2013–14, 2014–15, and the number of short cases (12 sessions or more) and long cases (20 sessions or more) that had been seen, or were being seen, were broadly in line with the College's estimated figures. We were therefore confident that the survey's findings were generalisable.

- Out of a national total of around 1600, an estimated 22 core trainees were unlikely to complete their psychotherapy training competencies by 2016's final Annual Review of Competence Progress (ARCP). Although the exact non-completion figure was somewhat unclear, the vast majority of core trainees were completing their psychotherapy requirements.
- Challenges to training completion mirrored broader challenges currently faced by the NHS. They included psychotherapy service closures, rotation pressures, and premature therapy termination by patients. Reassuringly, access to supervision was not cited as a challenge.
- Trainees who were unable to achieve their psychotherapy competencies by the end of their core training year 3 (CT3) ARCP were given more time to complete within core training (ARCP Outcome 3). Therefore, deaneries were adhering to quality assurance standards.
- Secondary care psychotherapy services were the main source of psychodynamic long cases, followed by rehabilitation, general mental health services, and Improving Access to Psychological Therapies (IAPT) services for CBT short cases. Tutors adapted to the health service's changes by developing innovative patient pathways for training cases.
- Almost 90% of respondents said psychotherapy tutors held GMC specialist registration with a certificate of completion of training (CCT) in medical psychotherapy or equivalent (certificate of eligibility for specialist registration (CESR)). Within this proportion, almost 80% were fulfilling the role of a consultant psychiatrist in medical psychotherapy in an NHS psychotherapy setting.
- Consultant medical psychotherapists were most involved in trainees' clinical supervision, followed by clinical psychologists and cognitive behavioural therapists.
- While most non-medical professionals were aware of workplace-based assessment (WPBA) tools, less than half were trained in their use (a GMC recommendation from the 2012 survey).

Specialist medical psychotherapy training

- The training programme director (TPD) for medical psychotherapy, psychotherapy tutors, non-medical practitioners, and other professional groups spent an average of one programmed activity (PA), two PAs, 5 hours and 3.5 hours respectively each week providing and overseeing higher medical psychotherapy training.
- Schemes were positive about dual CCT training. It is now the primary delivery mode for higher specialist training. Medical psychotherapy training appears to have been thriving since dual training was introduced.
- Respondents believed weaving medical psychotherapy into the fabric of general psychiatry leads to significant benefits. It ensures the speciality flourishes, improving patient care and trainee employability.
- While most were supportive of dual training programmes, some respondents stated a preference for the single CCT in medical psychotherapy to remain an option. Both the single and dual CCT can coexist within psychiatry.
- As with core training, consultant psychiatrists in medical psychotherapy play the predominant role in delivering higher medical psychotherapy training. After medical psychotherapists, psychoanalysts and psychodynamic psychotherapists were most involved with teaching, clinical supervision and assessment of patients. Non-medical practitioners appeared well integrated in training delivery.

Higher specialty psychiatry training in psychotherapy

- General adult, child and adolescent, and old age psychiatry had the highest proportions of advanced trainees. Almost three times more trainees were in Balint/case-based discussion (CBD) groups, than were seeing short or long therapy cases.
- Consultant medical psychotherapists were most likely to deliver psychotherapy training to advanced/higher specialty trainees, followed by clinical psychologists, psychoanalysts/psychodynamic psychotherapists and systemic family therapists.
- Leadership, governance and quality assurance for higher specialty psychiatry training in psychotherapy within schemes were primarily conducted by TPDs, consultant psychiatrists in medical psychotherapy, and core training programme tutors.

- On average, psychotherapy tutors committed one to two PAs per week to delivering psychotherapy training. Professional groups spent an average of 3.5 hours providing psychotherapy training experience.
- A significant number of trainees were using special interest time for psychotherapy experiences that should be facilitated by trainers.
- The SAPE (structured assessment of psychotherapy expertise) is the WPBA referred to in higher speciality psychiatric training curricula. It is recommended to assess psychotherapy experiences during higher speciality training. While its widespread use is admirable, it also raises significant questions around the kinds of psychotherapy experience that trainees were undertaking for this assessment.

Recommendations

The College, at a national and regional policy level via deaneries, should do the following:

- 1 Promote awareness of how NHS resource constraints and restructuring are affecting core psychiatric training in psychotherapy. Are NHS commissioners and influential policymakers aware of this?
- 2 Encourage NHS trusts to provide more support for consultant medical psychotherapists so they can continue to provide psychotherapy services and the most appropriate clinical settings for core training.
- 3 Promote awareness of innovative pathways to providing psychotherapy cases across the threshold between primary and secondary care, and develop IAPT services that are commissioned to take into account psychotherapy training needs of psychiatrists.
- 4 Continue to ensure all psychotherapy tutors hold GMC specialist registration with a CCT in medical psychotherapy or equivalent (CESR).
- 5 Continue to ensure multidisciplinary professionals are appropriately involved in delivering training.
- 6 Ensure all non-medical professionals are trained on the assessment tools before they assess trainees.

- 7 Continue to monitor the proportion of non-medical professionals who are trained on using assessment tools.
- 8 Expand dual training programmes in medical psychotherapy with other psychiatric specialities (e.g. intellectual disability and old age).
- 9 Work with the Faculty of Medical Psychotherapy Specialty Advisory Committee to provide guidance on determining what suitable psychotherapy training experiences are for higher specialty psychiatric training, and why both trainees and trainers need to know this. ('Best Practice Guide: Psychotherapy Training in Higher Specialist Psychiatry' was developed and has been available since January 2018.)
- 10 Clearly articulate what role the psychotherapy tutor should be playing in leading psychotherapy training of higher specialty psychiatric trainees. Details of their roles should be included in their job plans.
- 11 Support and nurture higher specialty psychiatric trainees who opt to use special interest time to gain psychotherapy experience.

Conclusion

Trainers and trainees are adapting well, notwithstanding the challenges they have faced due to NHS upheaval. Dual training's positive reception and widespread adoption is an example of this. Its expansion helps medical psychotherapy evolve to complement health service reconfigurations. While higher medical psychotherapy experience appears to be progressing well, we need to work on providing accessible psychotherapy training experiences for higher specialty psychiatric trainees.

We must continue to monitor psychotherapy training to ensure it benefits trainers, trainees and their patients.

Introduction

The health service needs psychologically-attuned psychiatrists to skilfully manage a patient's therapeutic experience. Psychiatrists must balance active listening and unobtrusive compassionate curiosity, while dealing with the uncertainties inherent in doctor–patient communication to foster a therapeutic alliance.

Medical psychotherapy training helps to achieve these aims, with significant benefit to patients. Its biopsychosocial approach increases psychiatrists' capacity to think psychologically about their patients, thereby guiding referrals to psychological therapy, strengthening therapeutic relationships, and helping patient management.¹

Core and specialty psychotherapy training aims to produce psychologically-attuned psychiatrists. We need high quality training to do this. This involves providing the best-suited psychotherapy encounters for trainees within well-resourced training environments. But are we meeting these aims? Are trainees gaining the required psychotherapy competencies?

To this end, the College conducts routine quality assurance audits of psychotherapy training to identify challenges to effective training delivery and promote solutions. The previous audit began with 2012's psychotherapy survey which was the first of its kind. Its main findings were:

- More psychotherapy tutors were needed for effective psychotherapy training.
- Trainees were more likely to achieve their psychotherapy competencies if the psychotherapy tutors were consultant medical psychotherapists (statistically significant: $p < 0.05$).
- The best training schemes for developing psychotherapeutic psychiatrists attracted trainees.
- We need to regularly audit psychotherapy training provision.

Had the quality of training improved since 2012's survey? We conducted the second psychotherapy training audit in early 2016. Its three sections reflect the specific areas of training that we were interested in: core psychotherapy training, specialist medical psychotherapy training, and higher specialty psychiatric training (not surveyed in 2012).

¹ RCPsych (2017). Using Formulation in General Psychiatric Care: Good Practice.

The 2016 survey aimed to answer the following questions:

- 1 Did this survey adequately represent psychotherapy training in the UK?
- 2 Were core trainees achieving their psychotherapy competencies by the end of CT3 ARCP, and what challenges did they face?
- 3 To what extent did consultant medical psychotherapists lead core psychotherapy training?²
- 4 To what extent were multidisciplinary professionals involved in psychotherapy training delivery?
- 5 Who was likely to be leading and taking responsibility for psychotherapy training in higher specialty psychiatric training?
- 6 How much time was allocated to trainers for training?
- 7 To what extent were higher specialty psychiatric schemes following the curriculum's WPBA assessment tool recommendations?
- 8 What were respondents' opinions about the dual and single CCT within the context of medical psychotherapy training?
- 9 What other useful information did this survey reveal?

We hope this report identifies ways to improve psychotherapy training which translate to high quality psychotherapeutic psychiatric practice.

² This requirement was mandated by the GMC following 2012's survey findings: Core training's psychotherapy tutors were required to have a CCT in medical psychotherapy or equivalent.

