An exploration of the issues related to the future of private sector psychotherapy in Ireland. An e-Delphi study.

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DECLARATION

I certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctorate in Psychotherapy (DPsych) is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed (Candidate): _____   Student Number: 10104097

Date: 8 September 2016

For Zakariya and all the wonders he may see.

Dedicated to the memory of my father and to my mother, and my brothers Joseph and Damien.

ACKNOWLEDGEMENTS

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GLOSSARY OF TERMS USED

Psychotherapy, Psychology and Counselling

If there is a need to distinguish among psychology, psychotherapy and counselling, the terms will be explained in the text (Totton 2000). While there are historical-epistemological differences underlying the interpretations of words such as 'psychology', 'psychotherapy' and 'counselling', the focus of this study is on private sector psychotherapy and not on terminology, except where it is directly relevant to the studied phenomenon.

Evidence-Based Practice (EBP)

In relation to EBP, Sackett et al. (1996) focused on openness and selective use of evidence for use in treating patients. In what is known as the Sicily Statement, Dawes et al. (2005) discussed EBP, saying that it focuses on practice (including medicine but also other care treatments in formal contexts) that is informed by the integration of evidence, clinical knowledge and patient preferences. They focus on the concept of EBP as a process. They say that EBP,

> requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources. (Summary, para.2)

Related to EBT is the term Empirically Supported Therapies (EST), which is used in a psychological context. Chambless and Hollon (1998, p.20) recommend that the term be applied to treatments that are supported by research that is based on reliable and valid comparison studies and that shows the treatments as significantly superior in efficacy and specificity to pills, placebos or alternative treatments.

ABSTRACT

BACKGROUND: There is a lack of research and data on the mental health field in Ireland. The history of the provision of mental health services in Ireland involves both the private and public sector. However, this thesis argues that current policy broadly ignores contemporary private sector psychotherapy (PSP). PSP may be defined as counselling and psychotherapy that is provided in private clinic settings to clients who pay for their therapy (including low-cost services provided in private clinics).

AIMS AND OBJECTIVES: The aim of this study was to explore issues relevant to the future of PSP in Ireland. The objectives of the study were: to use an e-Delphi to establish what level of consensus or dissensus could be achieved in relation to the issues identified, and to inform policy and psychotherapists of relevant emerging issues.

METHOD: The e-Delphi (n=26) was undertaken over three rounds. The first round used open questions to elicit opinions from participants on their views of the future of PSP in Ireland. The second round used first round responses to generate a questionnaire for distribution to participants. For the third (final) round the items from Round 2, which had not reached consensus, were redistributed in order to establish if consensus could be attained.

RESULTS: The e-Delphi themes in which consensus was reached were related to: the need for PSP to promote its value (91% consensus), the risk for PSP becoming irrelevant to government policy in Ireland (74%), PSP having adequate links with other professionals (78%), the benefits of collaboration within psychotherapy (65%), the overuse of medication in response to mental distress (82%), the under-utilisation of psychotherapy (82%), a prevailing quick-fix mentality in public sector responses to mental distress (78%) and support for the use of outcome measures in PSP (65%). Dissensus was reached in relation to academic requirements, the credibility of PSP among referral sources, the effectiveness of technology over face-to-face treatment and the impact of low-cost therapy on PSP.

KEY FINDINGS: Key findings related to the possible future irrelevance of PSP in an Ireland policy context (including the porous boundaries of PSP practice), the need for PSP practitioners to be more assertive in promoting the relevance of PSP, and the potentially disruptive future impact of technology on PSP in Ireland, and elsewhere.

CONCLUSION: Study limitations and strengths were discussed. Implications for PSP, research, policy and training were considered. A stance from which PSP might define its boundary was offered.

CHAPTER 1   <u>INTRODUCTION</u>

1.1   <u>BACKGROUND AND RATIONALE FOR STUDY</u>

The World Health Organisation (WHO 2012) described mental health problems as one of the most significant, and an increasing, health burdens across the world, leading to poverty, foreshortened lives and physical disease among other consequences. WHO also recognised a significant gap in the provision of treatment resources for mental health issues, with rates of untreated debilitating mental illness ranging from 35% to 85% across high to low income countries. According to Richards et al. (2010), many countries are undertaking a redirection of the focus of public mental health care towards the treatment of more prevalent mental health issues such as depression and anxiety away from the traditional, costly focus of mental health responses and resources on severe diagnoses such as psychosis. In confirming the prevalence of depression and anxiety a UK report produced by Layard et al. found that, "crippling depression and chronic anxiety are the biggest causes of misery in Britain today" (2006, p.1). Layard et al. also believed that given the evidence base for psychological treatments, at least 50% of those affected by these causes of misery could be helped. These developments acknowledge national governments' desires to focus resources on areas that provide the greatest national economic benefit.

There are divergent views on what psychotherapy is (Campbell et al. 2013). However, a definition of psychotherapy, from an eclectic perspective, is provided here for clarity (Norcross 1990, pp.218-220):

> Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors [sic], cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable.

Psychotherapy is considered one of the interventions that have efficacy in treating mental illness and distress (Lambert 2013; Nathan and Gorman 2007; Lambert and Forman 2002; Wampold 2001), and is economically beneficial in treating many mental health difficulties (Lambert 2013).

In exploring the history of psychotherapy, Paris (2013) observed that it emerged as a novel treatment in the context of a cultural shift towards individualism, observed at the turn of the 20th century. As such, as an activity it is clearly located within the culture in which it operates. Fish (1999, p.55) in discussing Foucault wrote:

> I believe that it is critical for psychotherapists to keep in mind the immediate, inescapable connection between, on the one hand, clients' and therapists' subjectivity and behaviour and, on the other, historical, ongoing institutional and cultural processes.

Fish described how different layers interplay in the field of psychotherapy, including issues of objectivity versus subjectivity. In addition, related to the behavioural dimension there are the ethical and practical demands on the practitioner both from within, in the dimension of the therapeutic encounter, and externally, from the interaction with institutional and cultural layers. From this, the complex cultural contexts for psychotherapy that have existed since its inception are evident; these have led to the contemporary, increasingly identified need for mental health resources.

Another contextual layer to consider for psychotherapy is the research environment for psychotherapy. Paris (2013) argued what there was a divide between clinical practice and scientific understanding of psychotherapy from its beginnings and that this divide is only now beginning to be addressed, but that this division may persist. In exploring related perspectives on the future of psychotherapy discussed by policy makers, researchers and clinicians in the USA context, Newman and Castonguay (1999) believed:

> The challenges that confront contemporary psychotherapy… rest on many competing interests. Unless genuine dialogues and serious efforts of conciliation are launched to address these challenges, irreconcilable factions may result between clinicians, researchers, and policy makers. A number of therapists certainly have deep concerns about the influence of empirically supported therapy research. On the other hand, many applied researchers are worried about private practitioners' limited use of empirical findings. At the same time, those who make decisions about federal funding for psychotherapy research are concerned about monetary allocation. (p.1407)

The authors encouraged the participation of clinicians in research as being valuable for psychotherapy and as part of the dialogue among the different interests while warning of division, similar to the concerns expressed by Paris (2013).

In considering the research context for policy in Ireland, the 2006 document Vision for Change (Department of Health and Children) focused on policy implementation in the area of mental health in Ireland. This report was produced by a consultation process carried out by an Expert Group reporting via the Irish Department for Health and Children and may have been representative of the prevailing opinion of many mental health practitioners in Ireland at the time. The report acknowledged a "dearth" of research (p.15) in the Irish mental health arena. In speaking of the Irish context Mental Health Reform (2015a), an organisation focused on prioritising mental health services in Ireland, found that:

> Mental health services have not been prioritised by Government and the quality of services lag behind international best practice and developments in other areas of health care. There is over-reliance on the medical model and in-patient treatment.

There is no mention of private sector provision in the Vision for Change report. It did report a recurring topic of submissions received in preparation of the report, in support of a need for wider access to psychotherapy services in Ireland. The report identified (Department of Health and Children 2006, p.13):

> The need for greater access to psychological or 'talk' therapies. The demand for psychological and social therapies and the evidence for their effectiveness has been growing in recent years and the consensus among users and service providers was that they should be regarded as a fundamental component of basic mental health services, rather than viewed as additional options that are not consistently available.

From the report, there was at best an implicit recognition of the provision of services outside state funded resources. While there is little explicit recognition and support for private sector psychotherapy (PSP) in policy, the above shows that there is also an identified need for more provision of psychotherapy services. This implies a treatment gap between need and available resources which might, in turn, suggest a need for resources to fill this gap. A survey by the

Irish Health Research Board (Tedstone-Doherty and Moran 2009) reported 12% of participants in Ireland reported "moderate to severe" psychological distress in the "past few weeks" (p.12).

In practical terms, the provision of PSP services in Ireland has evolved in parallel with the state provision of health services that have historically been more focused on more extreme manifestations of mental distress (senior Health Service Executive official, personal communication). From an Irish perspective, O'Morain et al. (2012) described a historical context for psychotherapy which might be summarised as colonialism followed by Catholicism, in turn, followed by what might be described as a post-Catholic cultural fragmentation. From the establishment of asylums for the insane in the eighteenth century (Baker 2007), to excessive institutionalisation up to the 1960s and up to the contemporary vision of care in the community (Irish Medical Times 2007), the provision of mental health services have evolved in both public health and private sector contexts. During the history of the provision of such services, the power of the Catholic Church played a significant part until its power began to diminish in the 1990s (Feldstein 2011). O'Morain's 2012 description of Irish psychotherapy in the private sector context was characterised by a lack of state resources and support, which mirrored the comments of Mental Health Reform above. During the historical development of these services, the meaning of what constitutes mental ill-health has expanded and become more widely known. A combination of the reduced power of the Catholic Church, the increasing awareness of mental distress and the lack of state provision of resources for mental health care have provided a context in which private sector psychotherapy has emerged. In the contemporary Irish setting, psychotherapy is delivered by both private sector and state health providers. In the private sector, psychotherapy is essentially unregulated and accrediting bodies, who operate outside the auspices of the state, await statutory recognition.

In the UK context, the British Association for Counselling and Psychotherapy (Wallace 2015) believed that given considerations related to waiting lists, choice, diagnostic labelling, location and convenience there is an ongoing need for the availability of private practice resources. There is no doubt that psychotherapy is carried out in private contexts outside state provision in Ireland. This points to the need for recognising and considering the need for incorporating PSP more explicitly in our national policy framework and a possible need to explore the future of PSP.

An important consideration arising from this absence of recognition for PSP is how the policies, activities and responses of the state mental health sector may impact on practitioners working in the field of psychotherapy, who are outside the employ of state-funded mental health organisations. In the example of Ireland-based private sector practitioners, it seems that many have difficulties in making a basic, consistent living while working as counsellors and psychotherapists (O'Morain et al. 2012), a difficulty which was also experienced during the 1990s in the US with the introduction of managed care (Grodski 2000). The US experience demonstrates the potential impact of increasing state involvement and regulation of mental health on PSP. However, it may be that from a cultural and policy (or political) perspective, PSP might not be envisaged as having a significant role to play in future mental health provision in Ireland given the political, cost and competitive realities that prevail. The thesis will also consider these realities.

Considering readings, discussions with experts in the sector, as a practicing clinician in private practice, the lack of research in this area in Ireland, an identified need for PSP, and with limited resources to carry out research, this research study intended to carry out formal research into the issue of the future of private sector psychotherapy (PSP) in Ireland. In this study the dimensions discussed above including the cultural, competitive, policy, technological and regulatory contexts, will be considered in order to explore what issues might impact on the future of PSP in Ireland. This study will attempt to establish if PSP might offer a distinct professional boundary, which encompasses a viable alternative to other mental health responses.

1.2   STUDY AIMS AND OBJECTIVES

The aim of this study was to explore issues relevant to the future of PSP in Ireland. Experts were invited to participate in a Delphi study, which as informed by a literature review of relevance to PSP in Ireland. This Delphi study was completed to establish if stability in consensus or dissensus could be reached on important issues that may impact on the future of private sector psychotherapy in Ireland. These issues included: regulation and recognition, collaboration and links with others active in the field of mental health, the impact of the medical model, concerns related to a quick-fix approach to mental health, technological developments, the impact and benefits of low-cost therapy, the use of outcome measures and evidence-based practice, views on training standards, the promotion of PSP and funding issues in the mental health arena. It was also hoped that this study could offer

psychotherapists information about issues relevant to PSP and emerging issues in the field. In order to achieve this aim, the objectives were:

To explore some of the key issues related to the future of PSP in Ireland arising from the literature review and expert opinion explored in an e-Delphi study.

To establish what level of consensus or dissensus could be attained related to these issues over the subsequent two rounds of an e-Delphi study.

To inform psychotherapists and psychotherapy policy of emerging issues.

1.3   STUDY METHODOLOGY

Given the study aims and objectives, and the future-oriented focus of the study, consideration was given to an appropriate methodology for considering the issues being explored. Future-focused Delphi studies are carried out in policy areas on the basis of the predictive understanding of anonymous participants, which in turn is grounded in their extensive experience in the area of study (Dalkey 1969). On reviewing a series of USA based Delphi research studies on the future of psychotherapy (Norcross, Pfund and Prochaska 2013; Norcross, Hedges & Prochaska, 2002; Norcross, Alford & DeMichele, 1992; Prochaska and Norcross, 1982) it was considered that the Delphi might be a useful way of bringing together perspectives of different and sometimes competing interests in the mental health arena and referred to by Newman and Castonguay (1999) above, in order to consider the future and the possibilities for PSP. For this study, though user perspectives are providing an increasingly vocal input into service provision (MacGabhann 2014), given resource and ethical considerations it was decided not to focus on users or clients of psychotherapy but instead focus on the perspectives of providers, trainers, referrers and policy makers in the field of psychotherapy. Rather than replication of the Norcross approach, which explores the field of psychotherapy as a whole and is focused on the USA experience, the Delphi approach was utilised to generate an original, future-oriented perspective from the viewpoint of PSP in Ireland.

1.4   CHAPTER OUTLINE

Chapter 2 will contain a review of literature relevant to the field of PSP. Harte (1998) described the need for a literature review to provide a historical context for the thesis. He contended that this naturally leads into a need for reviewing current research into the phenomena being

studied. In looking at the history and current state of a field of knowledge, he believed that issues of concern can be identified and should also be included in the literature review.

Broadly, the literature review will be structured in three main elements. These are: the past, the present and the future. In line with Hartes' (1998) recommendations, the literature review will explore historical milestones psychotherapy. This will lead to consideration of the contemporary research context including issues around efficacy, evidence-based practice and the use of outcome measures. The historical and contemporary Irish context for policy will also be explored, with issues related to low-cost therapy identified in the literature. In addition to exploring the scant literature available in Ireland on PSP the review will also consider the phenomenon of PSP in other countries. For comparison and additional context, recent developments in UK policy provision will be reviewed. In considering issues of practice, equity and access, literature related to provision of low-cost therapy services will be reviewed. Placing the thesis in the mental health context will also involve an exploration of psychiatric practices. This will lead to consideration of referral practices related to psychotherapeutic interventions and related concerns on the use of medication. Related to the importance of context for understanding the PSP phenomenon, political issues concerning the provision of psychotherapy and regulation and professionalization will also be considered. This will be followed by an exploration of possible future directions in psychotherapy and the impact of technology in the field. Though these may overlap in some instances, in summary, the three elements of the literature review are:

The Past
Milestones in Psychotherapy
Psychotherapy Efficacy
Evidence-Based Psychotherapy
Outcome Measures in Psychotherapy

The Present
Mental Health Provision in Ireland
PSP in Ireland and Elsewhere
UK Policy Changes
Low Cost Therapy
Evolving Psychiatric Practices

GP Referral Practices

Critiques of Excessive Medication

Politics and Psychotherapy

Statutory Regulation

Accreditation and Professionalisation

The Future

Future Directions in Psychotherapy

Technology in Psychotherapy

In Chapter 3, the methodology and methods of the Delphi study was outlined. In doing this, the historic background of the Delphi study, its application in health settings and a rationale for its use in this study were considered.

An explanation of the process of carrying out three rounds in the Delphi study was provided and the decision-making processes for each round discussed.

In Chapter 4, the results of the Delphi study including frequencies of themes identified in Round 1 of the Delphi study were presented. These themes were used to form the basis for a questionnaire that was distributed for Round 2 and 3 and results from these rounds were included and summarised.

As part of the process of establishing the Delphi, an opportunity arose to interview a senior official of the Irish Health Service Executive (HSE), involved with mental health policy oversight in Ireland. A summary of this interview is included in Chapter 4.

In Chapter 5, findings contextualised in the overall study and the literature review and Delphi study rounds combined. The chapter discussed issues arising from the literature review and Delphi study and how these relate.

Finally, in Chapter 6 the contribution, key findings, strengths and limitations and implications of this study were discussed. The implications discussed relate to PSP, future research, training and policy. This chapter included a conclusion that offers a number of points of difference that may help in defining a professional boundary for, and relevance of, PSP in the Irish context.

CHAPTER 2 <u>LITERATURE REVIEW</u>

2.1 <u>INTRODUCTION</u>

This literature review explores available research and literature relevant to the field of private sector psychotherapy (PSP) in Ireland. It begins with a review of some milestones in the development of psychotherapy, including its foundation and evolving research context. This context includes research related to efficacy, evidence-based practice and the use of outcome measures. Given resource constraints and the focus of this research, the review does not provide a detailed exploration of the origins and development of specific theories of psychotherapy or counselling. However, it does provides an outline of the broad history of psychotherapy, as this may relate to the contemporary context for psychotherapy practise in Ireland.

Following this overview of the history and context of psychotherapy, a review of policy and service provision development in Ireland will provide an understanding of the contemporary context. This review will also incorporate some of the scant literature specifically related to PSP. In exploring the Irish policy changes, it will explore the evidence that has, or has not, been used to ground domestic policy. Some reports that have emerged in relation to the implementation of this policy will also be explored. An exploration of policy changes in the UK leading to the introduction of the Improving Access to Psychological Therapies (IAPT) will be included (Clark 2011). Somewhat related to this, the issue of low-cost therapy will be discussed. This will provide a comparative context for Irish policy. This will be followed by a consideration of historic and contemporary changes in psychiatric practices. Given the importance of referral sources for PSP, there will be a review of research on General Practitioners (GP) referral practices. As an alternative to or adjunct for psychotherapy, medication is often used for treating mental distress. Therefore, the use of medication and related controversies will also be explored (Davies 2013; Szasz 2010; Conrad 2007). The need for political commitment in making significant policy changes is evident (Evans 2013) and because of this, the literature review will provide additional context (Harte 1998) by including an exploration of issues related to the interaction of politics and the clinic. This leads to an exploration of the interaction between psychotherapy and society in general, in addition to an exploration of related issues of statutory regulation and accreditation. A review of some

literature concerning the future of psychotherapy and the impact of technology will also be discussed. Finally, a summary of the literature review will be provided.

2.2   LITERATURE SEARCH

This literature review was completed based on materials studied following discussions with experts in the field of psychotherapy. The definition of an expert is problematic in Delphi research: it has been recommended that experts should be chosen for their knowledge and standing in the field being studied (Powell 2013). Experts in Ireland were approached based on personal recommendations, in line with Gordon's (1992) advice regarding the Delphi method. Notes of interviews with experts who discussed the study were made after the interviews took place. Loo (2002) suggested initiating a Delphi study in the same way as creating a survey, by generating a literature review based on a clear objective for the study. Ideas emerging from themes identified in the interview notes, which addressed the aims and objectives of the research, were used to inform the literature review searches.

The views of the experts interviewed were incorporated by way of the exploration of relevant books, journals and articles, including those sourced via online searches using Google Scholar and the DCU online library system. The search strategy included searching online for terms such as "psychotherapy", "psychology", "counselling" combined with "future" and reviewing search results in relation to the aims and objectives of the research. Other search terms combined with "psychotherapy", "psychology" and "counselling" included: "efficacy", "evidence based", "efficacy", "outcomes", "history", "history Ireland", "private sector", "independent", "development", "policy", "psychiatry", "referral", "general practitioner", "medication", "regulation", "accreditation" and "technology", among other terms.

Searches of literature known as grey literature, such as that produced by government bodies or private institutions, were also undertaken by reference to searches of specific websites. Examples included the Health Service Executive (HSE) website, the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) website and the Irish Association of Counselling and Psychotherapy (IACP) website.

2.3   MILESTONES IN PSYCHOTHERAPY

Batt et al. (2002) noted that a breakdown in traditional supports, caused by the industrial revolution in the late nineteenth century, resulted in the development of family care supports from which family therapies, counselling and psychotherapy emerged. In reviewing important

events in psychotherapy, Lambert (2013) believed that the establishment of psychotherapy that is recognisable today began with Freud in the late nineteenth century. Paris (2013) believed that this coincided with the development of the culture of individualism. From the turn of the century, psychoanalysis remained the most eminent and powerful approach in psychotherapy, until the 1950s. In the 1920s, learning-based approaches with a focus on client behaviours had been developed. As a result of the efforts of Wolpe, an influential behaviouralist, these began to have a significant impact in the late 1950s. Lambert (2013) noted that the spread and power of psychoanalysis were interrupted by the arrival of Carl Roger's client-centred approach, which emerged in the 1960s. Lambert pointed out that the Rogerian and behavioural schools, compared with psychoanalysis, offered clearer economic and practical benefits. He believed that they were relatively brief and also focused on client outcomes and therapist interventions, rather than what he described as the therapist behaving as an expert. Lambert outlined the emergence of the cognitive therapies of Beck and Ellis at that time, partly as a reaction to difficulties with psychodynamic approaches and limitations of the behavioural approaches. Lambert referred to the contemporary expansion of research into psychotherapy and its effectiveness. He suggested that a lag between research findings and clinical practice persists. He found that research pointing to a need for changes in practice can take 20 to 30 years to filter through into practice, which he observed equates to a generation. In recent times, he believed, the insurance reimbursement system in the US had been a powerful force which has resulted in the increased focus on clinical guidelines emerging that are based on efficacy and economy. Cummings (2006) described how the increase in the use of psychological interventions after the Second World War, was followed by the profession failing to take account of the development of managed care. In addition, he believed that it did not respond effectively to the immense impact of the biomedical model.

In considering the research basis for psychotherapy, Goldfried (2013) wrote that outcome research occurred in three phases, beginning in the 1950s, followed by the next phase in the 1960s and 1970s and arriving at the third phase in the 1980s. In the 1950s, the question that he believed was explored by the basic research approaches used is whether psychotherapy works. In discussing Snyder's 1950 Annual Review of Psychology, Goldfried (2013) held that it took only one chapter to summarise psychotherapy outcome research up to that time. In reviewing research carried out in the field of psychology, Snyder (1950) reported 400 research studies up until 1949. A Google Scholar search of the terms psychotherapy, psychology and mental health for 2013 returned 28,000 results, which demonstrated the increase in the volume of research in

these areas since that time. Goldfried (2013) believed that psychodynamic treatments had up until the 1950s been the focus of most research. He believed that the research methods used at the time were not rigorous and that findings and descriptions of therapeutic interventions were imprecise. However, he thought that research up to that point had provided a platform for later studies. In 1952, Eysenck published a survey of patient outcomes, in a sample of what were then considered neurotic patients. He compared these with estimates of recovery rates among those who did not receive the reviewed interventions. Eysenck (1952) claimed that his analysis confirmed that psychotherapy did not demonstrate a better outcome than non-treatment and the passage of time. His outcome measurements considered participants who did not complete their treatment as treatment failures. His report highlighted the need for more studies in the area of psychotherapy. Eysencks' findings have been criticised by Strupp (2013) and others, though the influence of these findings and other perspectives of Eysenck have been far reaching.

In discussing what he described as the second generation of research in the 1960s and 1970s, Goldfried (2013) believed the overriding research question in this period was what treatments are appropriate for identified client issues. Research in this phase involved the exploration of behavioural and cognitive-behavioural approaches. Goldfried recorded that behavioural therapy was grounded in basic research, and there was often an assumption that laboratory findings could be generalised for use in the clinic. This period involved increasingly refined methods of research. Given the promising outcomes of behavioural research at that time, Goldfried (2013) observed that the National Institute of Mental Health (NIMH) in the US began to make funding available for research into outcomes. From a national funding perspective in the US, an outcome-orientated research focus became an expectation.

During this phase, a collection of interventions was studied from within the sphere of behavioural approaches. This included desensitisation, relaxation and the application of role-playing techniques to areas such as phobias, anxiety and assertiveness. In this phase manuals were a hallmark, including clearly defined interventions in prescriptive guides for the clinic. Goldfried (2013) criticised this era as being limited, as much research consisted of studies of undergraduates, while many of the therapeutic interventions were carried out by graduates rather than experienced clinicians. It could be argued that this perspective confirms a dubious underpinning for much of modern research, focusing as it did on the experiences of middle-class white students who Parker (2007) described as the ideal candidates for the kind of therapy often practised and studied.

Following this phase in the 1980s, many of the more sophisticated methods from the previous phase were kept and improved. Such improvements, Goldfried (2013) believed, included an independent review of adherence to manualised treatments used in research. At this time, he reported that NIMH changed its research format to that used in pharmaceutical research and began utilising randomised controlled trials (RCTs), with a focus on diagnostic disorders rather than on a behavioural focus. Goldfried believed that this shift was portentous, in that it preceded a transformation by the biological model of psychiatry of mental health problems into one focused on disorders. The power of the psychiatric model grew, and began to develop a focus on abnormal psychology, in addition to a more medicalised view of human mental distress, which will be discussed later in this review.

Based on their analysis of the prevailing trends in the US context related to evidence-based psychotherapy, Gaudiano and Miller (2013), in discussing the key factors related to evidence-based psychotherapy, predicted the reduced use of psychotherapy. They also, while confirming the preference of users for therapy over medication, predicted the increased use of medication in psychotherapeutic contexts. Arising from the dynamics generated by government, as well as economic and research imperatives, they foresaw an increased influence of evidence-based approaches, which would suggest the emergence of more prescriptive treatment guidelines. They believed that the usage of medication, either combined with or in place of psychotherapy should be addressed more thoroughly. They concluded that research has demonstrated the evidence for an increased application of psychotherapy, but the research evidence has not always translated into treatment responses to mental health issues.

The above shows how psychotherapy has evolved from a more theoretical perspective of Freud and his followers to an increasingly powerful research-based approach. These issues are informative in the study for providing background to the e-Delphi study.

Given the development and growth of research in the field of psychotherapy, some related literature concerning efficacy and evidence was reviewed.

2.3.1   PSYCHOTHERAPY EFFICACY

Psychotherapy has been found to be generally effective for a range of mental difficulties (Lambert 2013; Nathan and Gorman 2007; Lambert and Forman 2002; Wampold 2001). In relation to the efficacy of psychotherapy, Lambert (2013, p.178) believed:

Not only are psychological interventions statistically superior to control conditions, but the size of this effect is larger than the effects of many medical treatments across a variety of conditions. Although the effect size statistic overestimates the proportion of individuals who experience clinically meaningful changes, there is substantial evidence that the psychotherapies also produce outcomes that are clinically meaningful. Both primary studies and meta-analytic reviews find that many clients improve to levels that might be considered a full recovery.

Lambert stated that many individuals with emotional problems, also experience benefits to their physical health from participating in psychological therapies. In a large-scale, longitudinal study of over 270,000 people with a recently occurring, serious mental health problem among patients in Denmark, Sweden and Finland, Nordentoft et al. (2013) reported a reduced life expectancy of 15 years for women and 20 years for men. This study represented an "alarming" (p.10) finding, demonstrating the impact of mental distress in shortening lives and a worsening of associated poor-health outcomes. Though the Nordentoft study did not only consider psychological interventions, Lambert (2013) predicted that the probable economic benefit of psychological interventions will offer future gains to psychotherapy arising from research.

Some researchers have stressed the need to be aware of the possibility of poor outcomes; between 5% and 10% of therapeutic interventions may worsen the condition of patients (Goldfried 2013; Boisver 2010; Nutt and Sharpe 2008; Fossy et al. 2002). Goldried (2013) maintained that although non-treatment may have resulted in the worsening of a patient's condition, the research suggested that factors related to the therapeutic alliance and the actual interventions applied were the main causes of patients' conditions worsening. Nevertheless, Goldfried did concede that therapist warmth and relational factors were correlational and not necessarily causal in therapeutic outcomes (as does Kazdin 2007). According to Goldfried, the effects reportedly arising from therapeutic alliance factors may be due to the impact of improvements that had already occurred in the patient; although he acknowledged that both relationship and technique may have a substantial impact on improvement. Boisvert (2010) believed that more idiographic research was needed on this research on negative outcomes. He believed that this should be carried out by collaboration between practitioners and patients to make clients more aware of therapeutic potentials. He believed this was preferable to imposing guidelines on practitioners that were overly prescriptive about the therapies that should not be utilised. This reveals an apparent conflict between the manualised, prescriptive approach to

treatment, that has a preference for the use of medication, which is referred to by Gaudiano and Miller (2013) above, and the more client-focused treatment approach outlined by Boisvert (2010).

In a 2005 article, discussing the function of relationship and technique in bringing about therapeutic change, Goldfried explored the perspectives of humanistic, behavioural, psychodynamic and experiential approaches. He suggested that "general principles of change" (p.421) resulted in movement and that the focus of research should move away from attempting to determine whether the technique or the relationship were more important. He proposed that research focus should be on these principles of change and how technique and relationship assisted with the process of change.

Another area of research, related to efficacy, is the study of dose effect. This type of research seeks to measure the number of sessions it takes for statistically significant therapeutic change to occur and how the number of sessions impact improvement. This is also relevant in a public health setting in the context of the numbers of sessions that clients are permitted. In 1986, Howard et al. produced a seminal review (Kopta et al. 1994) of the relationship between treatment length and benefits for patients. The Howard et al. study used data from more than twenty-four hundred patients that covered more than thirty years of research. After a treatment of eight sessions, it was found that 50% of patients improved, and 75% improved after twenty-six sessions. Different results were reported for different diagnostic cohorts and were also dependent on outcome variables. Howard et al. concluded that this had implications for peer review guidelines and the financing of psychotherapy treatments. Kopta et al. (1994), perhaps redolent of Eysenck (1952), demonstrated in their study that 14% of clients manifested clinical improvement before their first session. Similarly to Howard et al., Kopta et al. reported that 53% showed significant improvement after eight weeks and 75% after twenty-six weeks, while 83% showed improvement after fifty-two sessions. Stulz et al. (2013), in their study of 6,374 clients in twenty-six centres, suggested that the rate of improvement in clients diminished over the course of treatment. They found that the number of sessions allocated in time-limited approaches to treatment were arbitrary, that individual progress was variable and should be measured by psychometric testing rather than by a generalised approach. These findings are of relevance in an Irish context considering the availability of eight sessions for patients availing of care under the Counselling in Primary Care (CIPC) initiative (Cahill 2014). While 50% of clients may improve significantly, this number of sessions does not appear to be adequate in

successfully treating the greater number of clients. This may indicate a need for services to be made available outside limited state provision.

In connection with a concern about a generalised approach, in 1999 Newman and Castonguay criticised research funding from state sources in the US for being overly focused on short-term therapies. They also criticised the research funding focus on Randomised Control Trials (RCTs) in psychology research, saying that research in the area was at an early stage. Priebe (2006) noted that the prevalence of the Cognitive Behavioural Therapy (CBT) model, and its application via primary care settings in England, was not reflected in other European countries. He also reported that the number of expected therapy sessions elsewhere is also higher than in the UK. He suggested that funding needs for provision will be large and continue to increase. Glover, Webb and Evison believed that there was much more to be gleaned from the dataset of eighty-thousand records produced for their 2010 review of the IAPT dataset. Their analysis of the IAPT data showed that, with a few exceptions, actual numbers of sessions attended fell far below NICE guidelines.

From reviewing the literature, it seems relevant to consider the importance of early intervention in psychological distress. Kessler and Wang (2008) discussed the importance of age of onset (AOO) perspectives in epidemiology, which they believed was lacking research. This kind of research might allow for an increased focus on prevention by using age-appropriate interventions rather than grounding responses to issues presenting in adulthood. Looking at the descriptive epidemiology of common DSM-IV disorder occurrence in the US, Kessler and Wang observed that approximately half of the US population met the criteria for at least one lifetime occurrence of a disorder while approximately a quarter of the population might meet the criteria in a one-year period. They pointed out that most of those diagnosed with a mental disorder demonstrated onset before adulthood and that later occurrences involved additional comorbidities. They suggested that attempts must be made to ensure that early intervention for children takes place and that early diagnosis prevents the later onset of what may become more chronic conditions. Lack of a preventative focus, they believed, resulted in increasing difficulties in treatment connected to greater severity, the endurance of the disorder and poorer treatment responses. They supported the consideration of a greater focus in research and treatment on dimensional rather than categorical models as responses to mental distress. They found that these early onset disorders often remained untreated. The relevance of this will be

seen later in the literature review when Irish data for child and adolescent treatment, which confirms lengthy delays in treatment, are discussed.