Method

Dr William Burbridge-James led 2016's psychotherapy survey, assisted by Mr Adrian Husbands, Dr Barbara Wood and Dr Jo O'Reilly. We electronically distributed the survey between January and June 2016 to the following training schemes and larger areas:

North East	North Central and East London
North West	Kent, Surrey and Sussex
Yorkshire and the Humber	South West
East Midlands	Wessex
West Midlands	Thames Valley
East of England	Wales
South London	Scotland
North West London	Northern Ireland

We wanted the most appropriate person(s) within training schemes to complete the survey. We therefore sent it to heads of schools, and asked them to distribute the survey to:

- core training programme directors and psychotherapy tutors for each scheme in the deanery delivering core psychiatry training
- training programme directors for higher specialty psychiatric training schemes
- the medical psychotherapy training programme director for advanced medical psychotherapy training.

Demographics

Response rate

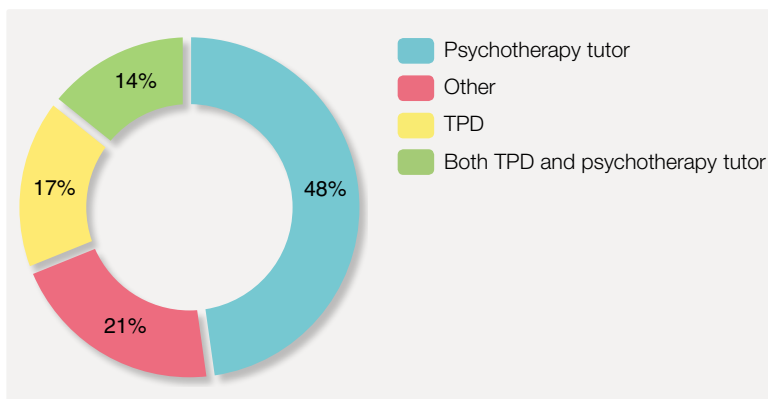
Not all questions were answered, and some responses were unclear. Responses from one person who should not have responded were excluded.

This left us with 58 respondents. They represented 41 of 46 (89%) training schemes. This provided good representation from training schemes across the UK which had slightly increased from 2012's response rate of 83%.

Respondent groups

Psychotherapy tutors were the largest respondent group (48%), followed by 'other' (21%), training programme directors (17%), and 'both TPD and psychotherapy tutor' (14%).

Figure 1: Respondent groups



We were disappointed by the underrepresentation of training programme directors for higher specialty psychiatric training. However, it was evident that the survey's respondents were invested in psychotherapy training. Responses from psychotherapy tutors suggested they were acutely aware of psychotherapy training and its delivery to specialty/higher psychiatric trainees. We were therefore confident that results adequately represented the current psychotherapy training landscape.

Other roles

Respondents represented the following 'other' roles:

- Acting psychotherapy tutor
- Consultant clinical psychologist in psychotherapy in a service without medical psychotherapist, who led psychotherapy experience for junior doctors
- Consultant psychiatrist in psychotherapy and director of medical education
- Current psychotherapy tutor and former TPD
- Director of medical education
- Head of school
- Local TPD (although not formally)
- Medical psychotherapy trainer
- Psychoanalytic tutor
- Psychotherapy coordinator
- Psychotherapy tutor and educational supervisor for ST4-6 in psychotherapy
- Psychotherapy tutor/coordinator
- Supervisor of trainees and Balint group facilitator.

We were satisfied that a wide range of professional groups responded, including a head of school, and training programme directors from core and higher specialty training. Other descriptions probably reflected respondents' desires to describe their roles as accurately as possible.

Core psychotherapy training

Introduction

Core psychiatry training is the first stage of speciality training. The College expects its curriculum to provide a solid platform for specialty training. We wanted to know how well the psychotherapy training aspect was being delivered. Could it be improved?

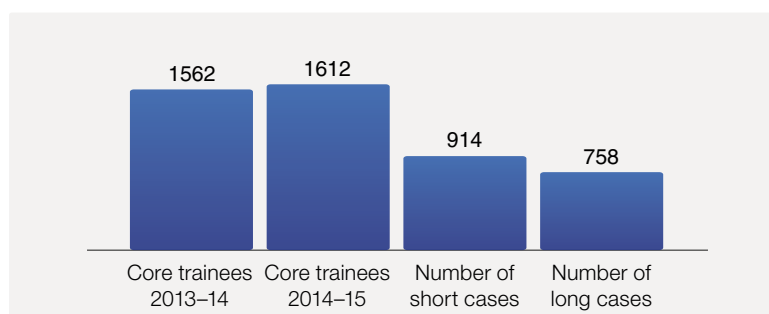
The first step was to verify that the survey's responses were representative of the national picture in medical psychotherapy. We were able to conclude that results were generalisable if the reported number of core trainees was similar to officially-held records.

We then invited responses regarding challenges to training completion, psychotherapy case settings, and training delivery roles. We also asked for general comments on training effectiveness.

Trainee audit

Schemes provided figures for the number of core psychiatry trainees in 2013–14, 2014–15, and the number of trainees who were seeing or had completed therapy in short and long cases (Figure 2).

Figure 2: Number of core trainees



The figures were broadly in line with official College estimates. However, the combined total of long and short cases was slightly more than the given total. This could be because some trainees were seeing both short and long cases. We were therefore confident that we could extrapolate the survey's findings to the national population of core psychiatry trainees.

Training completion and challenges

Background

Psychotherapeutically-trained psychiatrists have a pivotal role in meeting society's demand for high quality mental health care. Their enhanced reflective capacity can increase the effectiveness of psychiatric interventions, thereby reducing pressures on the NHS.

Ideally, all trainees would complete their psychotherapy curriculum training requirements by the end of year 3's (CT3) Annual Review of Competence Progression (ARCP). However, some trainees start the programme but cannot finish it. One estimate suggests 40% of core trainees don't progress to higher training³. We were keen to know if, and to what extent, the psychotherapy training requirements may be contributing to this drop-out rate.

We accept that some trainees are likely to fail for various reasons. This is inevitable. However, local education providers and their NHS mental health trusts should strive to mitigate this loss. We therefore aimed to identify barriers to trainees achieving core psychiatry psychotherapy competencies and advancing in training, as well as ways to help trainees achieve these competencies.

Non-completion rates

Twenty-five respondents (43%) reported that 35 trainees failed to complete their psychotherapy training by the end of their core training, making an average of 1.4 failing trainees per respondent.

In contrast, 16 respondents (27%) anticipated one or more trainees would be unable to complete by final ARCP at the time of the survey. A tentative comparison therefore would suggest that 22 trainees (16×1.4) would have been unlikely to complete by 2016's final ARCP.

These results indicate there were fewer failing trainees in 2016 compared to those found in 2012's survey. However, the numbers were unclear.

³ Health Education England (2017). Stepping Forward to 2020/21: The Mental Health Workforce Plan for England.

Challenges to completing training

Trainees achieving core psychotherapy competencies should leave feeling enriched and rewarded by the experience. They should not see achieving the competencies as an added barrier to training completion, or a burden. Core trainees therefore need the right support along this path. What roadblocks might be in the way? Were trainers well placed to support core trainees?

Respondents identified key challenges to psychotherapy training completion by CT3 – for both trainers and trainees – as shown in Table 1 below.

Table 1: Challenges to training completion	
For trainers	For trainees
<ul style="list-style-type: none">• Service restrictions• Reconfigurations• Secondary care psychotherapy service closures	<ul style="list-style-type: none">• Rotation pressures• Difficult shift rotas• Premature therapy termination by patients

Notably, respondents did not say access to supervision was a challenge. This suggests trainees obtained the appropriate supervision, despite the pressures on the health service. Also, not meeting competencies sometimes reflected more global training difficulties. These trainees were often released from the training programme (ARCP Outcome 4).

Dealing with non-completion

How did schemes handle trainees who were unable to achieve their psychotherapy competencies by their end-of-CT3 ARCP? Responses suggest schemes were flexible by giving trainees more time within core training (ARCP Outcome 3). Crucially, therefore, schemes did not lower the curriculum's requirements or quality assurance standards to accommodate trainees who were unable to complete in time.

Responses indicated the following:

- Schools of psychiatry and deaneries were clear with local education providers about the potential consequences for not delivering the specified psychotherapy training experiences: they would lose their training status.
- Some trainees couldn't complete their psychotherapy training by the end of CT3. ARCP panels extended the time for training, awarding Outcome 3 to these trainees.

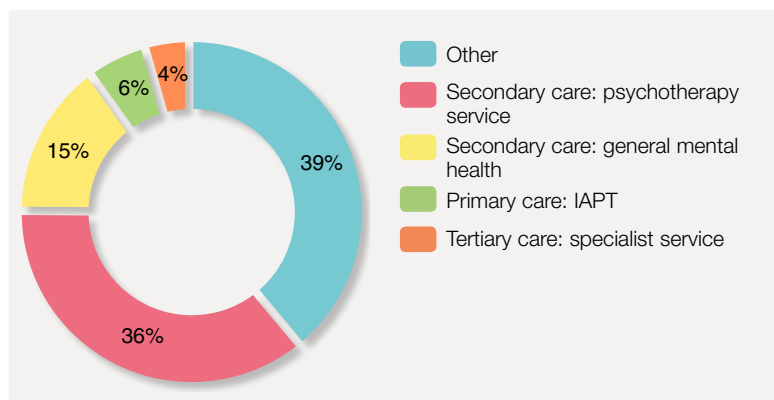
- Trainees who needed to:
 - (a) meet the required number of sessions (usually for their long case), and
 - (b) undertake their summative Psychotherapy Assessment of Clinical Expertise (PACE), were allowed more weeks following the June ARCP. This date falls before the end of the training post at the beginning of August.

Psychotherapy case settings

IAPT stands for Improving Access to Psychological Therapies. IAPT services are NHS-commissioned initiatives designed to offer short-term psychological therapies (mainly CBT) to people suffering from anxiety, depression and stress. First introduced in 2008, IAPT marked a significant investment and subsequent shift in psychological therapy service provision to primary care.

We therefore wanted to understand how IAPT's introduction contributed to schemes' ability to provide psychotherapy cases. From which settings were core trainees provided psychotherapy cases? Respondents painted a mixed picture (Figure 3).

Figure 3: Proportions of psychotherapy case settings



Secondary care psychotherapy services were the main source of psychodynamic long cases, followed by general mental health and rehabilitation services, and IAPT services for CBT short cases.

Combinations of sources of referrals were represented in 'other'. They mostly comprised three settings: IAPT, general mental health, and psychotherapy services.

Free text responses also showed how tutors were adapting to the health service's changes. They developed innovative patient pathways for training cases. For example, in one area, IAPT patients were directed to a 'training clinic' located in the psychotherapy service and

headed by medical psychotherapists within a secondary care setting. Trainees were immediately matched to patients according to trainee experience, mode of psychotherapy and clinical complexity. This bypassed the typically lengthy referral pathway for secondary care.

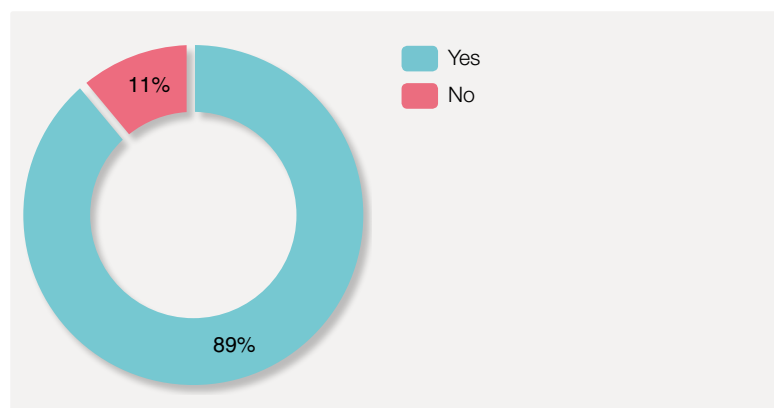
Respondents reported that psychotherapy service closures and workforce reductions also affected schemes' ability to provide training cases. Respondents believed NHS commissioners did not fully appreciate how important psychotherapy services were to patient care. They were concerned about this gap in understanding, and its negative impact on future psychiatric training.

Psychotherapy tutor roles

As previously mentioned, 2012's survey found the curriculum was more likely to be fulfilled if the psychotherapy tutor was a consultant psychiatrist with a CCT in medical psychotherapy. This key finding prompted the GMC's new mandate in 2015 that all psychotherapy tutors must be consultant medical psychotherapists. This rule accompanied a two-year grace period. We wanted to know if schemes were fulfilling this new GMC requirement.

Did the 2016 survey's psychotherapy tutors hold GMC specialist registration with a CCT in medical psychotherapy or equivalent (CESR)? Almost 90% of respondents said 'yes' (Figure 4), compared to 66% in 2012. Overall, schemes were therefore complying with the new GMC requirement.

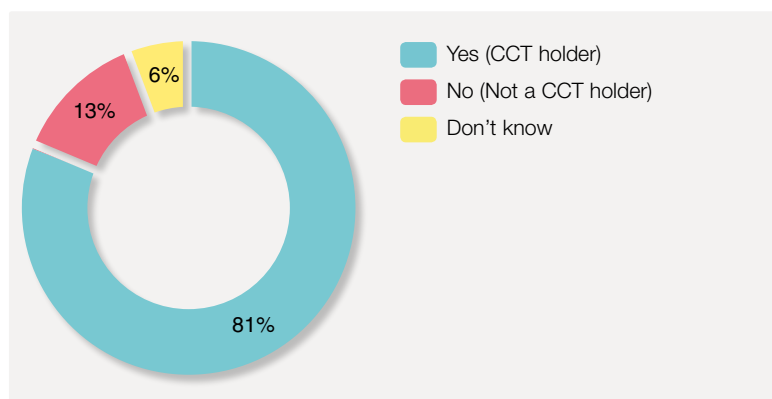
Figure 4: Tutors with GMC specialist registration and CCT in medical psychotherapy or equivalent



The subspecialties of the remaining 11% of tutors were varied. They included general adult, liaison and older adult psychiatrists. Respondents reported high levels of psychotherapy training for some tutors, but not others.

We also investigated what proportion of CCT holders in medical psychotherapy were NHS medical psychotherapists (as a proportion of the 90% of Figure 2's respondents who said 'yes'). Almost 80% were fulfilling the role of a consultant psychiatrist in medical psychotherapy in an NHS psychotherapy setting, in concordance with the curriculum requirements for the psychotherapy tutor's role (Figure 5).

Figure 5: CCT holders in medical psychotherapy who were NHS medical psychotherapists



We believe these consultant medical psychotherapists whose clinical practice is embedded in the psychotherapy services they lead are in the best position to provide trainees with an accessible, psychologically-containing and safe setting for their psychotherapy training experiences.

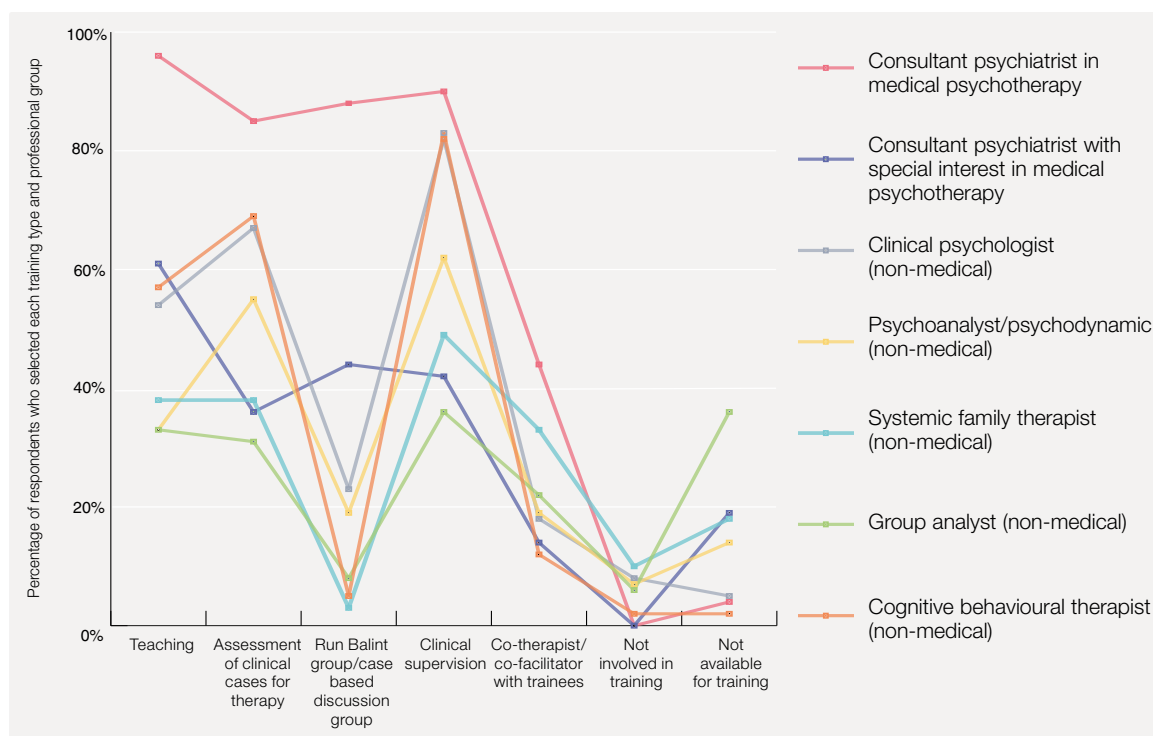
Multidisciplinary involvement

Background

Successful core psychotherapy training programmes depend on contributions from various professional groups. We investigated the extent to which multidisciplinary groups were involved in core training delivery, and their level of engagement with WPBA tools. The GMC requested this information as a quality assurance marker.

We asked respondents to indicate each professional group that delivered training within their scheme (Figure 6). Figures are therefore presented as percentages (arrived at by dividing the total number who selected each professional group by the total number who responded to this question overall). For example, 96% of consultant psychiatrists in medical psychotherapy delivered teaching across schemes, compared to 33% of group analysts and psychoanalysts/psychodynamic family therapists.