This section introduced how research has shown the efficacy of psychotherapy as a scientifically grounded intervention for mental health issues, albeit with the limitations inherent in all health interventions. This efficacy is important in contextualising PSP as an alternative to medically grounded biological models of mental distress. It may also be relevant in challenging the possibly excessive use of medication-based interventions which is discussed in section 2.9 below. In addition, the dose effect research clarified the need for a subjective understanding of client outcomes, rather than a restrictive adherence to a time-limited application of a minimum or a maximum number of sessions for each client. The e-Delphi study will explore the question of whether participants perceive there is enough psychotherapy being used by those needing help.

2.3.2 EVIDENCE-BASED PSYCHOTHERAPY

In 1993, the American Psychological Association created a task force to establish scientifically supported interventions (Gaudiano and Miller 2013). This task force eventually led to an evidence-based treatment focus in this area of research. Kazdin (2008) discussed the relative merits of EBP approaches and how these should be used in therapy. He believed that critics in the clinic criticised research for not reflecting the realities and nuances of working with complexity in client presentations. Kazdin (2008) believed that in clinical practice the process of learning to respond to life was more beneficial than focusing on the eradication of the symptom or additional symptoms that often presented in the clinic. He also observed that less clear outcomes, such as an improved quality of life were usually not addressed in research trials. In relation to this Gaudiano and Miller (2013) maintained that agreement was not comprehensive in relation to evidence-based treatments and that recommendations were disputed. However, Kazdin (2008) expected that these differences could be overcome. A divide between the clinic and research was reported (Gaudiano and Miller 2013; Thomason 2010; Kazdin 2008; Newman and Castonguay 1999). Thomason in his 2010 article believed that psychology has been divided as a result of the emerging popularity of EBP and empirically supported treatments (ESTs), which contrast with what might be described as more subjective views of therapy. He noted that many therapists were open to trying new approaches for working with clients irrespective of scientific proof. He saw this as a practical desire on the part of practitioners to help their clients. From the alternative perspective, practitioners who

are more orientated to research and evidence are critical of innovations that have no basis in scientific rigour. He believed that this issue was of huge importance for psychologists and observed that the use of evidence was problematic, where it was applied without being aware of importance caveats and limitations. Irrespective of how conditional and considered the use of research may be, he noted that it could always be that something was missing or that complexity in the clinic has not been accounted for in research. Reflecting this contrast between complexity and research, Welling (2005) considered psychotherapy to be an art as much as a science.

In their 2013 Delphi study of views on the future of psychotherapy, Norcross, Pfund and Prochaska observed the issue of evidence-based practice as an important future driver of change in psychotherapy. They described the issue emerging as a result of forces from two directions. The first was the growing demand in health care practice for evidence-based, effective interventions. Secondly, there was the related but the potentially separate possibility for practice guidelines becoming an integral part of clinical applications. Related to this, they identified the possibility that research may lead to prescriptive treatment rather than the use of clinical judgement as has been already referred to above (Gaudiano and Miller 2013, for example). Norcross, Pfund and Prochaska (2013) observed that the more controlled research-based approaches were predicted to increase and also noted that digital approaches would also generate data. Related to all of this, may be the increased demand to reduce and manage costs. They believed that scientific advances were usually generated by four influences: ideas, evidence, technology and money. The predicted that psychotherapy was entering a period when these forces would drive innovation in the field.

In the Australian context, Richards and Bower (2011) expressed their concern that their review showed a lack of enticement to utilise lower intensity, less costly, interventions such as internet and bibliotherapy practices because of a lack of focus on EBP. They expressed a concern that less effective and costlier interventions had become more prevalent in Australia. Gaudiano and Miller (2013) suggested that in the US context, resistance to EBP among psychologists had the result of encouraging the increased use of medication over psychotherapy.

In reviewing research about private practice, Steward and Chambless (2007) discussed the link between research and the clinic. With a sample survey of 591 (n=591) psychologists working in clinics, they found that though EST research was taken into consideration, the psychologists surveyed most often relied on clinical experience in arriving at treatment choices. In

considering the value of clinical perspective on best treatments, Kazdin (2008) observed that clinical judgement alone in treatment choices had not stood up to research scrutiny. He questioned the availability of research relevant to the clinic in two areas: those that consistently examined reliability and validity of clinical judgement over time, and those that focused on making a difference in outcomes. He believed that this lack of relevant research reflected the divisions between practitioners and researchers in the field. He discussed the need in the clinic for individual, patient-focused interventions. He believed that research had failed to address this issue. In terms of the scientific concepts of reliability and validity, he claimed that there were no structured approaches to help a clinician gather a number of interventions, to develop a specific response to an individual client. He criticised research as often not being applicable in the clinic for various reasons, and yet he noted that practitioners often generalised their experience, via erroneous heuristics and applied their erroneous thinking processes to their client base.

Gaudiano and Miller (2013) observed that, while care was needed in the application of recommended treatments, some psychologists maintained contrarian positions irrespective of the scientific evidence. Cummings (2006) believed that as debate continued on the dangers of prescriptive guidelines for interventions, the managed care system in the US had already moved on. It had implemented a more scientifically grounded selection basis for interventions and began developing increasingly prescriptive treatment regimes.

Kraemer et al. (2002) supported a focus on mediators and moderators of change in randomised clinical trials saying "Moderators identify on whom and under what circumstances treatments have different effects. Mediators identify why and how treatments have effects." (Abstract). Related to this idea, Rosen and Davidson (2003) recommended that research in the area should focus on the principles of change, rather than on facilitating the increased use of profit-motivated interventions. McHugh and Barlow (2010) observed that there was a problem with implementing effective interventions as these, again, were not feeding into practice. They reported an increased effort and funding in the US to spread information about effective treatments. They described the need to provide more training on how to measure effective interventions. Wampold (2001, p.225) argued that the American Psychological Association had adopted approaches to empirical evidence that were poorly thought out. He described the medical model as favouring EST approaches. He believed that these approaches were applied rigidly and focused on generating research support for specific treatments. He reports that 70% of treatment effects were due to "common factors" (p.207) such as relationship influences

rather than the treatment approach used. Beutler et al. (2012) looked at these common factors and suggested that an integrative approach should be used to assess the best treatment for the client at each stage of change.

This clearly reveals that difficulties persist in identifying a body of research, or even an approach to research, that is universally acceptable to clinical practitioners and researchers.

Lambert and Barley (2001) suggested that therapist factors played a significant part in successful treatment outcomes. They believed that relationship factors were more relevant to these improvements than the specific technique applied. They recommended the importance of focusing on the therapeutic alliance in training. Kazdin (2007) believed that despite an extensive history of research in psychotherapy it was impossible to explain the how or why of change in psychotherapy. He believed that there had been excessive reliance on clinical impressions in evaluating client progress rather than on more objective measurement. In this work, he was critical of research that presumed the therapeutic relationship as a mediator of change, arguing that most studies did not exclude the potential that relationship improvements arose from symptom improvement or another variable. He emphasised that he was not disagreeing with how crucial relationship factors might be in psychotherapy but was challenging what he believed was the inaccurate assumption that the therapeutic relationship has been proven to be a mediator of change. He also reported that many different kinds of life experiences have been shown to bring about change and improvement in functioning, including talking with friends, religious beliefs, exercise, being hypnotised and writing. He stated that understanding the mechanisms of change within therapy may have an impact in the world outside psychotherapy and he posited therapists might be able to learn from mechanisms identified in the outside world. In relation to a suggested focus on mediators and mechanisms of change, he was critical of the number of new interventions that were being introduced, many without research bases, saying that in child and adolescent interventions there were more than 550 treatments being used. The proliferation of these treatments seems to be indicative of a lack of psychotherapy research that supports a basic, agreed underpinning for clinical practice which can be built on, rather than the reality of a research base grounded in a contentious and varied research base that is often ignored.

In a 2012 study, comparing client and therapist factors in relation to outcomes, Beutler at al. concluded (para.5):

Given the complex relationship that is revealed in this study among patient, treatment, and variables indicative of a "fit" between patient and treatment, it appears to be short-sighted to study the so-called "specific" effects of psychotherapy separately from relationship and patient (so-called common) factors. Evidence of consistently strong interdependence among relationship and treatment factors argues for more complex methodologies than the randomized clinical trial paradigms that are currently in vogue. Such methodologies assume a degree of independence among patient, relationship, and treatment variables that is not warranted by such findings as these.

From the above, optimistically it would appear that psychotherapy is beginning to grasp the scope of the problem it has to deal with, while significant differences related to interpretation, application and direction of research persist. Emmelkamp et al. (2014) argued that research lacks an adequate conceptual structure, which brings together existing findings. They supported a better use of these findings in clinical settings. Gaudiano and Miller (2013) characterised these as differences between nomothetic and ideographic approaches to EBP. There are questions over the focus on relational aspects as agents of change in psychotherapy. However, the assumption of relational aspects being associated with change seems to dominate the current discourse.

This reveals that there is an apparent gap in the varied research context between what may be effective from a scientific perspective and what practitioners considered acceptable in the clinic. This lack of acceptance may lead to clinical decisions that are not optimal for the client. For the e-Delphi study, these issues informed the research and suggested a need to consider the use of outcome measures in PSP.

2.3.3   OUTCOME MEASURES IN PSYCHOTHERAPY

The measurement of therapeutic outcomes might be important in arriving at a greater understanding of the mediators and mechanisms of change discussed by Kazdin (2007). In his 2008 article on evidence-based treatments, Kazdin discussed the importance of a refocusing of clinical activities on the client. He believed that evidence-based therapy of itself was no guarantee of a good outcome and that this is why the progress of the client should be, when feasible, observed systematically. Given generally accepted knowledge of problems with memory and perception, he asserted that this was essential. He maintained that research had demonstrated that there were measures which demonstrated scientific validity and reliability that could be utilised in therapeutic contexts. He went on to claim that there was no other field that could offer the same scientifically supported measurements and interventions.

He also offered measurement of client progress as a way of avoiding what he believed was a lost opportunity to capture data and valuable information from clinical experience. Apart from the notable examples of new approaches to treating clients that arise in rare circumstances, he believed that when clinicians retired or ended their practice much valuable data was lost. He suggested statistical measures did not indicate whether improvements had been attained in the day-to-day lives of service users. There were some measures, however, which could clearly demonstrate this, such as measuring the reduction in frequency or the cessation of panic attacks.

Davies in discussion with Pope (2013) criticised what he described as a "one-size-fits-all" approach which does not accommodate an individual's movement through the therapy process. He critiqued filling out questionnaires, which he believed did not help with recuperation. Pope discussed the Patient Health Questionnaire 9 (PHQ9) and its use throughout the UK National Health Service. He believed its use had led to a huge increase in prescriptions for medications. In this discussion, Davies agreed with this, arguing that the threshold for depression was low and that the copyright to the PHQ9 questionnaire, established in DSM-III, was owned by Pfizer, a major pharmaceutical supplier.

In relation to the use of outcome measures, Bowman (2002) speaking from a psychoanalytical position believed that what he called "a publicly pre-established definition of cure" (p.25) had the effect of taking an individual's right to have a conscience, and defining what it should be. Bowman believed that the danger science poses in this context is that it imposes a scientific dogma on what constitutes a cure.

In discussing the establishment of IAPT, Clark told Evans (2013) that the idea for the session-by-session outcome measurement used in the implementation of the approach came about as a result of experiences in operating a community service in response to the Northern Ireland Omagh bombing in 1998. Due to the proven effectiveness of the centre in responding to a community need for support, the Northern Ireland Centre for Trauma and Transformation was established. Clark believed that the use of outcome measures helped by proving the model to politicians and therefore justifying investment in the approaches used. It also provided transparency which he believed was a driver for quality improvement, although practitioners in many treatment contexts had problems with the use of measures in therapy.

Walpole (2011) maintained that research increasingly pointed to the need to assess factors related to therapist qualities in relation to outcomes. DeRubeis et al. (2014) echoed this need; however, they presented a critical exploration of the existing literature, arguing for the

inclusion of factors related to the quality of therapy, in addition to client-focused outcomes in measurement. They also found that there was little consensus on what factors lead to successful outcomes.

A divide occurs between the importance of measuring outcomes and the risk of objectifying clients through a focus on the symptoms, rather than the subjective experience (Bowman 2002). From the e-Delphi perspective, it may be of interest to establish how supportive the participants are of the use of outcome measures in PSP. This may also speak to issues of evidence-based practice discussed in the previous section.

Having looked at some of the historical contexts for psychotherapy and related research issues, it would be of use to explore the provision of mental health services in Ireland and how it has evolved.

2.4   MENTAL HEALTH SERVICE PROVISION IN IRELAND

Baker (2007) described mental health services as beginning in Ireland in the 1720s with the provision of services by way of a combination of philanthropic contributors. This provision was described as "sporadic and uncoordinated" (Walsh and Daly 2007, p.14). Walsh and Daly wrote how in 1745 Dean Swift bequeathed a legacy to establish St. Patrick's Hospital in Dublin for the mentally unwell while in Cork a hospital, Citadella, was opened in 1799 by Dr. Hallaran. In 1787, the Prisons Act provided for the establishment of "lunatic wards" in Houses of Industry that had been established as a result of increasing problems with begging and poverty (Walsh and Daly, p.14). Baker (2007) observed that in the nineteenth century, both religious and lay organisations became involved in the provision of services. He wrote that workhouses established in the nineteenth century for helping the poor were later converted into county homes by the Free State government in the 1920s. Walsh and Daly (2004) wrote that the provision of workhouses was relevant to mental health, given the coincidence of poverty and mental illness. They observed that this connection between poverty and mental health problems had been confirmed by the 1850s. The nineteenth century was characterised by an increased awareness or social conscience following industrialisation in the UK (Walsh and Daly 2007). In 1842, the Private Asylums (Ireland) Act attempted to regularise the operations of private asylums that had been established following the 1817 Asylums for Lunatic Poor (Ireland) Act (Mauger 2012). Mauger claimed that the acknowledgement of the private provision of asylum services also recognised that such institutions were not only for the impoverished but also for the wealth; it also highlighted inadequate provision of services for the growing middle class. It

can be seen from these law enactments that private and public provision of mental health services have been parallel phenomena in Ireland since the initiation of the regulation of the provision of services for the mentally distressed.

Baker (2007) wrote that following the establishment of the National Health Service (NHS) in the UK after World War II, the Irish government produced similar proposals for Ireland. He noted, however, that many of the proposed improvements were opposed by medical and religious groups as well as the Irish Department of Finance. As a result, the wholesale replication of the NHS was prevented, ostensibly on the basis of cost, and the provision of health services in Ireland grew incrementally over the following decades. The Mental Treatment Act (1945) was enacted in Ireland in 1947 (Latif and Malik 2012). This was designed to facilitate admission to public institutions (private institutions having been covered by previous legislation) followed by the Mental Treatment Act (1953) and was followed by the Mental Treatment Acts of 1961. Walsh and Daly (2007) described provision as moving from the early implementation of institutionalisation to deinstitutionalisation beginning in the 1950s. In their book *Mental Health Policy in Ireland*, Higgins and McDaid (2014) wrote that in 1958 Ireland had the highest ratio in the world of psychiatric patients per capita. In different chapters of this book, Brennan (2014) and MacGabhann (2014) described how historical factors allowed medical perspectives to maintain control over mental health responses in Ireland. As a result of the very high level of hospitalisation in Ireland, in 1961, a Commission of Enquiry on Mental Health recommended a change in focus from institutional to community care, which was already occurring in the US. Changes in the US and UK occurred in relation to deinstitutionalisation and to the increasing availability of psychotropics starting in the 1950s (Irish Medical Times, 2007).

Latif and Malik (2012) wrote that a Health (Mental Services) Act was passed in 1981 but was never implemented due to political opposition. The existing Irish mental health-related acts were mostly repealed by the 2001 Mental Health Act which updated the legal framework to enact principles of the Irish Constitution, the European Court of Human Rights, the European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950, and the 1991 United Nations' Principles for the Protection of Persons with a Mental Illness and the Improvement of Mental Health Care (Mental Health Commission 2001). The 2001 Act covered aspects related to mental health provision in institutional contexts, including consent for admissions, management, approval and oversight of mental health centres. It also provided for the establishment of the Mental Health Commission, which was responsible for quality

assurance and regular reporting on mental institutions (Irish Medical Times, 2007). The Irish Medical Times (2007) also reported that a change in focus from a reliance on medication to treating mental distress with a recovery focus emerged. Service users began to increasingly demand alternatives or adjuncts to pharmaceutical interventions, including psychotherapy and counselling. This recovery perspective was further emphasises into the policy arena with the publication by the Department of Health and Children of the Vision for Change document in 2006 (Irish Medical Times, 2007). In 2005, the Health and Social Care Professionals Act provided for the establishment of CORU as Ireland's regulator of health professions.

As outlined in the introduction, in Ireland the Vision for Change (Department of Health and Children 2006) document was produced by the Department of Health and Children in 2006. The report was created following a consultation process and the consideration of interested participants' submissions. The consultation included service users and 19 subgroups. The purpose of the document was to modernise and update mental health policy in Ireland. It offered a "comprehensive model for mental health services" and recommended a person-centred approach (p.8). It described a need for greater access to psychotherapy services, and acknowledged the growing research body supporting the efficacy of these interventions, which the report believed should be consistently available. It discussed the international move from institutional to community care. It also recommended the establishment of catchment areas of two hundred fifty thousand to four hundred thousand people and the implementation of Community Mental Health Teams (CMHTs) to provide services in each catchment area. It included the objective to close "mental hospitals" (p.9) and develop a recovery-focused approach to mental health. The establishment of an "implementation committee" (p.9) was recommended. In relation to the Irish context the Vision for Change (Department of Health and Children 2006) report stated:

> There is no centrally collected information on the type of treatments given to people with mental health problems in primary care. For example, figures on the availability of psychologists, counsellors or other mental health professionals who work from GP practices are not available. Anecdotal evidence suggests their numbers are very low. (p.62).

The Vision for Change, referring to non-Irish studies, reported that a quarter of primary care presentations were somehow related to mental health problems (Goldberg 1991, p.62) and that mental health concerns were the second most frequent presentation in primary care

(McCormick, Fleming and Charlton 1995, p.62). In addition, 90% of the presenting issues were dealt with in primary care without an external referral (Goldberg and Hixley 1992, pp.62-63).

In a published memo that may be of relevance to PSP, a 2008 report by Barrett from HSE West in Limerick listed "exclusion criteria" (p.12) for treatment prioritisation by Community Mental Health Teams (CMHTs). These criteria were: "bereavement reactions, relationship difficulties adjustment disorders, mild depressive disorders, sexual abuse without a psychiatric disorder, acute stress reactions without a risk to themselves or others and post-viral fatigue syndrome". No detailed explanation of each of the criteria were provided. For those who do not meet the eligibility criteria, it was recommended that referral back to the original referrer should be made. Though it is not known from this report whether these criteria applied to the country as a whole, they are of relevance to understanding the resource priorities of the service as these may impact on potential referrals to PSP. The exclusion criteria might indicate some of the kinds of referrals expected to be seen in private practice. The document also included explanations of the different professional titles found in CMHTs and detailed referral protocols and assessment guidelines. It included different definitions (pp.4-5) of counsellors and psychotherapists saying that the latter may go more "in-depth" than counsellors.

In 2009, the Mental Health Commission completed a review of the implementation of the Vision for Change (Department of Health and Children 2006) document. It found that while there was some progress and that while the changes needed were very complex, many service users were disappointed with the level of change that had taken place (p.4). The report claimed that the Vision for Change report was not being comprehensively implemented and that progress was slow. The commission reviewed implementation approaches in other countries (p.11). The need for clear leadership, specified outcomes, coordination of the allocated budgets, communication and ongoing monitoring were identified as elements of effective implementation. The report showed that many of these elements were lacking in the rollout of the Vision for Change. In 2013, the HSE via its Counselling in Primary Care (CIPC) structure initiated a national rollout of its services providing counselling resources to primary care teams for medical card holders. This service offers up to eight weeks counselling to qualifying patients (Cahill 2014).

In a report published in 2011, the Irish Mental Health Commission reviewed the use of psychological therapies in the country's thirteen catchment areas. For prioritised cases, the

waiting time was between two days and two weeks. The average waiting time between a referral and the start of therapy was between six months to two years. The catchment areas had not developed policies for training therapists, and this was reported as being left to the accrediting bodies. No supervision policies were reported in the areas, with some uncertainty in the catchment areas about what supervision meant. The commission reported that seven of the thirteen areas were unable to provide data on the throughput of psychological therapy users. Four areas provided some data, and just two provided detailed information. This demonstrated a basic lack of data which was needed to provide a clearer understanding of what was going on at an aggregated level. It is also indicated a lack of consistency in the measurement of resources utilised in reviewing the aspects considered by the report. No consistent, national performance measures were available to establish the benefits of the resources employed. These data demonstrated the lengthy treatment waiting periods. This may point to a need for alternative referral options, including PSP.

In a 2013 report from the Roscommon region of Ireland, McHugh et al. evaluated the treatment of forty-three adult service users in a primary care, stepped care model, with brief CBT. The evaluation was carried out by use of the CORE-OM instrument with satisfaction feedback from users. 44% completed the treatment. The report divided treatment into clinical and non-clinical assessments of severity. Of those in the clinical range (n=13), 86% achieved clinically significant improvement; of the non-clinical sample (n=6) 50% achieved clinical improvement. Of the one hundred GP referrals received by the service in a one-year period, 63% had depressive or anxious presentations. Of referrals to the service, 89.3% were from GPs, and just over 30% of all referrals were male. Users were generally satisfied with the service. The non-completion rate of 56% compares favourably with the dropout rate of nearly 50% reported in a 1993 meta-analysis carried out by Wierzbicki and Pekari, within the range of 30-60% reported.

Amnesty International (Faedo and Normand 2013) reported that the lack of primary data was an obstacle to carrying out their review of the Vision for Change implementation. While acknowledging difficulties in making direct comparisons, Faedo and Normand reported that the proportion of health spending dedicated to mental health in Ireland ranked tenth out of fifteen studied countries. Their report criticised the three-year delay in executing the implementation plan that was prescribed by the Vision for Change document. They found that "much of the momentum was lost" and that the plan produced was not sufficiently detailed for

implementation purposes (p.23). They reported that in Ireland, the proportion of the public health budget for public mental health fell by 60% between 1984 and 2008 when expenditures were generally rising. The report showed that this proportion fell from 13% in 1984 to 5.2% in 2012. They found that funding cuts were severe and no temporary funding was made available to assist with the move from institutional to community settings. The authors acknowledged recruitment embargoes and staffing cuts had made the implementation of the Community Mental Health Teams difficult. They also noted the increase in referrals for mental health issues, possibly arising from the economic turmoil at the time. From their report, the mental health services appeared to be caught in a combination of falling budgets and increasing demand. They described the situation as a "crisis" yet believed that there was an opportunity to provide lower-cost interventions in the context of cost restrictions (p.26). However, they believed that this presumed the availability of relevant data that as well as providing "transparency and accountability", affords the possibility to compare performance of different jurisdictions. They found that, based on the 2011 available data, mental health spending per capita in different regions of Ireland ranged from €116 per head to €248 per head. While it was not clear whether these inter-regional figures were comparable, this was a variation of over 100%. Faedo and Normand reported significant cost savings for community-based care versus hospital care for mental health patients, in addition to better outcomes for community-based approaches. The report made additional observations about the mental health services that are beyond the scope of this work.

Hughes et al. (2013) reported an audit of child and adolescent psychology services in County Roscommon in Ireland. They reported that two psychologists were serving seventeen thousand children in a twenty-five hundred square kilometre catchment area. In auditing cases on the area's child and adolescent service waiting list between May 3 2012 and August 1, 2012, they reported 197 cases and an average of a sixteen to eighteen month waiting period for the first appointment. It is clear from this report that in waiting for an appointment and treatment, service users may experience significant difficulties in navigating developmental milestones.

By way of illustration of rigidity in traditional models of care (Richards et al., 2010), a recent newspaper article (Baker 2014) alleged that the implementation of mental health policy in the Galway/Roscommon area of Ireland was thirty years out of date and continued to rely on institutionalised care approaches. This is consistent with findings of the Mental Health Reform (2013) report previously referred to. The report referred to in Baker's article (HSE 2014) was created by an expert group on mental health policy and was generated in order to review the

implementation of the 2006 Vision for Change (Department of Health and Children) policy changes. One of the recommendations in the report was that "all staff should be educated on the philosophy of 'recovery model'" (p.32). It also reported that the area was still running its services on the basis of a "mini-institution" (p.19). The report highlighted variations in funding per capita in different areas also recorded by Faedo and Normand (2013).

The Vision for Change document produced by the Irish government was viewed by its authors as an important step in the development of policy in an Irish context (Department of Health and Children 2006, p.4). The document was supportive of a biopsychosocial model (p.18); however, critics such as Higgins and McDaid (2014) presented a view that clinical practice in Ireland was more influenced by historical factors, which made a diagnostic model more prevalent. MacGabhann (2014) believed that the Irish system was over-reliant on psychiatric diagnoses and he supported the incorporation of user perspectives in treatment approaches. From a psychiatric perspective, Ghaemi (2009) argued that the biopsychosocial model may be merely reductionist and eclectic. He believed that the terminology used had passed its usefulness and that there was a need for a new paradigm that encompassed the complexity and, perhaps, the art of medicine in patient's treatment.

Mental Health Reform (2015b) reviewed the Vision for Change's (Department of Health and Children 2006) policy implementation. While some policy developments were acknowledged by this report, in the main it did not acknowledge a substantive implementation of the envisaged policies. Specifically, in relation to Chapter 4 of the Vision for Change document (Department of Health and Children 2006), which addressed mental health in primary care policy, the report held that there remained "significant gaps" in provision and that:

> While the introduction of the Counselling in Primary Care Service in 2013 was welcome, this service is available to medical card holders only and has a limitation of eight counselling sessions for each individual accessing the service. Lengthy waiting lists for CIPC for a small number of people have been reported with approximately 81 people waiting more than six months to be seen by the service. CIPC is available to adults only and does not provide support to children and adolescents under the age of 18 years. (pp.54-55)

The Vision for Change (Department of Health and Children 2006) document acknowledged that professionals working in the area of mental health may have differing emphases focus based on their training and professional backgrounds (p.18). The job titles used for the

practitioner headcount included Clinical Psychologist, Cog (sic) Behaviour Therapist, Family Therapist, Addiction Counsellor and Other Therapist (Annex 17.2, Staffing and Infrastructure Requirements). It is possible that the term 'Psychological Therapist' (agreed by the Psychological Therapies Forum submission in 2008) as it may apply to statutorily registered practitioners will eventually replace the terminologies used in the Vision for Change report (Department of Health and Children 2006). There were no acknowledgements of alternative titles or recommendations in relation to practitioner terminology in the Vision for Change report, though it preceded the 2008 Psychological Therapies Forum submission.

From the literature review, there has been little domestic research evidence available or used to measure and monitor the effectiveness of Irish mental health policy in the private sector. This was confirmed by O'Morain et al. (2012) in respect of counselling measurements, by Faedo and Normand (2013) and also in the Vision for Change (Department of Health and Children 2006) policy document, which acknowledged the lack of, for example, national clinical outcome data. It was not clear how an effective national policy can be implemented without such basic data.

In addition, as has been seen, no national data is available on the numbers of psychotherapists or counsellors in the independent sector. This might be useful basic data for considering the importance and relevance of PSP. One plenary grouping of psychotherapy practitioners estimated that there were over five thousand practitioners in the Republic of Ireland, though many of these practitioners may operate in both private and public setting (Psychological Therapies Forum 2008, p.4). The participants in this plenary group included the IACP, the Irish Council for Psychotherapy (ICP) and the College of Irish Psychiatrists, among others. It might be said to be a representative assembly of practitioners. There do not appear to be any data collated by the state in relation to the numbers of private clients attending independent counsellors in Ireland. The fact that these numbers are not known or surveyed from a national statistics perspective is disappointing as it makes it impossible to evaluate the importance of PSP in the national context. However, the IACP (2013), which represents a sizable proportion of those working under accreditation bodies in PSP in Ireland, has made some inroads to collating these data among members in its 2013 survey and this will be discussed later in the review.

A review of some non-Irish data may provide some context for what is occurring in the domestic context. In 2006, Priebe provided a comparison of the accrediting models for psychotherapy among a number of selected countries. As Priebe acknowledged, the comparison is limited in that it is a non-systemic comparison of data from a range of countries with very different treatment and accrediting contexts. The table below summarises the estimated ratios of psychotherapists per each one hundred thousand people, calculated from the numbers provided by Priebe. Priebe stated that the ratio is a factor of the popularity or acceptance of psychotherapy in different countries, the manner of access to services, the stage of development in mental health services and what he believes appears to be a cultural bias in favour of more or less liberal accreditation thresholds. At the time of his study, Priebe noted that the UK health services were planning to double their number of therapist which would bring the ratio up to approximately forty-six per one hundred thousand:

TABLE 1: PSYCHOTHERAPIST PER CAPITA

Estimated ratio of psychotherapists per 100,000 head of population (summarised from Priebe, 2006)	
Canada	124
France	13-20
Germany	24
Italy	60
Netherlands	37
Spain	7
Russia	6
Switzerland	59
UK	23

Care is important in considering these data, as the selected countries have significant variation in their legal and training regimes (Van Broeck and Lietaer 2008; Priebe 2006). Bearing this in mind, on the basis of the planned UK increase in therapists to a ratio of forty-six to one hundred thousand people, and on the assumption that policies in Ireland will eventually reflect UK policy, to some extent, one could take an assumed need ratio of, for example, forty psychotherapists per one hundred thousand people in Ireland. Using this ratio and applying it to the 2005 census figures, which showed a population in the Republic of Ireland of 4.24 million (www.cso.ie n.d.) this would suggest that the required number of therapists is just under seventeen hundred. Looking at this ratio, in consideration of available estimates for the number of therapists in Ireland might also be useful. Based on the Psychological Therapy Forum (2008) figures, if we assume there was an Ireland therapist population of five thousand in 2006, then this would suggest an actual ratio of 118 per one hundred thousand people in Ireland. This is far in excess of Priebe's reported figures for any of the countries covered by his analysis, with the exception of Canada. This significantly higher ratio for Ireland may be for a number of reasons implicit in the differences contained within the country data presented.

In the context of IAPT recruitment making a significant effort to train the required number of therapists for delivery of the programme in England (Layard 2006) and in light of the above numbers, it would appear that there is a significant availability of therapists in Ireland. There

is, therefore, a question about how the ratio of psychotherapists to head of population in the Republic of Ireland apparently differs so greatly from that of other European countries.

It may be that practice in Ireland reflects the absence of statutory regulation, the historical development of the helping professions (O'Morain et al. 2012), a historically low accreditation threshold (Feldstein 2011) and a prevalence of part-time practitioners (IACP 2013). A cultural openness to psychotherapy may also be an unexpected factor among other possible explanations. Further research would be needed to explore this issue. From the perspective of the Delphi study, it may be of interest to establish if participants believe there is an abundance or oversupply of therapists in Ireland.

While there were no national data for training attainment levels available for Ireland, a scoping study of training provision in the mental health sector by the Mental Health Commission (2010) provided a review of the statutory process in Ireland and future requirements for the training of Psychological Therapists:

> In response to the Health and Social Care Professionals Act 2005, an umbrella group (Psychological Therapy Forum, (PTF) 2005-2008) convened at the request of the Department of Health and Children… The PTF (2008) submission proposed a registration board for "Psychological Therapists", which would require an academic qualification for entry to training (degree or equivalent in human sciences for psychotherapy and Leaving Certificate for counselling), a baseline qualification on exit (Master's level for psychotherapist and undergraduate degree or equivalent for counsellors) together with professional experience for registration. It was also proposed that course input, clinical practice hours, clinical supervision, and personal therapy would have baseline standardises requirements. The forum called for the titles 'psychotherapist' and 'counsellor' to be protected as professional titles (p.21).

The statutory submission by the group also agreed "grandparenting arrangements" for transitioning practitioners already registered with their respective organisations into the new regulatory regime (pp.10-11).

While there appears to be agreement in the above forum for training standards, and an acknowledgment of a difference between counselling and psychotherapy, from a training perspective at least, a recent position paper issued by the Irish Association for Counselling and

Psychotherapy (IACP 2013a), which was a member of the Psychological Therapy Forum above, appeared to row back on this agreement and asserted that there was no difference between counselling and psychotherapy, saying that training for psychotherapy or counselling should be at degree level rather than at master's level. Van Broeck and Lietaer (2008), in carrying out a review of psychotherapy regulation in 17 European countries, recommend master's level training for practitioners, observing that there was much variation across Europe in who was allowed practice and on whom.

O'Morain et al. (2012) described training in Ireland as possibly labyrinthine compared to US structures. Personal therapy is an integral part of many training contexts in Ireland, as is supervised practice and the study of various modalities. Much training takes place in private colleges outside university settings. Students study to the diploma, degree, masters or doctorate level in counselling and psychotherapy.