Figure 6: Multidisciplinary involvement



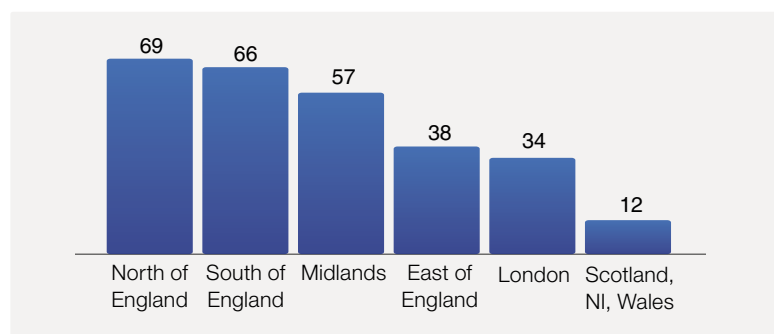
Responses showed meaningful levels of involvement across the spectrum of roles. Consultant medical psychotherapists were most involved in trainees' clinical supervision, followed by clinical psychologists and cognitive behavioural therapists. Non-medical professions were the least involved in running Balint/case-based discussion (CBD) groups.

Non-medical professionals and training delivery

How many?

Responses showed that 276 non-medical professionals delivered training to core trainees across the regions (Figure 7).

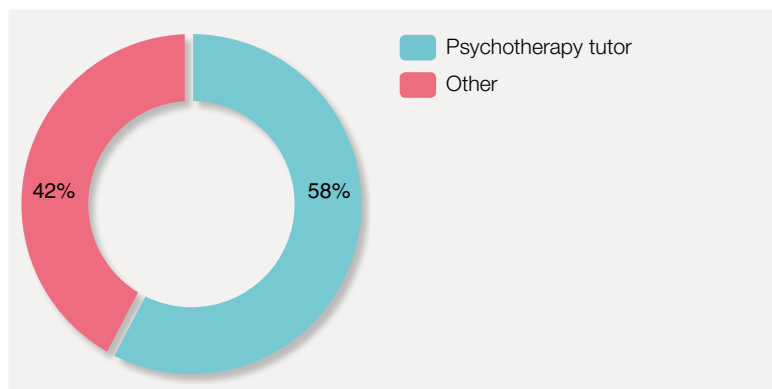
Figure 7: Non-medical professionals delivering training to core trainees by region



Who delivered their training in WPBA tools?

Psychotherapy tutors were more likely to be responsible (58%) for training these non-medical professionals compared to 'other' professional groups (42%), namely the higher training programme director, or the school of psychiatry (Figure 8a). Additional responses for 'other' included a supervisor's guidance manual showing WPBA tools and their use in training.

Figure 8a: Who delivered training to non-medical professionals?



Training and awareness of WPBA tools

WPBA tools included CBDGA (Case-Based Group Discussion Assessment), SAPE (Structured Assessment of Psychotherapy Expertise) and PACE (Psychotherapy Assessment of Clinical Expertise). Respondents indicated what proportions of non-medical professionals were aware of, and trained on, these WPBA tools (Figures 8b and 8c).

Figure 8b: Non-medical professionals aware of WPBA

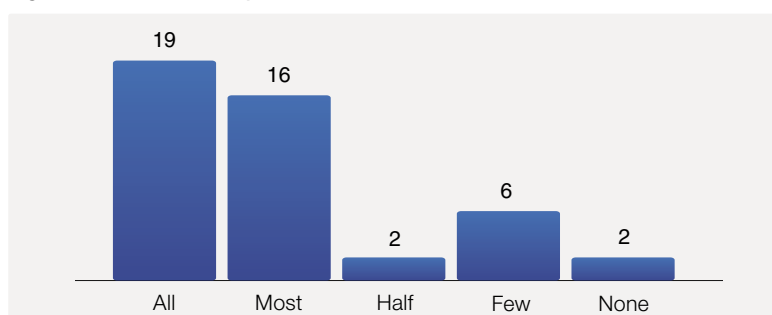
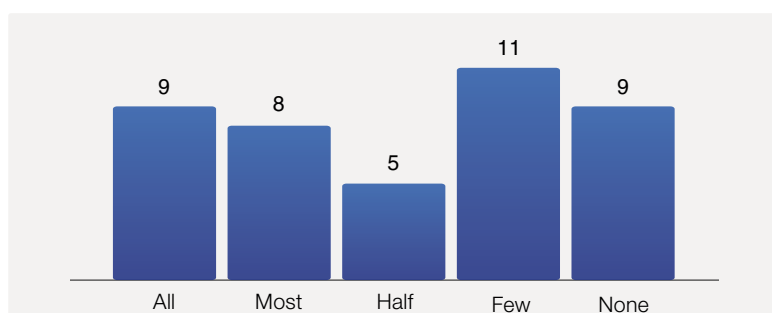


Figure 8c: Non-medical professionals trained on WPBA tools



Most non-medical professionals were clearly aware of WPBA tools. However, 41.7% of respondents reported few or no non-medical professionals were trained in their use.

Additional comments on core psychotherapy training

The main themes were:

- Respondents believed that the quality of long case training improved when psychotherapy training was conducted by psychotherapy tutors who were consultant psychiatrists in medical psychotherapy within a secondary care psychotherapy service.
- There was a perception that secondary care psychotherapy service closures, as well as reductions in medical psychotherapy posts from retirement or restructuring, had a negatively impact on training delivery.
- Trainers appeared sensitive to trainees' needs, levels of experience, and pressures faced to complete their psychotherapy competencies by the end of CT3.
- Trainers described adjusting to service reconfigurations and the increasing complexity of patients accessing secondary care mental health services. Adaptations made included developing innovative patient pathways and encouraging multidisciplinary involvement in training and supervision. Respondents believed these changes increased the likelihood that patient and trainee needs can be met.

Discussion

Positives

- Nationally, very few core trainees (less than 30) were identified as being unable to complete psychotherapy training by the end of CT3 ARCP.
- Schemes gave trainees who were unable to complete psychotherapy training more time without sacrificing quality assurance standards.

- Core trainees appeared to be adequately supervised. Access to supervision was not cited as a barrier to training completion.
- Trainers appeared to be adapting to service pressures such as the increasing complexity of patients accessing secondary care psychotherapy services. One scheme's respondent described developing an innovative system to bypass the typically lengthy secondary care referral process to provide training cases rapidly. This could be a model of good practice for other areas to adopt.
- Schemes were fulfilling the GMC's 2015 mandate in that almost all psychotherapy tutors held GMC specialist registration with a CCT in medical psychotherapy or equivalent (CESR). This could explain why the number of trainees unable to complete psychotherapy training had dropped in the latest cohort compared to in 2012.

Negatives

- We asked schemes whether 'one or more trainees' would be unable to complete. Our resulting estimate could be too imprecise.
- NHS policymakers may not have been fully aware of how resource constraints and restructures were affecting core psychotherapy training. Loss of secondary care psychotherapy services and medical psychotherapy posts through retirement and restructuring continue to challenge the quality of core training.
- Too many non-medical professionals weren't trained in WBPA tools.

Recommendations

The College should do the following:

- 1 Promote awareness of how NHS resource constraints and restructures have been affecting core psychiatric training in psychotherapy. Are NHS commissioners and influential policymakers aware of this?
- 2 Encourage NHS Trusts to give more support for consultant medical psychotherapists so they can continue to provide psychotherapy services and the most appropriate clinical settings for training.
- 3 Promote awareness of innovative pathways to providing psychotherapy cases across the threshold between primary and secondary care, and develop IAPT services that are commissioned to take into account psychotherapy training needs of psychiatrists.

- 4 Continue to ensure all psychotherapy tutors hold GMC specialist registration with a CCT in medical psychotherapy or equivalent (CESR).
- 5 Continue to ensure multidisciplinary professionals are appropriately involved in delivering core training.
- 6 Ensure all non-medical professionals are trained on the relevant assessment tools before they assess trainees. For example, psychotherapy tutors can provide regular training seminars, and RCPsych's Medical Psychotherapy Specialty Advisory Committee could create online training programmes.
- 7 Continue to monitor the proportion of non-medical professionals who are trained on using assessment tools.

Summary

Core training's results are encouraging. Trainers and trainees are adapting well, notwithstanding the challenges they have faced due to NHS upheaval. Schemes expect most core trainees to successfully complete their psychotherapy training. However, they must remain proactive. Are NHS policymakers aware of how resource constraints and restructuring affect the quality of core training? The College should continue to raise awareness of these issues.

Future research should:

- Determine whether the proportion of trainees not completing psychotherapy training by final ARCP is significantly changing over time, and if so why.
- Precisely audit the number of trainees who are not expected to complete core psychotherapy training. What proportion of this figure is experiencing more global difficulties with psychiatry training? Can we identify ways to help trainees complete their psychotherapy competencies?
- Use surveys to get more information from both trainees and trainers. What do trainees think are barriers to effective core psychotherapy training delivery? Do their perspectives correspond with trainers' perspectives?
- Help us understand what prevents non-medical professionals from accessing adequate training on WPBA tools. Are they well motivated to assess trainees? Do they believe their assessment duties are adequately supported?