The above provides a more detailed context for Irish policy approaches and limitations that have been identified, including the lack of national outcome measurement, the lack of practitioner data and the lack of an explicit reference to private sector provision in policy. It begs the question, from the perspective of the e-Delphi study, as to what relevance participants perceive that PSP may have in policy development and implementation

2.4.1 PRIVATE SECTOR PSYCHOTHERAPY IN IRELAND

In their report on the history of Irish psychotherapy, O'Morain et al. (2012) used the term 'counsellor' to mean counsellor or psychotherapist. They reported that in Ireland there was a difference between counsellors and psychologists, but that the public did not make this distinction. They believed that the Catholic Church in Ireland stymied the progress of counselling in Ireland before the 1960s so as to defend its standing in society. They described the high walls of the mental institution as the prevailing response of the state to mental health at that time. They traced the evolution of Church-provided counselling in Ireland and its establishment of marriage guidance facilities in the 1960s to impose a Catholic perspective on couple's counselling. At around the same time a Protestant-led organisation for couple's counselling was established. From these beginnings, a group of practitioners emerged to establish the Irish Association for Counselling and Psychotherapy. At the time, the profession of counselling was not very highly regarded or recognised in Ireland (Feldstein 2011). O'Morain et al. (2012) described the second stage of development as the evolution of career

guidance counselling in second level education. During the 1970s, there was an increase in the provision of secularised counselling services which developed in parallel with the religious-based organisations. During the 1980s and 1990s, the profession of counselling became more established. This included the founding of a non-statutory accrediting body, the Irish Association for Counselling and Psychotherapy (IACP), in 1981. However, as demand for the services of practitioners grew substantially at that time there were questions raised around standards and regulation (Feldstein 2011). In 1985, Carl Rogers visited Dublin and facilitated group work undertaken by an accompanying group of practitioners. O'Morain et al. (2012) remarked on the popularity of William Glasser training courses in the mid-1980s in Ireland. This period was followed in the 1990s by a loss of power by the Catholic Church which O'Morain et al. suggested was significantly due to the child sexual abuse scandals by the Church that begin to emerge in that period. This resulted, they believed, in counselling replacing the Church context where people sought advice. In 1990 (Feldstein 2011) minimum training standards were put in place for accreditation purposes by the IACP.

In 1991, the then Taoiseach (Irish Prime Minister) Charles Haughey firmly located counselling and psychotherapy among what he called "professions that only operate in the private sector" in denying calls to extend state regulation to what he described as "non-medical psychological disciplines" (Feldstein 2011, p.67). In 1992 (O'Morain et al. 2012) another accrediting body, the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), was established. The IAHIP was created to support the interests of integrative and humanistic practitioners. In addition, in 1993 issues presenting in the clinic around child abuse presentations began to emerge as an issue for the profession in Ireland (Feldstein 2011).

In their 2002 survey "Perspectives on the provision of counselling for women in Ireland" Batt et al. reported that the increase in the provision of counselling and psychotherapy services caused confusion among users of these services who were historically accustomed to using GP services for assistance. The report recorded that 50% of respondents acknowledged a difference between counselling and psychotherapy. This is contradictory to the position of O'Morain et al. (2012) who were dismissive of attempts to differentiate between the terms. This contradiction confirms the confusion that surrounds the use of the terms counselling and psychotherapy (Totton 1999).

In 2005, the Irish government introduced the Health and Social Care Professionals Act which included a list of "designated professions" including psychologists and social workers (section

4) but did not include counsellors and psychotherapists without prescribed qualifications in psychology attained under the accreditation of the Psychological Society of Ireland (PSI). This is significant in that it excluded many members of the IACP who have become practitioners through pathways outside the PSI accrediting process. The act included provision for the relevant government minister to include other professions in this designation (Health and Social Care Professionals Act 2005); however, to date, the minister has not expanded the designation to cover those accredited by bodies other than PSI, such as IAHIP or IACP. The Act established CORU as the regulator of health professionals in Ireland. To date registers have been established under CORU for Dietitians, Occupational Therapists, Radiographers and Radiation Therapists, Social Workers, Speech and Language Therapists in addition to Optometrists and Dispensing Opticians.

In 2008, the Psychological Therapies Forum (IACP 2008), established by different groups of psychological practitioners in 2005, submitted proposals to the Irish government for regulation of the profession and included recommendations for differentiation between counselling and psychotherapy for regulatory purposes.

O'Morain et al. (2012) recorded that at the time that the IACP had approximately thirty-five hundred members and the IAHIP had seven hundred. The demand for services was increasing. In 2003, the accredited membership of the IACP was 993 (IACP 2003).

The IACP 2013 survey of over seven hundred of its members showed that members on average saw twenty-one clients per month with a range between zero and eighty hours per month (average of twenty-eight hours per month). The average age of participants was fifty-one and most were female (78% of survey respondents). Participants charged an average fee of €44 per hour equating to an average monthly income of €1,200-€1,300. However, 26% of all practitioners reported charging €20 or less, including 11% who reported charging no fee. In addition, 29% reported that they worked full-time in the field. The bulk of the membership appeared to work in the field on a part-time basis, though the report found that many of those who were part-time in the field did not work elsewhere. The promotion of the IACP emerged as a difficulty in the survey, with just 25% of those surveyed believing that the organisation's profile was good or very good. Of the sample reported, 86% of the five hundred and forty participants who declared they were accredited were working in private sector contexts (combination of individuals in private practice and those working in group practices). Accreditation in this context refers to practitioners who have met the educational, personal

therapy, supervision and clinical experience requirements prescribed by the IACP to practice under the auspices of the organisation. Though the survey reported 44% have referrals from GPs, it was not clear what proportion of overall clients were generated by these referrals; the categories used appeared to overlap. The major difficulty reported by participants in a professional context was the impact of the economic depression. The survey participants appeared favourable towards research in counselling and psychotherapy believing that it promotes better outcomes (78%), results in beneficial developments in treatments (78%) and facilitates the recognition of user perspectives (72%).

In 2014, the Irish Government (www.dcya.gov.ie 2014) introduced the Children First Bill which placed a legal onus on practitioners and organisations to report sexual abuse when they become aware of it. This bill, among other requirements (para. 2), puts in place "A requirement on defined categories of persons (mandated persons) to report child protection concerns over a defined threshold to the Child and Family Agency". This includes psychotherapists, though psychotherapy is still not recognised as a designated profession. It seems contradictory to impose one law on practitioners while not recognising practitioners in other areas of legislation.

The above information provides a historical context for PSP as a separate grouping in the Irish context and demonstrates some of the developments that have taken place in the area. From the perspective of the e-Delphi study, it would be useful to establish how participants perceive PSP in the context of policy and its relevance to service provision.

2.4.2   PRIVATE SECTOR PSYCHOTHERAPY ELSEWHERE IN THE WEST

Beginning in the 1960s, in the face of rapidly increasing healthcare costs, the US began to regulate and ration the provision of health services under a system known known as 'managed care' (Sanchez and Turner 2003). These regulations were developed under the 1973 Health Maintenance Organization Act. As managed care evolved, government regulations rapidly incorporated mental health services. As a result of this, Sanchez and Turner reported, there was increasing competition among practitioners, leading to lower cost services. They believed that these changes resulted in larger, formal networks of providers emerging, who could afford the financial burden of managed care administration. In containing costs, the system utilises a range of processes (p.117):

Methods used to offset costs include utilization review (after a predetermined number of sessions, the utilization reviewer evaluates the patient profile and treatment plan and must authorize the continuation of treatment), practice profiling (the monitoring of clinicians' costs and effectiveness), session limits, reduced inpatient stays, patient risk sharing (copayments and/or deductibles), "gatekeeping" (e.g., a primary care physician must authorize referral to a mental health specialist), use of less trained providers, and provider risk sharing (capitation).

We can see from this how a focus on cost-management has emerged. Speaking in 2000 of the US context for private practitioners, Grodski believed that the system was confusing for practitioners and equated it with a medical model of care. She observed that previously generous provision by insurance providers had been replaced by cost-focused approaches arising under managed care. She believed that practitioners had to choose between the restrictive limitations of working in managed care or working outside the system to find clients who could pay directly. She maintained that moving away from managed care and reliance on insurance reimbursement, would lead to psychotherapists becoming more focused on meeting clients' needs rather than on working primarily on containing costs within diagnostic frameworks. Grodski suggested that practitioners could move into private or independent practice, to focus on offering personal development and growth services. She foresaw that the changes would force therapists to explain what they do in non-technical language, thereby reducing the lack of regard that she believed the public in the US had for psychotherapy. She also acknowledged that therapists were ill-prepared by their training for the business side of therapy.

Writing in a US context in 1994, Edward Beck believed that successful experiences of therapists in private, independent practice pointed to the possibility that professional private counselling could survive as a professional grouping in its own right, rather than as an add-on to the prevailing hierarchy. He proposed that private psychotherapy could be viewed as a respected vocation. He predicted, however, that unless the representative bodies considered and responded to the issues of private practice, then those private practitioners would become less well regarded and their professional status would diminish. He believed that professional bodies may not have the best interests of those in private practice in mind. He concluded that there are significant differences between full and part-time therapists, and the needs of those in full-time practice were only recently being prioritised by representative associations in the US.

In discussing the possible future of psychotherapy and alternative health therapies in the UK Lees and Cleminson (2013) noted that practitioners, partly due to their base among individuals sidelined by society, remained outside traditional power groupings of the medical model and state control and manifested distinctive reactions to existing power discourses. They reported that practitioners' responses to changes in public health care provision varied. This ranged from the integration of emerging practices with the predominant medical model, such as the Improved Access to Psychological Therapies (IAPT), to challenging prevailing and officially sanctioned treatments, and especially, control exercised via the medical model.

In reflecting on the position of Beck (1994) in the US, the position of Davies (2009) in the UK can be considered. Davies discussed the creative energy of dissent which he believed could go against mainstream thinking and provide alternatives to the prevailing, possibly intolerant centres of power in psychotherapy. He believed that dissenters such as Jung, Adler, Stekel, Reich, Horney, Fromm, Lacan and others established alternative groupings whose influence still resonates today. While private sector therapy may not occupy a primarily dissenting voice, it may represent the possibility and importance of a creative tension with the prevailing discourse that can be fundamental to a creative process. The two discourses of the prevailing power centre and private sector therapy are not exclusive and Davies had the opinion that historically many dissenters moved between mainstream and alternative positions while ultimately contributing to reform of the mainstream approaches. Davies reasoned that state-organised professionalization results in division among existing therapies rather than facilitating discussion among them. He believed that this division had occurred in Germany, France and Italy. He discussed the example of Germany, where he believed prescriptive guidelines with state sanction had cemented differences between different modalities such as psychoanalysis, psychodynamic and cognitive-behavioural therapies and had placed integrative approaches out of favour.

Private practice may also be seen as a place to work on a longer-term basis with clients than is facilitated in publicly provided psychotherapy (Pope 2013a). Pope was concerned that clients can be captive to prevailing short-term approaches to therapy. In working in private practice in the UK, Pope observed in the UK context that there were significant changes in the kind of referrals that he was receiving from prospective clients who were looking for a longer engagement in therapy. He believed that private psychotherapy allowed practitioners to be

more creative, make errors and facilitate clients to recuperate at a speed that was comfortable for them.

Regulation impacting the availability of private sector psychotherapy services in European countries is highly variable. In Greece (Manthouli 2011), the Network for Psychotherapeutic Care in Europe (NPCE) reported that there is effectively no recognition of psychotherapy by the state. Some services were provided in addiction settings. While there was psychiatric provision in state hospitals, private health insurance did not reimburse psychotherapy services and private services were often used. In contrast, in Switzerland NPCE reported that provision was regulated and psychotherapy could only be provided by medically or psychologically trained practitioners, with a minimum of four to five years post graduate training in psychotherapy. Private practice was partially reimbursed for non-medically trained provision while most psychiatric provision is reimbursed. (Schnyder and Schulthess 2013). In France, the title psychotherapist has been legally protected since 2004 (Grosbois 2011). Provision in the private sector was regulated by way of prescribed educational standards for practitioners. The approved educational standards were a either a medical degree, a masters in psychology or a masters in psychoanalysis. Grosbois also reported that psychotherapy in France was usually not covered by social insurance.

In their comparison of the practice and regulation of psychotherapy in seventeen European countries Van Broeck and Lietaer (2008) also observed variability in oversight. They observed key differences in "polity, the organisation of the [sic] health care, and the organisation of the education system" (p.53), which made it difficult for them to make comparisons across the countries reviewed. They observed two models of regulation: one with psychotherapy as a specialisation of psychiatry and psychology (such as in Germany and the Netherlands), and the other a model of recognising psychotherapy as a separate profession encompassing practitioners of differing professional backgrounds, who are permitted to provide psychotherapy (such as was being considered at the time in England). This second model is broadly speaking the approach that is being adopted in Ireland.

The above literature provides additional context for the PSP Delphi and possibilities for the benefits of independent practice, for practitioners and clients, as an alternative to state prescribed approaches to therapy. This can allow PSP practitioners to provide emerging clinical responses rather than to be stymied by officially sanctioned, prescriptive approaches to therapy,

or having to adhere to the medical model approach to treatment. PSP may also offer another voice with a different perspective to the state or other power groupings and facilitate longer-term treatment than the other short-term, publicly provided treatments available in Ireland. In addition, PSP may be able to participate in carrying out clinical research to bring the clinic and research perspectives together. It may be that a concerted effort in this area could strengthen the standing of PSP. These factors lead to a question for the e-Delphi part of this research about how PSP is treated in policy in an Irish context and how much credibility it may have.

2.5   POLICY CHANGES IN ENGLAND

In the UK context, Turner et al. (2015) provided a brief history of mental healthcare provision. They trace a history of regulation in the UK beginning with the Lunacy Act of 1890. This Act was replaced by the 1959 Mental Health Act. As was experienced in Ireland and the US, deinstitutionalisation and the increased availability of pharmacological treatments occurred at that time. Turner et al. reported that in 1990, UK legislation moved responsibility for community provision of mental healthcare to local authorities. They observed a focus on more severe mental health issues until the late 1990s while state spending on the area of mental health was low compared to other healthcare provision. Turner et al. reported the establishment in 2006 of the Improving Access to Psychological Therapies (IAPT) programme in England.

According to Richards et al. (2010), since the year 2000, there had been an increasing cultural concern with what they described as an epidemic of depression and anxiety in the West, which despite a general increase in wealth, showed no sign of abating. They reported a high prevalence and impact of depression and anxiety around the world. Their study recorded disappointing outcomes and relapse rates for treatment of depression with psychological and pharmaceutical interventions. They reported that this had led to changes in research and treatment, which was now more focused on interventions and treatment efficacy for high prevalence disorders such as anxiety and depression.

As part of its IAPT programme, the UK government embarked on an aggressive plan in England, to implement national guidelines in relation to depression and anxiety treatment. Richards (2010) confirmed that depression and anxiety were among the most common mental health disorders. The programme came about partly as a result of the influence of Professor David Clark and Richard Layard (Evans 2013). Evans stated, "It is the biggest expansion of mental health services anywhere in the world, ever – and arguably the only instance of a

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government providing free talking therapy on a mass scale" (www.philosophyforlife.org 2013).

In what they described as a narrative literature review, Bower and Gilbody (2005) discussed the models of service utilised in the UK. They believed that there was an important function for primary care service in responding to more severe presentations. However, they observed that the more common presentations (depression and anxiety) were the focus of UK policy. They asked what the aims of the model should be and suggest four areas of focus: effectiveness (improving health), efficiency (maximising gains from restricted resource), access (meeting need) and equity. In terms of improving quality, they presented four models which were not mutually exclusive: training (of primary care staff or educational efforts with the general or target populations), consultation-liaison (clinical support with individual cases), collaborative care (use of screening, education and practice changes by case managers who liaise between patients and clinicians) and replacement/referral (wherein the patient is treated by a psychological therapist). The identification of these models and the areas of focus suggested the complexity that was apparent in making policy decisions in this area.

Bower and Gilbody (2005) believed that the UK's top-down approach to quality enhancement had focused on the training model, while the increases in therapy services via the training of psychological therapists had been grounded in the replacement/referral model. They found that the collaborative care and replacement/referral routes to improving quality were effective, but that these had limitations as they both relied on specialist staff. They suggested that the self-help and stepped-care models then being introduced might point towards improved access but were uncertain as to how such improvements might impact quality. In a meta-analysis of self-help interventions used for depression, Gellatly et al. (2007) reviewed thirty-four studies. They found that, while not definitive, self-help methods that were guided by a clinician were more effective than self-guided approaches. This pointed to a need for some clinical involvement in treatment, though it also suggested the possibility that technological developments and overcoming cultural resistance to change may lead to more widely available treatments. This issue will be discussed further in the section on technology in this review.

In addition to having supportive evidence for effective therapeutic treatment of depression and anxiety (Evans 2013), and given their prevalence in presentations, as part of a rationale for this implementation it was estimated that when fully rolled out, the IAPT approach would save the public sector £700 million in net benefits (Clark 2011) including money saved from lower

welfare costs, lower health costs and increased tax revenues (Clark 2011). Clark observed that the policy was supported by the coming together of a number of forces, including clinical evidence from academics, an economic rationale accepted by the government, and the views of the voluntary sector, who were increasingly concerned by the level of medication being prescribed. In addition, Clark said that service users' complaints about prescribing practices, and their expressed preferences for psychological interventions, were also important factors (Evans 2013).