Specialist medical psychotherapy training

Introduction

Specialist medical psychotherapy trainees can obtain single or dual certificates of completion of training (CCT). We wanted to know if medical psychotherapy training was thriving within the context of dual training given a historic anxiety around the sub-specialty's survival.

Political and demographic changes in the past 30 years resulted in changes in secondary care mental health funding. These changes were associated with a progressive shift in psychological therapy services provision towards primary and community care, especially since the introduction of IAPT in 2008.

Over time, the NHS gradually began to replace secondary and tertiary care adult psychotherapy and medical psychotherapist consultant posts with less expensive practitioners. The College was therefore concerned that funding changes were at the expense of medical psychotherapy posts and, ultimately, patient care.

Consequently, dual training programmes were introduced to help ensure medical psychotherapy's future. These programmes combined higher medical psychotherapy and higher psychiatric training. Dual training with psychotherapy was first introduced in the 1990s in forensic psychiatry, followed by general adult psychiatry in 2008. Benefits of dual training included the following:

- Reducing the time needed to learn both specialties.
- Increasing trainees' employability and personal choice. Dual-trained CCT holders could work as medical psychotherapists or in forensic/general psychiatric settings.
- Combining psychiatric and psychotherapeutic clinical skills can improve the quality of patient care – especially in areas where these combined skills can be used in work with complex and severe mental health difficulties.

Medical psychotherapy appears to have been thriving since dual training was introduced. We wanted to audit its role within higher training. We began with a general overview of higher training by auditing training post numbers, time allocated for training delivery, and multidisciplinary involvement. We were also interested in respondents'

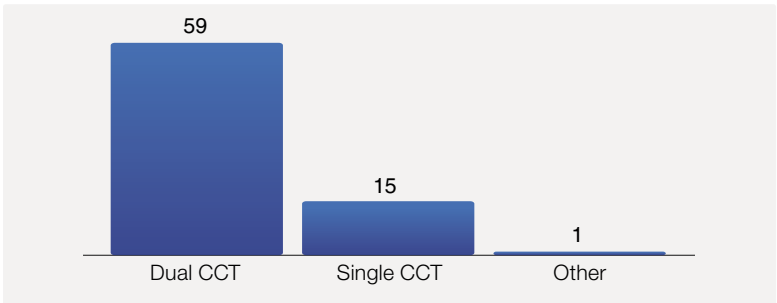
views regarding the sub-specialty's development over the years, and on the future of single and dual CCTs in specialist medical psychotherapy training.

Audit of single and dual CCT posts

How many posts?

We asked respondents how many single and dual CCT posts were in their higher training scheme (Figure 9).

Figure 9: Number of single and dual CCT posts in each scheme



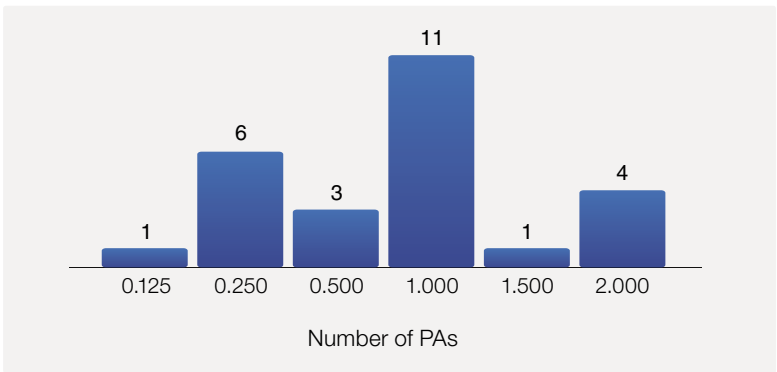
Dual training is now the predominant delivery mode for higher medical psychotherapy training.

Time allocation

TPD programmed activities (PAs) per week

Educators need job plans with adequate time for training delivery. Respondents estimated how many PAs per week were typically allocated in the job plan for the training programme director (TPD) for medical psychotherapy.

Figure 10: Number of PAs per week typically allocated per week in the TPD for medical psychotherapy's job plan



The most frequent response was one PA per week (given by 42.3% of respondents), as shown in Figure 10.

Other practitioners' training time

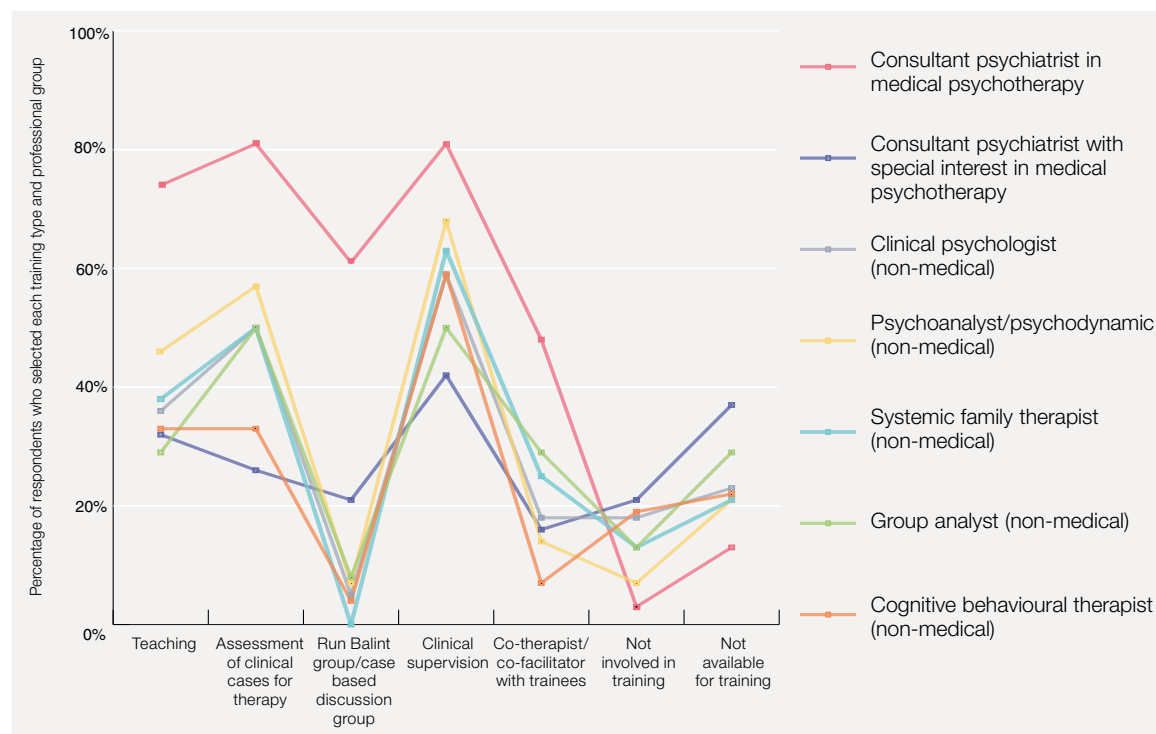
As with core training, delivering higher medical psychotherapy training involves multidisciplinary non-medical professionals. Effective training delivery could not happen without them. Respondents reported the number of hours non-medical professionals spent delivering training each week.

Sixteen respondents reported 1–20 hours per week. Non-medical practitioners reported an average of 5 hours each week delivering training to medical psychotherapists.

Multidisciplinary involvement

Figure 11 shows responses to multidisciplinary involvement and types of training delivered.

Figure 11: Multidisciplinary involvement



Consultant psychiatrists in medical psychotherapy played the predominant role in delivering higher medical psychotherapy training. Figures were comparable to involvement in core training, with some variations reflecting differing training priorities and needs.

Psychoanalysts and psychodynamic psychotherapists also stood out. After medical psychotherapists, they were most involved with teaching, clinical supervision and assessment of patients. Other professional groups were well represented.

Results clearly showed that non-medical practitioners were well integrated in training delivery. They were involved in different capacities – from delivering teaching and providing clinical supervision, to working alongside trainees as co-therapists in systemic family therapy, and in group psychotherapy.

Perspectives on higher training

Background

How about the future of specialist training in medical psychotherapy? Did anxieties around the specialty's survival prompt a shift to dual training programmes? If so, was the single CCT still relevant? We asked respondents for their views on the following:

- 1 Dual higher psychotherapy training combined with other sub-specialty programmes.
- 2 Whether the single CCT in medical psychotherapy has a place in future training, and why.

Dual higher training and sub-specialty programmes combined

Seventy percent of respondents gave free-text comments. Most supported dual training programmes. However, they wanted the single CCT in medical psychotherapy to remain as an option.

Respondents also commented on the costs and benefits of dual training. They believed dual training:

- broadened psychotherapeutic psychiatrists' knowledge base, thereby improving overall psychiatric practice and patient care
- bridged the gap in services between acute psychiatry and psychotherapy
- increased employability for dual CCT holders as NHS commissioning evolved
- ensured the sub-specialty's survival
- led to increased time pressures on trainees, compared to the single CCT
- should be extended to all areas of psychiatry.