These efforts have resulted in an ostensibly impressive set of outcomes with targeted coverage of 60% of the adult population and training of over thirty-six hundred psychological therapy workers up to 2011 (consisting of 60% therapists trained in the NICE approved CBT approaches and 40% psychological wellbeing practitioners (PWP) trained in low intensity interventions), followed by the training of twenty-four hundred psychological therapists between 2011 and 2014. This training and policy rollout was designed to meet the therapeutic needs of 15% of the population who had depressive and anxiety disorders (Clark 2011). In the UK example, this process included permitting self-referral for treatment which Clark described as a revolutionary element of IAPT (Evans 2013). This collaborative and stepped care approach, which also incorporated telephone contacts into the care model (Richards and Suckling 2009), effectively placed IAPT practitioners on a par with other primary care providers for depression and anxiety issues. This is in contrast to the Irish model identified in the Vision for Change (Department of Health and Children 2006) policy document, which confirmed the ongoing centrality of GPs for treatment and referral decisions.

The IAPT approach was initially tested in two pilot locations in Doncaster and Newham. In their report of the Doncaster location, Richards and Suckling (2009) presented a review of a field trial of outcome and process data over a twelve-month period from August 2006. In the IAPT approach implemented at Doncaster, all referrals were reviewed by a service manager. If there was a doubt about the appropriateness of the referral, contact would be made with the relevant GP to discuss the case. An assessment process was completed and the patient was offered phone contact or face-to-face therapy. Stepped care progressions of low- and high-intensity CBT-based approaches was offered depending on the severity of the patient's anxiety or depression. Computer-based CBT treatments were also offered for less severe cases. Available treatments were based on efficacy reviews carried out by the UK National Institute for Clinical Effectiveness (NICE). While Richards and Suckling acknowledged that their

analysis was based on data from symptom checklist outcomes, they also recognised a number of other significant limitations to their approach, and with the IAPT model. They concluded that the IAPT approach was useful but required determination from the administration and bravery in the clinic. From their report, it can be understood how difficult it is to assess the complexities of the approach. However, it is clear from this report on the IAPT approach, that a comprehensive effort is being made to address mental health issues in primary care, beginning with anxiety and depression. In this study, it was also found that self-referrers had conditions that were as severe but more long-standing than GP-referred patients. In addition, patients needed less time in therapy which may have been a result of the self-referrers being enculturated by their own efforts to gather and assess information before engaging with services (Evans 2013). Self-referral may engender empowerment. This possibility might suggest that alternative points of entry in the Irish example, such as PSP, might provide additional pathways to treatment which could encourage more individuals to avail of services.

Chiesa (2008) offered a contrary approach to what he described as the commercial mind-set that he believed was gradually becoming fundamental to the UK health service approach. He looked at the provision of outpatient services for personality disorder treatments for a small sample in London. He found that the administrative delays from seeking an assessment to treatment being approved in a cost per case model of care ranged from 45 days to 391 days with a median of 141 days. Chiesa believed that these delays could result in a reluctance to refer out on the part of GPs as among other reasons, patients could not rely on timely referral. While this model is not quite the same as the IAPT model being rolled out, the study is a stark warning of the risks of overly bureaucratic, cost-driven structures. He observed that the ability of the individual seeking treatment to assert their needs was a factor in successful access to treatment. He contended that rigidity in procedures could be used by Primary Care Teams (PCTs) to justify not referring on, echoing Richards et al. (2010).

It must be acknowledged that approaches similar to the IAPT model may actually focus on solving simple problems in a cost-effective way. Nonetheless, as Eisenberg pointed out, "The fact is that patients do not arrive at the doctor's office neatly packaged and pre-sorted" (Eisenberg in Goldberg & Huxley 1992, p.x) which would confirm the complexity involved in treating clients. Eisenberg defended the talking cure saying, "Psychotherapy is far preferable to routine medical prescription of psychotropic drugs; but it does require time and time is a precious resource in a busy office practice. Whether public authorities will be persuaded to

provide the funds needed to make brief psychotherapy widely available remains to be seen." (Eisenberg in Goldberg & Huxley 1992, p.xiii). Richards et al. (2010) reported that demand for services still outstrips supply.

Glover, Webb and Evison (2010) reviewed the dataset from nearly eighty thousand UK patients. Approximately 84% were GP referred and only 8.6% were self-referred (Glover, Webb and Evison 2010, table 9). In addition, 30% of patients were receiving welfare benefits while 64% were not, and 39% had full-time employment (table 10). This finding suggested that the focus of the IAPT policy on getting unemployed persons with mental issues back to work is not where resources are being used in practice.

In table 13 of the report, in terms of comorbidity patterns, 6.5% reported anxiety alone, 3.9% depression alone and 4.4% phobia alone. Of the valid sample of patients, 24.3% showed anxiety and depression, 41.6% presented with combined anxiety, depression and phobia and 42.3% reported low-intensity-only treatments. There appeared to be access issues for men, older persons and ethnic minorities, while data for those with disabilities was not available. This may speak to issues of equity. The dataset clearly demonstrated the predominance of GP services in the existing model, despite the alternative referral pathways facilitated. In addition, the large proportion of patients reporting a combination of depression, anxiety and phobia illustrated the complexity of clinical presentations. The report was based on a significant database, one of the largest of its kind in the mental health field, and it contains important results for primary care in the UK and is also relevant to Ireland. These issues may also speak to an issue of equity or fairness in ensuring that services are widely available on the basis of need irrespective of gender, age, cultural or disability considerations. Clark noted the inclusion of non-completers in the analysis of the data. This was different to historic approaches to research which Clark contended would only include results for those who completed a full course of treatment (Evans 2013), though it can be recalled from Eysenck (1952) that non-completers were effectively included as treatment failures.

There may also be difficulties in the collection of data reviewed by Glover, Webb and Evison (2010), arising from the kind of data collection methods used. In the higher intensity face-to-face work, the service users completed the outcome forms while waiting for therapy sessions. For phone-based service, the surveys also took place over the phone. The high-intensity environment might have increased the impact of demand characteristics, while the phone-based

surveys might have resulted in bias arising from the provider of the service also being responsible for administering the survey (Evans 2013).

Glover, Webb and Evison (2010) also reported that low-intensity treatments were prevalent and many attending to therapy were employed which might indicate a need for lower-intensity training among practitioners, and a demand from those in work. However, this aspect may indicate equity issues among disadvantaged populations who may be less likely to access services, as referred to above.

From this brief review of recent UK policy changes, an underlying statistical rationale in the review of policy changes and resource provision is apparent. This contrasts with the focus of Irish policy which apparently is not grounded in any substantial national data. It also leads to consideration of what Delphi study participants might wish to see in future policy developments in Ireland in addition to what impact they see current implementation having. The issue of equity is also of relevance, which may suggest a need to also consider low-cost therapy.

2.6 LOW-COST THERAPY AND EQUITY

Writing in the British Journal of Psychiatry, Richards and Bower (2011) discussed issues of equity which they believe arose in Australia following its 2006 introduction of the Better Access policy, which they described as being similar to the UK IAPT programme. Despite the apparent successes of this programme, Richards and Bower discussed the possible lack of access for disadvantaged populations. They found that factors of youth, marital status, ethnic background, education attainment and income levels in some of the locations studied indicated a reduced likelihood of using available services. They reasoned that this suggested the need to consider access and equity and the possibility that services may not help, or be sufficiently sensitive to those in some marginalised groups. From the perspective of PSP in Ireland, this may be relevant to the issue of cost in terms of facilitating access for those who require therapy.

In relation to paying for services, Friery (2011) posed a question about payment for therapy in the UK context. He contended that many clients there began therapy via the voluntary sector, where no-fee or low-fee payment regimes prevailed. He suggested that more investigation was needed about who pays for these services. In the private sector, he believed that while there was no formal regulation of fees, there were two elements that impacting charges: the market's willingness to pay the fee and the counsellor's position on fees. He disliked the idea that

counsellors should not be paid, saying that this speaks to the issue of how counsellors value the profession and their work. He believed that in any profession, those who were trained should get a return on their investment of time and money into their training. However, he did not believe that it was a given that greed arose from professional registration. While he acknowledged that he was avoiding a discussion of the issue of money as a symbol in therapy, he believed that the issue of money should be considered and suggested that high fees indicated a very negative view of the client. He noted that some US organisations prevented members from working for free and was aware that, given the history of counselling in the UK voluntary sphere, it might be seen as a low-cost profession. However, he didn't think this could be "fixed" by higher rates.

Dixon-Wood et al. (2005), in a report on access to health care for vulnerable groups, maintained that there had been a sensitivity created among those seeking help to avoid being too demanding on a professional's time. The prevented some patients with clinically significant illnesses from seeking help. In discussing the permeability of services, they believed that some services were easier to access than others and that some services had an implicit expectation of a user who perfectly fitted the manner in which the service was intended to be offered. They observed, however, that there was also a "cultural dissonance" between the culture of the organisation providing care and the expectations of minority users or those on the margins of society. They gave the example of a lack of sensitivity that may arise in dealing with those who were from different ethnic backgrounds. However, they acknowledged that evidence of this was not available. They also reasoned that there were possible variations in resources that, depending on how and where services were provided, could lead to disadvantage. They believed that those who were economically disadvantaged responded to disease as sequential crises rather than as issues that required ongoing care and prevention. This, in turn, resulted in the "normalisation" of poor health in disadvantaged communities, which impacted on the kind of services provided. This confirmed the WHO (2012) view that mental illness leads to poverty. They suggested that providers of health services needed to reflect on the reactions they may have had to presenting clients or patients, and that the providers should consider the kinds of heuristics they may use in considering whether or not services could be accessed by those seeking care. In addition, they recommended the need to consider team decision processes and also to include patient perspectives in decision making.

Low-cost therapy is provided extensively via voluntary and charitable organisations in Ireland (O'Morain, 2012; Feldstein, 2011). Speaking of an Irish context psychotherapist and author

Edward Boyne (McCarthy, 2009), who was a member of the expert group that developed the Irish policy document Vision for Change (Department of Health and Children, 2006), found that there were very long waiting lists for medical card holders; this was not realistic for clients hoping to access therapy. Boyne also played a significant part in the establishment of the counselling profession in Ireland (Feldstein 2011). Boyne observed (McCarthy, 2009) that service users in low-income areas in Ireland were more likely to receive medication and less likely to receive psychotherapy while these areas were often in most need of mental health services. He maintained that often these areas were in five to six times greater need and that there were clear issues around equity of access, and the type of treatments available, reflecting issues identified in the Australian context as identified by Dixon-Wood et al. (2005) above. Though O'Morain et al. (2012) believed there was no sign of the Irish government providing counselling to those who cannot afford full cost counselling, the establishment of the Counselling in Primary Care (CIPC) in 2013 (Cahill 2014) made counselling available to approximately two million medical card holders in Ireland. The service offers up to eight weeks of counselling sessions with no direct payment required. However, Irish policy and this service provision does not appear to explicitly account for issues of gender, age, culture and disability.

Although waiting lists are lengthy, this provision of free counselling to so many potential users, in addition to the low-cost services already available in Ireland, may present a challenge for PSP practitioners. This review shows that the provision of low-cost counselling is of relevance in an Irish context both in terms of providing access to care for disadvantaged populations but also in the context of practitioners earning a living, and psychotherapy being valued. The issue of equity is also of relevance to PSP. For the purposes of the e-Delphi study, it may be of use to explore how participants perceive the impact of low-cost counselling on PSP.

2.7   EVOLVING PSYCHIATRIC PRACTISES

Dean (2012) believed that as a result of the introduction of antipsychotics and antidepressants in the 1950s, psychiatry began to develop as a medical specialty that was able to diagnose and treat specificity. He contended that specificity was a necessity in support of credibility, given the historically low regard that existed for psychiatry. He described how the term "alienist" (p.443) had been used to describe doctors working in asylums that began to appear in the US in the nineteenth century. Dean reported that there was a huge increase in admissions to asylums at the beginning of the nineteenth century, which was also reflected in large increases in the capacity of state hospitals used for treating mental illness (Grob 1983). There was also a

parallel increase in the length of stay for those treated, increasing from 40% of patients confined in 1904 for five or more years to 54% by 1923 (Grob 1983). The use of electroconvulsive therapy (ECT) was widespread by the end of the 1930s. Fallon (2015) critiqued the history of ECT and its continued use in the Irish context, claiming its use was not scientifically justified. He also outlined excessive incarceration for mental health issues, supported by psychiatry in Ireland during the 1950s. He believed psychiatry to be expedient and questioned its ethical stance. Dean (2012) observed that many supposed therapies were introduced by overworked staff. These therapies included many unpleasant and outlandish treatments such as the removal of ovaries and testicles on the basis that infection was the presumed source of mental illness (Scull 1987; Valenstein 1986). Dean explained that sleep therapy became popular then, and the use of chloral hydrate and paraldehyde as barbiturate replacement developed and persisted throughout the first half of the twentieth century (Healy 2002). Dean believed that during this period, patients were often treated with torturous interventions and had few rights; he also believed that an absence of informed consent and a lack of institutional oversight prevailed.

Hoenig (1983) discussed the development in psychiatric perspectives on schizophrenia, believing that without a clear understanding of how these perspectives had developed, there was a possibly negative impact on practice and research. Hoenig believed that Kraepelin was focused on a somatic view of schizophrenia, which resulted in the possibility of an approach based on subjectivity rather than on the objective diagnostic approach that emerged. Hoenig held that Bleuler and Jung made attempts at this, but new problems arose as a result. He wrote that subsequent developments facilitated the objective and subjective study of schizophrenia. Hippius and Muller (2008) maintained that Kraepelin had questioned his own separation of dementia praecox and manic-depressive insanity, and that the debate continued. Dean (2012) agreed with this interpreted position of Kraepelin, and criticised the specificity model which he believed was not true to Kraepelin's less definitive position, but which became prevalent in the early 1950s by the emergence of a neo-Kraepelinian school of psychiatry that began in the Washington University psychiatry department. Dean suggested that this emergence coincided with the development of psychopharmacology for use in disorder in the 1950s and 1960s. With this development, a need for a more rigorous, scientific approach to treatment and diagnosis became obligatory. He believed that this necessary development was delayed by the psychoanalytical control of psychiatry, and by vague diagnoses, in the 1940s and 1950s. He believed that this control by psychoanalysis was partly sustained in the US by the escape of psychoanalysts from Hitler's Germany.

Connected to these developments, there was the introduction and development by the American Psychiatric Association (APA) of the Diagnostic and Statistical Manuals (DSM). Dean (2012) referred to Shorter (1997) who pointed out that the first two editions of the DSM were overseen by the psychoanalytic domination of the Nomenclature and Statistics Committee. As a result, Dean believed that scientifically unsupported psychoanalytic terminology, and its underlying theoretical pathology for neurosis, were often used. Dean reasoned that schizophrenia diagnosis was similarly vague, with underlying elements applicable across a number of diagnoses. Dean explained that at the end of the 1960s, the persistent power of psychoanalysis was challenged by the emerging fields of psychopharmacology and biological approaches to psychology. The US Food and Drug Administration (FDA) also increased its influence and enforced randomised, placebo-controlled trials as the standard for drug approval, which resulted in a need for a more scientific system for diagnosis. The FDA decided in 1951 that new medications had to be prescribed. These changes, in turn, Dean maintained, resulted in a persistent commercial link between psychiatry and the businesses engaged in developing and promoting the burgeoning array of drugs for use with psychosis, depression and anxiety. This link was further enhanced by changes to the 1962 Food, Drugs and Cosmetics Act which he reported promoted the connection between drugs and specificity.

In the 1970s, Guze influenced the move towards more defined diagnoses despite acknowledging the overlapping realities seen in the clinic. The arrival of DSM-III in 1980 enshrined criteria checklists in diagnosis and included, just five years after the previous edition of the manual, 251 new diagnoses. Dean (2012) and Davies (2013) contended that this inclusion was not scientific but was often based on clinical opinion. While, as Dean pointed out, the foreword to the DSM manual pointed to the possibility of diagnoses overlapping, the criteria included in the actual diagnoses were specific, even though most of the categories were not scientifically authenticated. The DSM-IV was published in 2000 followed by DSM 5 [sic] in 2013. While the DSM 5 nods to dimensional and case formulation approaches to treatment, many of its criteria-focused diagnoses remained and the scientific grounding of many of the disorders included remained questionable (Davies 2013).

In connection with the diagnostic response to psychosis, Bentall (2006) believed that a new approach was necessary. He believed that the Kraepelinian approach was erroneous in assuming discrete diagnoses and in presuming a clear dividing line between normal and

abnormal. Craddock and Owen (2005) supported this position. Bentall suggested an abandonment of diagnostic approaches and endorsed an approach that focused on the symptom. He discussed the example of hallucinations, arguing that research had provided a good understanding of underlying mechanisms related to this occurrence. In the case of auditory hallucinations, he believed, the patient confused inner speech with an external input. In the example of delusions he claimed that research points to errors in thinking processes. In relation to the disease model of psychosis, he believed that rather than internal or endogenous factors being identified as causes, research was strongly pointing to the possibility of environmental influences including attachment difficulties and trauma. He believed that his recommended approach was more scientific than the Kraepelinian approach, as well as being more humane and respectful of patient agency. Parnass et al. (2012) supported his arguments and supported the idea of ontology and epistemology as a primary focus for research, believing that the symptom cannot be separated from the idea of subjectivity. They reasoned for what they described as a multidisciplinary approach which incorporated theories of mind, philosophy and psychological understanding of phenomenological domains.

Issues related to the medicalization of normal human suffering have been explored by a number of authors (for example Davies 2013; Szasz 2010; and Conrad 2007). Szasz contended that mental illness must be thought of as a metaphor rather than as a scientific fact. Szasz criticised diagnosis observing that conceptually mental illness "is firmly rooted in the notion of complaint, whether by the patient or about him" whereas an illness of the body is somewhat independent of the complaint (p.84). This reveals the inherent difference between a science engaged with finding and diagnosing visible or measurable illnesses of the body and a science (or perhaps art (Welling 2005)) that attempts to engage with the complexity of each individual who arrives in the therapy room. Here Szasz also presented the idea of mental illness in the context of normalisation of clients and cultural insistence on normative behaviours from both practitioner and client. This issue may also speak to the issue of outcome measures reviewed above and how these can be limited by a requirement to measure health outputs desired under government productivity objectives rather than being based on the subjective needs of the client.

Verhaeghe (2008) said that the diagnostic norms historically developed from the actual laws that ruled behaviours (p.69), which is in line with the views of Szasz (2010). Verhaeghe (2008, p.63) critiqued the scientific method, and held that the concepts of truth and knowledge are

very different; truth is either true or false and is not generalizable in the way knowledge can be. He also connected his view of knowledge and truth to the idea of normality, believing that the difference between normal and abnormal is arbitrary. Verhaeghe went on to say that people relied on an opinion in proving their positions where knowledge was unable to find truth (p.71). Accepting the views of Szasz and Verhaeghe leads to the counterargument that scientific knowledge will never find sufficient truth, that answers the problem of individual human suffering, partly because truth and suffering are always subjective. It may also be debated that individual complexity is impossible to adequately model, in order to establish a general truth. Verhaeghe demonstrates the inherent difficulty with diagnosis and its apparent bias in favour of culturally acceptable behaviour (Davies 2013).

De Leon (2013) pointed to the controversy surrounding the introduction of the DSM 5 which resulted in media challenges to the scientific credibility of the manual. He described how the language of psychiatry had two layers. The first was the description of the symptom and sign which initially developed in France and Germany during the nineteenth century. Secondly, psychiatric language was used in the description of disorders as developed by Kraepelin and the neo-Kraepelinians outlined above, and which led to the DSM-III. De Leon discussed the danger of excessive regard for the model and insufficient regard for its limitations. He described the discoveries of electro-convulsive therapy and pharmacological applications as occurring by accident rather than emerging from a scientific context. He believed that one of the difficulties for psychiatry was incorporating difficulties in human interactions which may form part of a pathology in which neuroscientific methods may have no place. He adopted a position in favour of a new language in psychiatry.

Coming from the perspective of genetic epidemiology, Cradock and Owen (2005) demonstrated that at the level of molecular genetic findings, there is no basis for the dichotomous (or Kraepelinian) model. In acknowledging the interaction between environment and genetic expression of pathology, they contended that spectrum and dimensional approaches may be required in responding to patient presentations. They concluded by saying that while it may have been valuable up to now, it was time to move away from the Kraepelinian model. Dean (2012) observed that in the clinic, a move from categorical diagnosis to dimensional approaches had already taken place.

In considering a clinical perspective in a New York Times article, psychiatrist Daniel Carlat (2010) recorded his thoughts on how his practice and his perspective on psychotherapy and medication had evolved over his career, saying that over time:

> Instead, I had come to focus on symptoms, as if they were objective medical findings, much the way internists view blood-pressure readings or potassium levels. Psychiatry, for me and many of my colleagues, had become a process of corralling patients' symptoms into labels and finding a drug to match.

In Carlat's article, he traced the arc of US-based psychiatry practices from an initial fascination with the workings of the mind to focusing on the use of medication in response to problems, at the expense of traditional psychotherapy.

Carlat's perspective was supported by a 2008 research study carried out by psychiatrists Mojtabai and Olson who analysed data from 1996 to 2005 from the US National Ambulatory Medical Care Survey (NAMCS). They found that "the decrease in providing psychotherapy corresponded with a decline in the number of psychiatrists who provided psychotherapy to all of their patients from 19.1% in 1996-1997 to 10.8% in 2004-2005 (P=.001)." (p.962). The authors acknowledged the financial considerations involved and observed that the decline in psychotherapy provision was reflected in a rise in pharmacotherapy specialists. The suggestion was that psychiatry was being drawn away from the practice of psychotherapy by the financial incentives offered by working in a medication model that is reliant on a diagnostic model which is anchored in the DSM. Looking at evidence-based treatment, from a research perspective, Gaudiano and Miller (2013) confirmed the dominance of the biomedical approach in mental health contexts while evidence-based treatments were underused.

The National Institute of Mental Health (NIMH) is leading a move away from funding research using the DSM model through the Research Domain Criteria (RDoC) project, to develop diagnosis by incorporating genetics, imaging, cognitive science, and other contexts for a new system of classification (National Institute of Mental Health n.d). Bracken at al. (2012), writing in the British Journal of Psychiatry, were concerned about the current focus in psychiatry on the use of brain science findings and the focus on medication. While not dismissing the importance of these they believed that psychiatry needed to become more focused on the evolving influence of service users and the evidence basis for interventions. Gaudiano and

Miller (2013) described the RDoC initiative as a move from the categorical to the dimensional use of diagnosis as psychiatric research had failed to find biomarkers for mental illness. They also recognised the financial reality of medications taking fifteen minutes to prescribe while an hour was required for each psychotherapy session.

Carlat (2010) observed:

> Leon Eisenberg, an early pioneer in psychopharmacology at Harvard, once made the notable historical observation that "in the first half of the 20th century, American psychiatry was virtually 'brainless.' . . . In the second half of the 20th century, psychiatry became virtually 'mindless.' " The brainless period was a reference to psychiatry's early infatuation with psychoanalysis; the mindless period, to our current love affair with pills.

Related to Carlat's comments, Fibiger (2012) predicted that significant changes would be required in psychiatry from research to the clinic. He reasoned that the field lacked an understanding of the brain and how its function was connected with psychiatric illness. He remarked that there was a gap in the existing array of medication responses to psychiatric illness. He recommended an increase in investment in neuroscience which would necessarily, given the loss of industry interest, involve the pursuit of academic knowledge, which in turn may encourage the return of the pharmaceutical industry to the field of mental health research. He claimed that research into cancer underwent a similar sea-change in researching the underlying biology of different cancers. Fibiger (2012, pp.649-650) summarised the arguments made by many researchers in the field, and as predicted by Craddock and Owen (2005), when he wrote:

> A major barrier to progress is the current state of nosology in psychiatry. A new taxonomy is a prerequisite for meaningful progress. Today, few would argue that syndromes such as schizophrenia and depression are single, homogeneous diseases. And yet when it comes to clinical research, including clinical trials, both are still almost always treated as such. For example, studies continue to be published on the genetics of both of these syndromes despite the fact that there never will be a robust genetics of either condition as the nature and severity of specific symptoms are too heterogeneous across individuals to have any consistent genetic correlates. Similarly, while DSM conceptualizations of psychiatric disease may have utility in current clinical practice, when it comes to research, they too are a barrier to progress… the

chances seem better that there will be a biology of subsyndromes such as negative symptoms, delusions, or hallucinations.

This part of the review presents a clear problem for psychiatry in incorporating an as yet uncertain psychological view of mental distress rather than one that is focused on finding through science the certainty of a physically located diagnosis. This difficulty presents problems for psychiatry as it would require a move away from a hard science to accepting more subjective variability in treating the human condition. In turn, this might present a challenge to the position and credibility of psychiatry among the medical sciences as it may have to return to the vagueries of working with the individual rather than beginning from diagnostic, supposedly scientific, certainties.

2.8   GP REFERRAL PRACTICES

According to the Vision for Change document, "when an individual experiences a mental health problem, contact with their general practitioner (GP) is usually their first formal attempt to seek help." (Department of Health and Children 2006, p.60). The report also says:

> There are approximately 2,250 practising GPs in the state, some of whom practice part-time. They operate from approximately 1,280 different practices throughout the country, with just over half (51%) still single-handed; the remainder are in partnerships or group practices. (p.61)

In considering the primacy of GPs as a first point of contact for many mental health issues, it is relevant to undertake a review of studies of GPs working with psychotherapists. In a 1976 study, Brook and Temperley explored the benefits of a psychotherapist working collaboratively with a UK GP in general practice. The study was among the first to demonstrate the high degree of variability in referral practices among GPs. Written from a psychoanalytic perspective, the study demonstrated the value of psychotherapy specialists in GP settings as well as the value of an approach that includes settings for feedback and review between the various professionals involved. In writing about Brook's contribution to this area, Elder (2009) believed that just a fraction of treatments by GPs utilised evidence-based treatments. While Elder was also writing through a psychoanalytic lens, it is perhaps a reminder of the complexity that presents in care settings that may be lost in treatment rigidities already referred to (Richards et al. 2010).

Complexity was also discussed by McQueen, Pennybacker and Doctor (2010). Reviewing the UK Improving Access to Psychological Therapies (IAPT) model, they reported that they could not locate published research on complexity in IAPT referrals. They critiqued the UK National Institute of Clinical Excellence (NICE) research on which the IAPT model is based as reliant on findings for patients with single diagnoses. Only 2% of the small sample reviewed by them had an uncomplicated disorder. They concluded that in reality presentations were very different to those used for including treatments for anxiety and depression in NICE guidelines. They believed that, given the reporting pressures of the model, top-line successes reported under IAPT do not always capture or respond adequately to underlying complexity and comorbidity. Complexity is a reality in practice but it is one that may be ignored or untreated given the productivity focus of public health care interventions. This focus may be played out in the publicly funded clinic via a process of monitoring and management, by reference to outcome measurement instruments used to achieve the goals of public health, rather than addressing the subjective suffering of the individual.

A 2002 German study by Fritzsche, Armbruster, Hartmann and Wirsching confirmed the presenting frequency of mental health issues in the GP consulting room, reporting that primary care prevalence for mental health presentations and related social difficulties were in the range of 20-30%. The UK Mental Health foundation reported that only one in four of those with widespread mental health difficulties were receiving formal care, and that the majority of these were being treated with medication (The Mental Health Foundation n.d)

Questions on how referrals were made were examined by a small-scale qualitative study by Cocksedge and May (2006) in the UK. The study found that despite the increasing evidence base for counselling, there was an issue on how GPs refer to these services. Cocksedge and May discussed various protocols and referral methods used by the GP sample and found that counsellor waiting lists varied from less than a week to ten weeks. The study found that counselling referrals may enhance GP patient rapport rather than place it at risk. However, some GPs were not comfortable with referrals and did not believe they were well trained in responding to patients awaiting counselling or in working with those who did not want to meet a counsellor. The study also found that a number of patients did not wish to receive treatment from anyone apart from their GP. In discussing this finding, Fritzsche et al (2002) concluded in their study of a German Psychosocial Primary Care (PPC) model that while there was resistance to referral, young patients and those who had previously received counselling were

more open to counselling referrals. Prevailing cultural attitudes towards GPs (and towards medication) may be relevant in this area.

Westmacott and Hunsley (2010) looked at termination reasons for 1,080 individuals selected from a large Canadian sample. They found that 40% gave feeling better as a reason for terminating therapy, and 15% reported that either the course of therapy had been completed or that the treatment was not helping. The authors acknowledged that given the unique characteristics of the Canadian care model, the results may not be generalizable; however, it does provide an indicative insight into termination reasons. They also concluded that those who earned less and those with more severe presentations were more likely to terminate treatment early. From this, there may be an issue around income and severity of mental health problems which speaks to issues around advocacy equity for vulnerable patients (Friers 2011; Richards and Bower 2011; Dixon-Wood et al. 2005).

In a 2003 study by Knight, described as a qualitative and descriptive pilot study, "patient-related factors considered in mental health referral decisions" (p.213) were examined along with treatment and referral rationales used by a small sample of GPs (n=9) in two practices with primary health care teams. Perspectives in relation to referrals, using a combination of responses to sample case study and qualitative approaches were explored. Knight also included a questionnaire exploring referral priority perspectives of GPs. The proportion of "total mental health referrals" made by GPs in the study ranged from 8% to 20% (p.210). Knight concluded that "referral decisions are complex… involving the weighing-up of various alternatives" (p.213). Knight suggested replication of the research and also a larger scale study to facilitate the appropriate use of statistical review of data. She also suggested a comparison between GP and counsellor responses to the case studies presented. In Ireland, Sundlov (2008) adopted this objective, discussed below. While limited given its size, the study would appear to confirm variation and complexity in referrals reflected in this review. The low referral rates and the variations in these rates, while recognising the complexity of individual cases, is of relevance to PSP as it may help with an understanding of how referral decisions are made and what PSP might do to respond to these decisions.

In a 2004 grounded theory study carried out by Sigel and Lieper, the authors suggested that GPs referred patients to another resource when their capacity to treat given personal and time restraints was reached, when the patient was non-responsive to treatments given, and when

they thought that patients were ready for psychological treatments. Patient suitability in terms of their preferences, insight and readiness were also given as considerations in the referral process. Access was also an issue and personal contacts were reported as factors in gaining access to referral resources. Their conclusion suggested the need for increased understanding between psychologists and GPs. Sigel and Lieper also referred to the Jenkins and Smeeton (1988) study that suggested a high degree of variability in diagnosis outcomes among GPs.

These studies may raise questions around referral practices of GPs in primary mental health responses. For example, there may be an issue of insufficient training for responding to presenting difficulties among GPs. In connection with the variation of responses and predominance of GPs in this area a meta-analysis was carried out by Mitchell and Kakkadasam (2010). Their analysis was based on studies carried out in primary care, secondary care and nursing homes wherein the authors examined diagnostic accuracy in relation to depression. The authors found that nurses and doctors working in similar settings had similar clinical accuracy in identifying depressive individuals. Though the authors acknowledged that the findings merited more studies under randomised conditions, and acknowledged the difficulty for accurately identifying depression in general, they suggested with more training that nurses might be more effective in identifying this problem among patients. The necessity of maintaining GPs in the front line of providing the bulk of mental health responses in Ireland may be questioned. It may be that GP's expertise and a more effective return on investment could be achieved through giving parity to other mental health professionals in the provision of front line mental health services. However, it must also be acknowledged that GPs and patients may have a preference for remaining under the care of their GP. This may speak to a need for educating GPs and the public in the availability of beneficial alternatives such as psychotherapy and PSP.

In the Irish context, in a 2003 survey of the South West Area Health Board (SWAHB) in Ireland, Copty reported that the SWAHB provided health and social services for a population of 581,000. The report, Mental Health in Primary Care, was produced in light of "the paradigm shift towards community and primary care" (p.1). The survey of 231 responding GPs, 76.5% reported over 10% of patients having mental health problems while 85% of GPs referred less than 5% of patients on to mental health practitioners. Anxiety disorders (49% prevalence) were the main reporting mental health issue, followed by depression (24%) and emotional difficulties (20%) in addition to other issues (7%). Most incidences of the top three disorders

were reported by GPs as treatable in general practice with support; however, 81.5% would have liked support from "counsellors or psychologists" (p.15). Just under 80% reported a waiting time of four weeks or more for "non-urgent referral for mental health assessment".

In reviewing the literature, some research studies carried out by master's level students in Ireland related to referral practices of GPs were located. A 2008 study by Sundlov submitted for an MSc in Counselling Psychology at Trinity College Dublin (TCD) looked at the factors influencing GP mental health referrals. The study was based on a sample of twenty-seven responding Ireland GPs who completed a lengthy questionnaire. Due to the low initial response rate, it was decided to carry out interviews and this was done by way of an additional eight interviews. The main part of the study included a set of case vignettes based on the Knight study referred to above but also included interview questions and demographic inquiries. Sundlov again found that the process was complex and believed that no one element had the most influence on referral decisions (p.57). However, Sundlov said that the level of potential referrals indicated by the study was higher than expected and therefore was not consistent with the literature (p.59). It may be that this kind of study demonstrates participant bias among responding GPs, and or that responding GPs who were willing to complete the lengthy questionnaire are more psychologically minded. Sundlov recommended that increasing "communication" (p.58) between GP, therapist and client was important. She recommended that fewer topics (p.59) be explored in future research and found that participation was the greatest difficulty of the study (p.58).