The single CCT in medical psychotherapy

Almost half of respondents (49%) believed the single CCT in medical psychotherapy had a place in future training, 30% did not, and 21% were unsure (Figure 12).

Figure 12: Does the single CCT in medical psychotherapy have a place in future training?

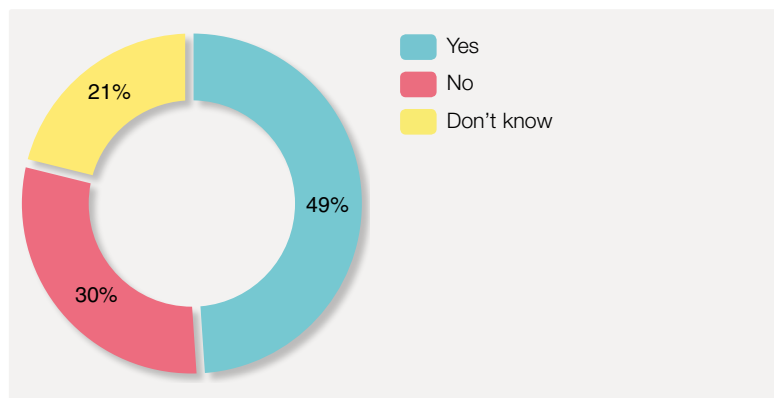


Table 2 shows respondents' arguments for and against the single CCT.

Table 2: The single CCT: arguments for and against	
For	Against
<ul style="list-style-type: none"> It maintains standards in medical psychotherapy training as a base from which dual training originates and develops. It allows for greater immersion, depth and focus in the specialty. It provides a training pathway for determined trainees – clear in their intent that medical psychotherapy is their preferred specialty choice. It provides a training pathway for trainees who already have a CCT in another psychiatric specialty. It ensures the longevity of the specialty. It is vital to maintaining psychotherapeutic understanding of patients, teams and services. 	<ul style="list-style-type: none"> The dual CCT allows for the embedding of psychotherapy in psychiatry in a more meaningful way than with the single CCT. There is a lack of employment possibilities for single CCT holders. Some people doubted its viability in the 'reality' of the NHS. Single CCT training was perceived as less relevant to trainees delivering short-term therapies, and potentially too far removed from 'mainstream' psychiatry.

Overall, both dual and single CCTs in medical psychotherapy remained desirable options. Notably, some respondents believed that the dual CCT was a response to pressures for more work in less time, rather than being connected to the quality of training or patient care.

Key free-text quotes:

- 'I am confident that there is a firm expanding base for medical psychotherapy in psychiatry in the long term and we will limit our training capacity if we only have 5-year training durations.'
- 'I feel dual training is important for the credibility of medical psychotherapy. It allows medical psychotherapists to gain some understanding of the nature and complexity of patients typically seen in, and managed within, general services, and to have some understanding of the nature of decisions that their colleagues are faced with in their day-to-day jobs.'
- 'I think the single CCT has a vital role in training. It holds not only a valuable training experience but also the significance and value, in its own right, of psychotherapy and psychotherapeutic understanding of patients, teams and organisations. I think we dilute this at our peril...'

Discussion

Positives

- Most higher medical psychotherapy training is now mainly delivered by dual CCT programmes – a significant shift since 2012's survey. Schemes were enthusiastic about its uptake.
- The dual CCT's uptake and popularity shows how medical psychotherapy adapted to NHS restructuring and evolving workforce demands.
- Schemes believed the single CCT was still important as a stand-alone feature of higher medical psychotherapy training.

Negatives

There were no specific negative findings.

Recommendations

The College should expand dual training programmes in medical psychotherapy with other psychiatric specialities.

Summary

Psychotherapeutic psychiatry needs medical psychotherapy. Dual training's curricula bridge the gap between these two specialties. The dual CCT's positive reception paves the way for more dual programmes – combining higher medical psychotherapy training with other psychiatric specialties such as child and adolescent (recently approved by the GMC in Nov 2017) and intellectual disability psychiatry. An expanding selection of dual CCT programmes ensures medical psychotherapy thrives as a specialty and, in combination with other specialties, enriches psychiatry.

Future research should:

- Investigate how popular single CCT higher medical psychotherapy posts were among trainees. The 2012 survey showed a disproportionately high number of these posts were vacant. Why were these posts unpopular? Were trainees anxious about employment prospects? Or were there other significant factors affecting the desirability of higher medical psychotherapy posts?
- Compare the fill rates of dual and single CCT in medical psychotherapy posts with other sub-specialties.
- Determine whether dual training made higher medical psychotherapy more attractive to trainees. While the survey's respondents strongly suggested this was the case, we want confirmation from trainees. Are there other significant reasons why trainees might opt for dual training?

Higher specialty psychiatry training in psychotherapy

Introduction

Higher specialty training aims to further develop clinical competencies following core psychiatry training. It equips trainees to practise autonomously as consultants in their chosen specialty.

We wanted a baseline understanding of the current engagement in psychotherapy training for higher speciality trainees. To do this we needed to know how many trainees were in advanced schemes by speciality, what psychotherapy training experiences they were undertaking, who delivered the psychotherapy training, and the time allocation for the professional groups involved in delivering psychotherapy training.

We also wanted to understand whether psychiatric speciality trainees were following the curriculum's recommendations on:

- a **attending Balint groups/case-based discussion (CBD) groups.** The core psychiatric curriculum recommends trainees attend case-based discussion groups for about a year. All advanced speciality training (general adult, child and adolescent, old age, intellectual disability and forensic psychiatry) retain CBD groups in their curricula, without specific recommendations on attendance in higher training. The groups provide a reflective space for trainees to explore their clinical work and the doctor–patient relationship from a psychotherapeutic perspective. We wanted to assess how this accessible method of developing psychotherapeutic thinking was continued into higher training.
- b **seeing psychological therapy cases,** short and long, in their advanced training speciality that is relevant to the trainee's future practice as a consultant.
- c **the structured assessment of psychotherapy expertise (SAPE).** 2015's specialist curricula update recommended the SAPE as the workplace-based assessment (WPBA) to use to assess psychotherapy competencies. We therefore wanted to determine how widespread the use of the SAPE was during the survey period.

Did trainees continue to attend CBD groups into higher training? Were trainees seeing short or long psychotherapy cases relevant to their chosen specialty? Were the curriculum’s recommendations regarding the SAPE clear and achievable? If not, what should be changed?

Trainee audit

How many ST4 and above psychiatry trainees were in advanced training schemes per specialty? Responses showed the highest trainee proportions were in general adult, child and adolescent and old age psychiatry (Figure 13).

Figure 13: Number of ST4 and above psychiatry trainees in advanced training schemes per specialty

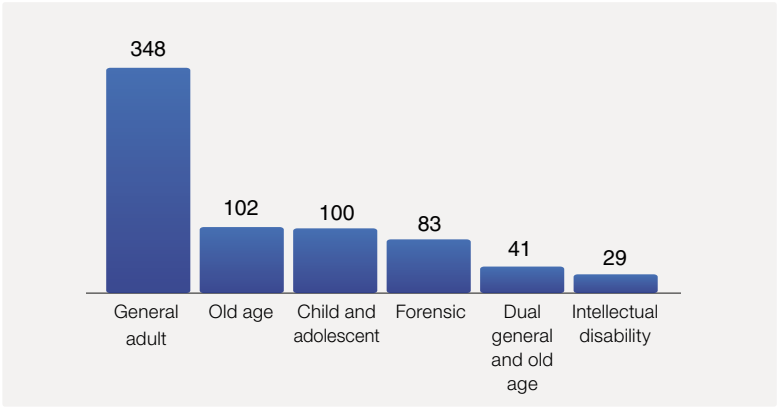
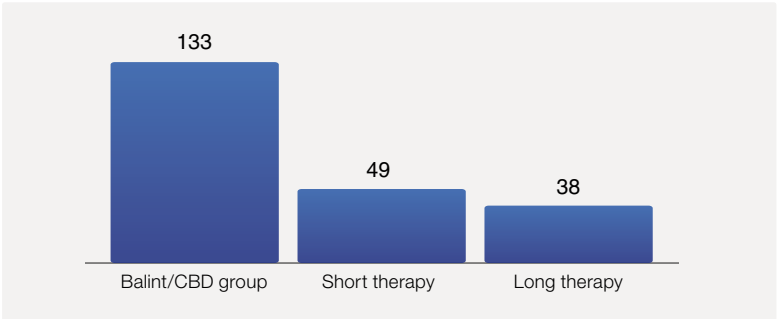


Figure 14, below, shows that almost three times more trainees were in Balint/CBD groups than were seeing short or long psychotherapy cases.

Figure 14: Number of trainees in Balint/CBD groups, seeing short psychotherapy cases, and seeing long psychotherapy cases



Balint/CBD groups meet a training need and do not require the level of commitment involved in taking a patient on for individual psychotherapy. The survey’s results were therefore understandable.

On the other hand, these figures should be interpreted with caution. We asked respondents to break down the total numbers per subspecialty

into Balint/CBD, short therapy and long therapy. However, Figure 14's figures did not correspond with Figure 13's totals. This mismatch suggests the survey didn't adequately capture TPDs' responses for each subspecialty. Future surveys should improve on how these numbers are collected.

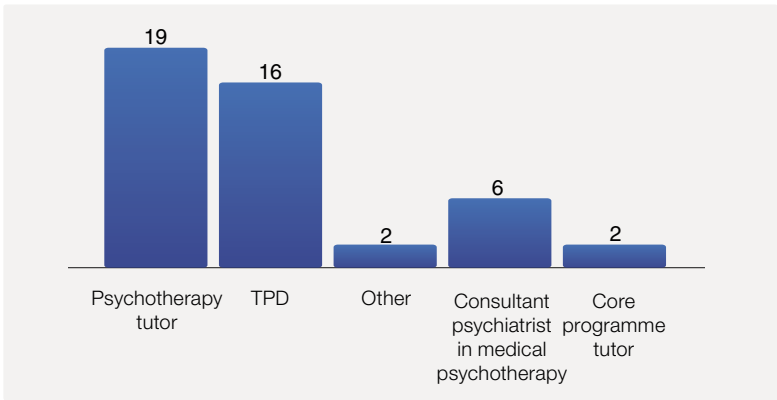
The psychotherapy tutor's evolving role

The psychotherapy tutor's leadership role in delivering core psychotherapy's curriculum is clear and unambiguous. Yet, this role is less defined within higher training curricula.

Which professionals were taking leadership, governance and quality assurance roles for higher specialty psychotherapy training? For this question, we allowed respondents to select more than one role.

Respondents across 47 schemes identified 65 professionals taking leadership roles (Figure 15a).

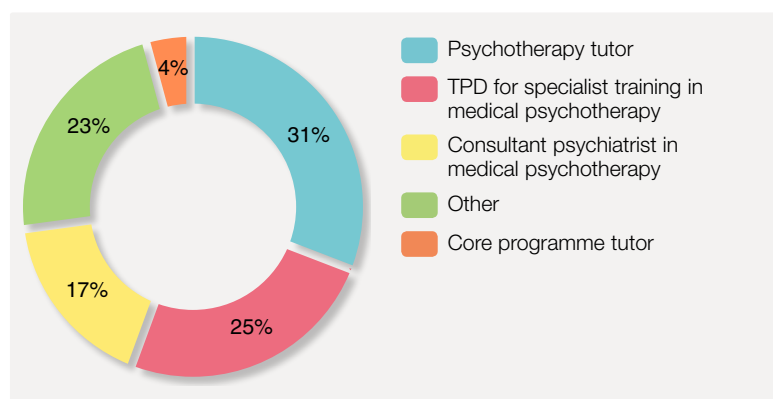
Figure 15a: The number of professionals taking leadership, governance and quality assurance roles across schemes



The most likely responses were psychotherapy tutors, TPDs, and 'other'.

Figure 15b shows each role as a proportion of the 65 responses. We expected schemes would be more likely to say psychotherapy tutors were taking leadership roles. This was true; psychotherapy tutors represented 31% of all roles selected. TPDs for medical psychotherapy, and consultant psychiatrists in medical psychotherapy accounted for a further 40%.

Figure 15b: Proportions of professionals taking leadership, governance and quality assurance roles (of total responses)



The results show that a diverse range of educational roles are leading advanced trainee psychotherapy experiences. At least 78% of these had a CCT in medical psychotherapy.

There were varied leadership responsibilities among the 15 schemes that selected 'other'. Most notably, some schemes showed the following:

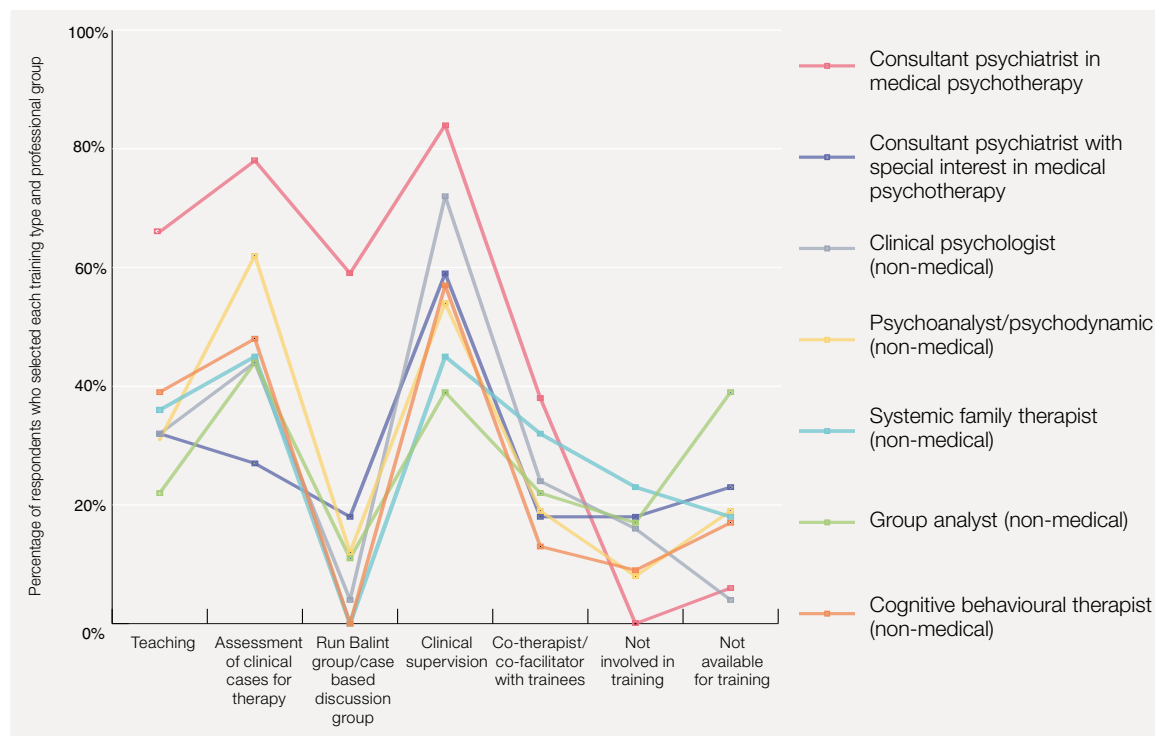
- 1 Shared local responsibility between the general adult TPD and psychotherapy tutor.
- 2 Deanery oversight was led by a training committee of psychotherapy tutors.
- 3 There was no formal leadership responsibility.

These responses suggest an evolving situation among the significant 'other' minority. Schemes progressively took on the commitment for higher specialty psychotherapy training since the WPBA-assessed psychotherapy training requirements were introduced. These requirements had a knock-on effect of clarifying roles and responsibilities for educational leadership and governance.

Multidisciplinary involvement

Figure 16 shows responses to multidisciplinary involvement and types of training delivered.

Figure 16: Multidisciplinary involvement



Once again, responses showed that consultant medical psychotherapists took the leading role in teaching, assessment of patients, running Balint groups, providing clinical supervision and acting as co-facilitators with trainees. These findings mirrored results in core and specialist/higher medical psychotherapy training.

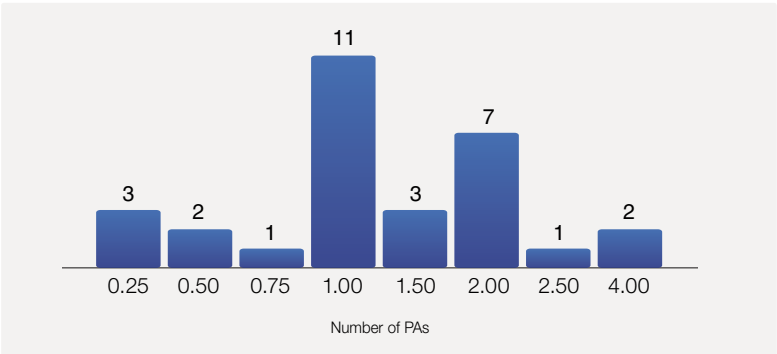
Clinical psychologists, psychoanalysts/psychodynamic psychotherapists and systemic family therapists were significantly involved in assessing patients for psychotherapy training.

Time allocation

Educational and clinical supervision PAs

How much time did psychotherapy tutors commit to delivering higher psychiatric training? Respondents reported how many PAs of consultant psychiatrist in medical psychotherapy time was spent delivering educational and clinical supervision, as well as teaching. The average time commitment was one to two PAs per week. (Figure 17).

Figure 17: PAs per week of consultant psychiatrist in medical psychotherapy time delivering higher training

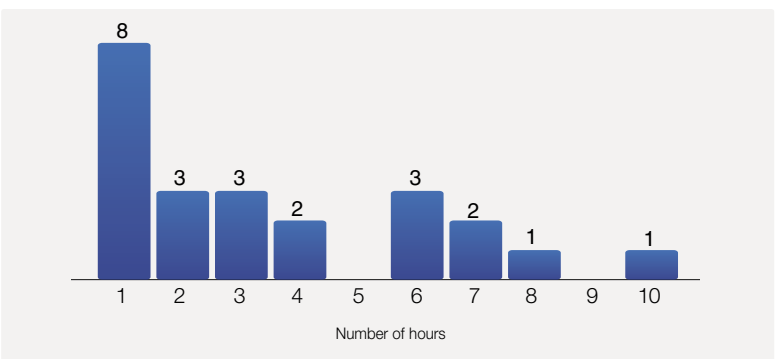


These results are significant for employers. Local education providers (LEPs) should factor this time commitment into a psychotherapy tutor’s job planning, in addition to their core training responsibilities.

Other practitioners’ PAs

Respondents also reported the time commitment for other professional groups providing psychotherapy training experiences (Figure 18).

Figure 18: Number of hours other professional groups spent providing training



Although the response rate was low, we found an average of 3.5 hours of other professional groups’ time per week was used for psychotherapy training provision. As with psychotherapy tutors, this time should be factored into their job planning and appraisal.

Additional perspectives

Trainees' use of special interest time

Higher trainees who undertake psychotherapy experience in their special interest time convey genuine interest. Their intrinsic motivation should be nurtured.

Forty percent of respondents indicated that one or two trainees across subspecialties were using special interest time in this way. TPDs and psychotherapy tutors must ensure these trainees are adequately supported.

The SAPE assessment of higher trainees

Was the SAPE being used to assess higher trainees for psychotherapy experience? Sixty-five percent of respondents answered this question, and of these 80% said 'yes'. This confirms widespread use of the SAPE post-2015. However, this response raised further questions.

Earlier results showed limited formal engagement in Balint/CBD groups or with seeing patients in psychotherapy settings. What kind of psychotherapy training experience were trainees undertaking to achieve their SAPE assessments? The College, through the Faculty of Medical Psychotherapy, needs to further explore this in future audits of psychotherapy training.

Additional advanced/higher psychotherapy training comments

Trainers noted the following criticisms:

- They lacked resources to deliver training.
- Leadership roles around training and decision-making needed clarification.
- They didn't know which psychotherapy training experiences were most relevant to higher psychiatric specialty trainees.
- What was an acceptable/unacceptable psychotherapy experience for assessment by the SAPE? This was also unclear.
- It was difficult to provide accurate feedback on trainees' psychotherapy experience undertaken for the SAPE.

Discussion

Positives

- A healthy number of higher specialty trainees used special interest time to gain psychotherapy experience. We expected this as some trainees would be more naturally attracted than others to working with patients in psychotherapy.
- Responsibility and leadership for higher psychotherapy training was shared. TPDs and psychotherapy tutors must continue to cooperate in this way to maintain high training standards.

Negatives

- The level of engagement in formal psychotherapy settings was patchy and unclear. Only a few trainees were in reflective Balint/CBD groups and even fewer were seeing individual patients. The survey didn't reveal what they were doing to obtain their psychotherapy experience.

Recommendations

The College should do the following:

- 1 Provide guidance through the Faculty of Medical Psychotherapy Specialty Advisory Committee on what suitable psychotherapy training experiences are, and why. Both trainees and trainers need to know this. ('Best Practice Guide: Psychotherapy Training in Higher Specialist Psychiatry' was developed and has been available since January 2018.)
- 2 Clearly articulate what role the psychotherapy tutor should be playing in leading higher specialty trainees. Details of their roles should be included in their job plans.
- 3 Support and nurture trainees who opt to use special interest time to gain psychotherapy experience.

Summary

The present survey was the first structured attempt at auditing the psychotherapy training experience in higher specialty psychiatric training. Overall there are encouraging signs. However, we need to ensure consultant medical psychotherapists who are psychotherapy tutors are adequately resourced within their job plans and clinical settings. They should be able to provide accessible psychotherapy training experiences for higher specialty trainees.

Future research should:

- Investigate what types of psychotherapy experiences are being undertaken for the SAPE (WPBA).
- Investigate whether more trainees are interested in using special interest time to gain psychotherapy experience. If so, what is stopping them? Can the College address any barriers? For example, we could encourage schemes to release them from other commitments. However, this can only work if trainers are willing and able to supervise them.

Conclusions

We believe 2016's psychotherapy survey was a success. It captured views from most training schemes across the UK. We now have a clearer picture of how psychotherapy training is evolving to meet NHS challenges.

Answers to the questions posed in the introduction are as follows:

1 Did this survey adequately represent psychotherapy training in the UK?

- Yes. The 89% response rate showed training schemes across the UK were well represented. It was evident that the survey's respondents were invested in psychotherapy training.
- Overall trainee numbers were broadly in line with College estimates. We believe the survey's findings are generalisable.

2 Were core trainees achieving their psychotherapy competencies by the end of CT3 ARCP, and what challenges did they face?

- Yes, schemes expected most trainees would achieve their competencies. Nationally, an estimated 22 trainees out of a total of around 1600 were unlikely to complete their psychotherapy training by 2016's final ARCP. While figures were somewhat unclear, some trainees are likely to have global difficulties outside of training schemes' control.
- Challenges to training completion mirrored broader challenges currently faced by the NHS. They included service closures, rotation pressures, and premature therapy termination by patients. Reassuringly, access to supervision was not cited as a challenge. Schemes gave trainees more time where necessary, without compromising quality assurance standards.

3 To what extent did consultant medical psychotherapists lead core psychotherapy training?

- Almost 90% of respondents said psychotherapy tutors held GMC specialist registration with a CCT in medical psychotherapy or equivalent (CESR). Within this proportion, almost 80% were fulfilling the role of a consultant psychiatrist in medical psychotherapy in an NHS psychotherapy setting.

4 To what extent were multidisciplinary groups involved in psychotherapy training delivery?

- Results clearly showed that non-medical practitioners were well-integrated in training delivery. They were meaningfully involved across the spectrum of non-medical professional roles, namely, in order of involvement: cognitive behavioural therapists and clinical psychologists (core training), psychoanalysts and psychodynamic psychotherapists (higher MP training), clinical psychologists, psychoanalysts, psychodynamic psychotherapists, and systemic family therapists (advanced/higher specialty psychiatry psychotherapy training).

5 Who was likely to be leading and taking responsibility for psychotherapy training in higher specialty psychiatric training?

- Psychotherapy tutors, TPDs in medical psychotherapy, consultant psychiatrists in medical psychotherapy, and to a lesser extent core training programme tutors, primarily led, governed and quality assured higher/specialty psychiatry psychotherapy training within schemes.

6 How much time was allocated to trainers for training?

- The TPD for medical psychotherapy, psychotherapy tutors, non-medical practitioners, and other professional groups spent an average of one PA, two PAs, 5 hours, and 3.5 hours respectively each week providing higher medical psychotherapy training. LEPs should factor this time commitment into job planning for all professional groups, in addition to their core training responsibilities.
- Advanced medical psychotherapy trainees typically received 1 hour for educational and 'other' supervision, 3 hours for clinical supervision and 4 hours for academic training per week.

7 To what extent were higher specialty psychiatry training schemes following the curriculum's WPBA assessment tool recommendations?

- Almost three times more trainees were in Balint/CBD groups, than were seeing short or long therapy cases. However, these figures should be interpreted with caution due to inconsistencies between component and total figures reported.
- While most non-medical professionals were aware of WPBA tools, responses suggested less than half were trained to use them. This must change.

- Most respondents confirmed higher/specialty trainees were assessed using the SAPE. However, we don't know what types of psychotherapy experiences trainees were undertaking for the SAPE.
- Non-medical psychotherapy specialty trainees who wish to use special interest time for psychotherapy experiences should be encouraged with appropriate support and access to psychotherapy training opportunities.

8 What were respondents' opinions about the dual and single CCT within the context of medical psychotherapy training?

- Schemes were positive about dual training. It is now the primary delivery mode for higher specialist training. Yet, their preference was for the single CCT in medical psychotherapy to remain an option. Both the single and dual CCT can therefore coexist within psychiatry.
- Respondents believed there were significant benefits to blending medical psychotherapy and general psychiatry. This interweaving improves patient care and trainee employability. It also ensures the specialty continues to thrive.

9 What other useful information did this survey reveal?

- Psychotherapy schemes were adapting to the health service's changes. For example, they creatively developed more accessible patient pathways for training cases. In one scheme, psychotherapy tutors funnelled patients directly through to a 'training clinic' from primary care services. This increased the number of readily available training cases by avoiding secondary care's lengthy referral process.
- Respondents believed commissioners did not fully appreciate how important psychotherapy services were to patient care. This could have a negative impact on future psychiatric training if we do not raise awareness.

Final words

Trainers and trainees are adapting well, notwithstanding the challenges they have faced due to NHS upheaval. Dual training's positive reception and widespread adoption is an example of this. Its expansion helps medical psychotherapy evolve to complement health service reconfigurations. While higher medical psychotherapy experience appears to be progressing well, we must provide clarity on suitable and accessible provision of psychotherapy training experiences for higher specialty trainees.

We will continue to monitor psychotherapy training to ensure it benefits trainers, trainees and their patients.