In a 2010 TCD MSc thesis submission, McCullagh explored the attitudes of clients, GPs and counselling psychologists to "seeking psychological help within primary care" (Title) and claimed to be the first study to explore this "triangle" (p.71). Though the study was limited in sample size and all participants came from the same primary care centre, the study used three different participant groups: clients, GPs and counselling psychologists within a primary care setting (p.29). McCullagh found that despite initial reluctance, after engagement with therapy clients generally found the experience positive (p.66). However, she also believed that a lack of access to or awareness of psychological therapy services was a factor in actually utilising therapy services and that it was also often viewed as a "last resort" (p.67) by clients. Awareness of services and stigma also has relevance for other psychotherapy groupings as referred to earlier in this review. McCullagh concluded by saying that steps should be taken to "normalise" (p.76) the use of psychotherapy.

A Scottish study of 119 Highland GPs and referral practices among elderly patients by Todman, Law and MacDougall (2011) found that a lack of awareness about psychological services among GPs meant that referrals were at a lower level than might be expected, though access delays were referred to as a factor. Objectives around improving awareness of psychotherapy resources among GPs were incorporated into the Irish Association for Counselling and Psychotherapy (IACP) Strategic Plan 2010-2013 (IACP website, n.d.).

In reviewing the implementation of the UK stepped care model in four National Health Service sites comprising of data for over seven thousand service users, Richards et al. (2010) reported, again, complexity and a high level of variation in patient pathways through the model. They found that there are negative patient views of medication and that psychological therapy referrals scored highly on effectiveness and patient-centeredness. They pointed out difficulties in improving the prescribing behaviour of GPs and reported that some psychological therapies were as effective as medication for depression and preferable to medication for most types of anxiety (NICE 2011; NICE 2009) and that service users may have a choice if not a clear preference for talking therapies (NICE 2009; Bird 2006).

In a 2011 review of the literature in the area of GP referrals, Ward reviewed a range of studies which he reported were not always consistent in quality. He added that there was a lack of a consistent terminology between studies. He concluded that the literature demonstrated the advantage of a good working relationship between GP and psychological therapist with a particular benefit associated with counselling services that are located in primary care settings. Ward also categorised referral potentialities in the context of patient-GP relationships, GP attitudes and training, early identification of patient problems and access to counselling services. He recommended further exploration of GP perspectives on referral processes and also more exploration of patient perspectives. He found that patients often preferred counselling to medication and that GPs often listened to their patients' expressed preferences but that, among other factors, cost issues could discourage a referral being made. There may also be a difficulties referring to PSP practitioners, as not all Irish private health insurers recognise psychotherapists or counsellors who are not accredited by the Psychological Society of Ireland (McBride 2009).

Speaking in an Irish context, McCarthy (2009) discussed GP referral practices with Edward Boyne. Boyne believed that there was a lack of faith in psychotherapy among doctors. He maintained that clients were more likely to be treated with medication for mental health problems than in Germany, Holland or the UK. Boyne believed that better links between psychotherapy and GPs would have a beneficial impact in the community, including the benefit of promoting patient independence and agency.

Among the most consistent finding of research into referral practices seem to be complexity (Richards et al. 2010; McQueen et al., 2010; Kingdon 2004; Herringdon et al. 2003; Knight 2003). Given the above complexity, a potential difficulty in increasing the frequency of referrals to private sector practitioners can be observed. The combination of historical pre-eminence of GPs in primary care, customer preferences, cost, lack of awareness and credibility, and perhaps the absence of full statutory regulation provide a challenging context for private sector practitioners. Issues around equity also emerge again in the referral literature. The e-Delphi study may be used to explore aspects of this complexity including participants' perceptions of the links and referral practices of referral sources and how important they see these links as being. The need for collaboration among professionals is apparent. The review of the referral literature points to a need to consider issues around medication.

2.9   CRITIQUES OF EXCESSIVE MEDICATION

Medical approaches and diagnosis were intimately connected (Davies 2013). In reviewing the evidence base for psychotherapy, Gaudiano and Miller (2013) discussed that despite the increasing support for the use of psychotherapy in preference to medication for many conditions, that medication was still increasingly used, particularly as prescribed by primary care doctors. The UK Department of Health stated that talk therapies were more desirable than medication responses as they were considered more effective over the long term for all but severe cases (Clark 2011). In the US context, a 2010 report by Olfson and Marcus found that between 1998 and 2007, while the use of psychotherapy remained stable in the overall population, the use of psychotropic medications without psychotherapy increased in outpatient settings.

Conrad (2007) offered an exploration about how changes in the forces that encourage the use of medication in the USA could be observed. He gave his perspective on how biotechnology (he included the pharmaceutical industry and genetic research under this umbrella), consumer

dynamics and managed care practices have changed over the years which resulted in the development of vast markets that medicalise normal human suffering. While many of these changes in diagnosis may be welcome there was, he suggested, a danger of objectifying individuals and mechanising responses to individual suffering. There is no reason to assume that these issues will emerge differently in an Irish context.

In considering the use of medications and in providing an economic justification for new medications, Kaitin and Milne (2011), of the Tufts Center for the Study of Drug Development, conducted surveys of biotechnological and pharmaceutical businesses. They concluded that the development of new drugs for the treatment of psychiatric and neurodegenerative disease in contemporary regulatory and risk contexts was too complicated and expensive for the pharmaceutical industry to undertake. As a result, they observed that many of the big players were reducing or eliminating research and development spending on psychiatric and other central nervous system (CNS) medications. They also concluded that CNS drugs were costlier and more risky to develop than many other drugs. In their report, they found that CNS drugs would on average spend just over eight years in testing on human subjects. This was more than two years more than all other medications. It also took longer for this kind of medication to get official approval. On average they reported that it took eighteen years for such medications to go from laboratory to clinical use. Only 8.2% of CNS drugs reached the market, which was just over half the rate of all drugs. Difficulties later in the development of CNS drugs were also more prevalent. They believed that the cost of developing CNS drugs was higher than most areas of development. One reason for this relative difficulty in developing these medicines was that CNS drugs were typically used for longer periods, as treatment could be ongoing, for chronic conditions. In addition, they argued that CNS drugs demonstrated a less clear efficacy outcome than substances designed to kill bacteria for example.

Fibiger (2012), a neuroscientist and former vice president at Eli Lilly, Amgen and senior vice president at Biovail Laboratories, acknowledged a crisis in the development of psychiatric drugs by the pharmacology industry. He maintained that despite all the investment no "mechanistically novel" (p.650) medications have been introduced to the psychiatric field in over 30 years. Research and development of novel medication had been abandoned or had been greatly diminished as industry focus moved to more promising areas such as cancer and immunology research. He questioned why it took so long for this change to take place. Fibiger also explained that the discovery of medications in the antidepressant, antipsychotic and

anxiolytic drug classes was effectively the result of clinical experience rather than scientific approaches to their development. Dean (2012) agreed, and also believed that prescription of these drugs often had little connection with the diagnosis. Tedstone-Doherty and Moran (2009), writing in an Irish context, acknowledged the overuse of medication. Fibiger (2012) observed that the biological mechanisms of action of these drugs were only understood after their applications were accidentally discovered and that contemporary research and development models would not have discovered the three main classes of medication referred to above.

In discussing the prevalence of medication in the GP surgery, Kingdon (2004, p.163) reported that:

> Regrettably, much confidence is placed in medication (by both the medical office and the patient) to manage crises. It has been alarming to see the extent to which medication has been used to mask and avoid many complex and traumatic experiences.

Davies (2013) presented an unequivocal critique of the use of medication. He referred to research that demonstrated the lack of significant benefits for medication for use with depression except in the most severe cases, saying that 40% of drug trials are not included in published reviews of efficacy. In their 2008 meta-analysis of these trials, including unpublished trials, submitted to the US Food and Drug Administration (FDA) in relation to the regulatory approval for the use in depression treatment of fluoxetine, venlafaxine, nefazodone, and paroxetine, Kirsch et al. found that, apart from some relative benefit for those with more severe depression, the use of the drugs reviewed resulted in outcomes that were no better than placebo. Davies also referred to the inability of psychiatrists to provide evidence for a brain chemical model of mental illness. He described psychiatrist's reluctance to acknowledge the use of medications for their relaxation and soothing characteristics, rather than having a biological aetiology that was scientifically connected to a specific DSM diagnosis.

The prescribing rights of physicians (McGivern 2012) might also be considered; it was questioned whether these rights are a necessity or merely a consequence of history. Prescribing psychologists were licensed in New Mexico in the US for the prescribing of psychotropic medications (Muse and McGrath 2010) and in other states. In their 2010 review of a small sample of training programmes in prescribing psychoactive medications by psychiatric nurse practitioners, physicians and pharmacologically trained psychologists, Muse and McGrath (both psychologists) concluded that psychiatric nurse prescribers were more capable in many

areas at entry level of patients than were pre-psychiatry trained physicians. There was also the development of nurse and midwife prescribing in Ireland which appears to be enhancing patient care (An Bord Altranas 2010). The question of referral privilege was addressed by McGivern (2012), writing from an Irish perspective. While acknowledging the risk of prescription privileges resulting in an adherence to the medical model, he observed that (para.8):

> Those in favour of granting prescriptive privileges are responding also to the gradual shift that health services are taking towards brief interventions within managed care… If one also considers the currently challenging economic environment, it would prove more cost-effective for individuals to consult with a single care provider who can provide a more comprehensive psychotherapeutic and medical intervention rather than moving between professionals who may possess fundamentally different conceptualisations of mental health. Continuity of care is a contentious issue for many service users who are discontent at having follow-up appointments with locum GPs and psychiatrists who have very limited insight into their lived experience. Psychotherapists can offer a continuity of care which other service providers struggle to achieve.

Antonuccio et al. (1995) found that CBT interventions for depression were less costly than and just as effective as ongoing treatment with medication. Davies in speaking to Pope (2013) discussed that following his earlier adherence to the idea that therapy with medication can be the most effective approach for some conditions, he had now come to believe that pharmacological interventions impeded therapeutic progress. He believed that medication made it difficult for clients to access necessarily difficult emotionality during therapy. Given these concerns it may be useful to consider the use of medication in the e-Delphi study.

Having considered the history and practice of psychotherapy, the developing approach of psychiatry and the increasing, problematic use of medication for responding to mental distress, the phenomena reported above seems to point to a societal or cultural context for considering responses to mental health. In light of this, a socio-political context for psychotherapy that also relates to PSP may be of relevance.

2.10   POLITICS AND PSYCHOTHERAPY

Schmid (2014) believed that psychotherapy was a political act. Randall (2006) wrote that "Psychotherapy is a cultural practice, subject to the broader ideologies of the day, and psychotherapists need to understand how these manifest in the individual psyche." (Abstract).

In speaking of the place of psychotherapy in these collective or cultural contexts, Totton (2000) reasoned that psychotherapy often worked on behalf of society and, arising from the inherent human tensions that this clash between culture and the individual generates, had resulted in schisms within psychotherapy. Lees and Cleminson (2013) claimed that politics had always been an important issue for psychotherapy. They believed that while Freud was a part of a conventional medical world and adhered to the cultural expectations of his time, his theories and clinical practice had a potentially undermining impact on the culture in which he operated. Freud firmly placed human experience in the context of collective or cultural behaviours in Totem and Taboo (1913). The early practice of psychoanalysis confirmed this position by way of the spread of the free clinic movement, the goal of which was to provide free therapy for the poorer masses, at least partly in the pursuit of social justice (Danto 2005).

Lees and Cleminson (2013) referred to subversive colleagues of Freud, including Groddeck and Gross, who saw the radical and political potential of psychoanalysis. There are also the examples of Fromm, Reich and Langer who were subversive in their perspectives. Fromm was involved with the neo-Marxist Frankfurt School while Reich worked with the German Communist Party in spreading his views. Langer was an activist who participated in the Spanish civil war, escaped from the Nazis by going to Argentina, and had to flee again as a result of her psychoanalytic group work with workers there. Lees and Cleminson (2013) compared the views of Laing and Szasz saying that Laing came from an existential position and believed that insanity was a product of culture. They maintained that Szasz believed that psychiatry perpetuated an arbitrary view of the dividing line between abnormality and normality. They believed that the state used its power to confine and control those who crossed that line.

Related to abnormality and normality, Prillitensky (1997) addressed what might be described as a post-modern confusion around values and ethics. He described a contradictory position in which psychologists discussed values while not being able or refusing to describe what these values should be. He portrayed our contemporary cultural influences and political context as destabilising of informed mores, which he believed were made worse by pressures from within and from without psychology. He contended that there were concerns in psychology about interfering with individualistic perspectives of clients, which he says has led to a moral immobility. In effect, he considered clarity was needed in order to evaluate the impact of ethical values and assumptions, yet on the other in the clinic he was concerned about the impacts of

said values and assumption on the client and the therapist. The risk for him arising from this, was that the ethical codes of practice might result in rigidity and legalistic approaches to therapy.

Bloom (2013), in speaking from the perspective of trauma theory which has emerged from the experiences of working with victims of trauma and which he said often considers the socio-political context of the survivors of trauma, warned against the risk of ignoring unconscious and evolutionary factors in understanding how groups work. Related to these factors, Bloom suggested that projections and vengeful tendencies could inform the activities of groups and that in times of apparent danger these tendencies could be corralled by leaders. This could result in the punishment or effective exile of those considered to deviate from the demands of the pressed culture. Bloom (2013) believed that the emotional contagion generated by these emotions played out in a political sphere. A report on a controversial (according to Chambers 2014) study carried out by Kramer et al. (2014) appeared to confirm the phenomenon of emotional contagion in a sample of seven hundred thousand Facebook users. Bloom (2013) believed that when confronting repeated stresses, groups may become continually hyper-aroused and this could result in covertly and overtly bellicose behaviours towards others. Under stress the group hierarchies moved to control and contain group direction. As a result opposition or difference was seen as a threat to concentration on group goals. Groups who were different to the norm may be used as scapegoats in order to enhance group unity in a subtle process that may gradually creep into the culture. Girard (1987) believed that scapegoats had to be found to facilitate the continuation of culture. Fallon (2012), in writing from a Freudian-Lacanian position, believed that the individual was often sacrificed in the interest of the prevailing discourse or norms. Bloom (2013) observed that research had confirmed that organisations had an unconscious memory and these could be passed on by way of group behaviours. Without an explicit recollection of these memories, there could be a huge reluctance to change in institutions, which could result in biases being enshrined unconsciously. These views portray the possibility of psychotherapy being used consciously or unconsciously for political or socio-political objectives, in the service of the state or culture. These biases may conflict with individual needs.

In discussion with Pope (2009), Davies considered the pressure of economic demands for productive workers resulting in a need to oversee any threat to the progress of a neo-liberal agenda. Davies maintained that the last three decades had seen psychiatry comply with this

agenda. He maintained that the Improving Access to Psychological Therapies (IAPT) policy was about supporting this agenda. He illustrated this by reference to the continual monitoring of welfare benefits and work status through psychology services in primary care. Davies disagreed with this approach. He reasoned that people needed time to recover whereas the UK approach seemed to be focused on getting people back into the workforce quickly. Davies recalled that when he started his work, he complied with the expectations of the system and didn't feel able to challenge psychiatric actions. He also identified a need for the availability of appropriate research to allow psychotherapy to stand up to the prevailing approaches to mental health, including the use of medication, which he believed prevented therapy taking place. From Davies' writing, it seems that his viewpoint can place practitioners working under state auspices open to the accusation of being part of a collaborative, containing function rather than one that prizes subjective experience. The above literature would suggest that psychiatry may already fill this role and that it may be focused on an expedient cultural demand to contain mental illness within available resources, rather than on a primary focus on providing a therapeutic context.

In speaking of psychologists, Parker (1999) wrote that while believing that they were part of the "psy-complex", psychologists were mistaken about the amount of power they had in this complex and this he believed made it problematic for them in developing "critical reflection" on how power impacted on clients' difficulties (p.9). He outlined a path via feminist critical psychology through the use of qualitative research to a contemporary interest in power and discourse in the field of psychology.

Totton (2000, p.111) placed DSM at the heart of US system of managed care, describing the prevailing diagnostic approaches as a political structure. He equated this US system with the UK approach. While acknowledging an increase in the availability of therapy he also believed that "audited, cost-effective, time-limited therapy becomes central" (p.112). He believed that the experiences of psychotherapy in the UK since the 1970s demonstrated how the domains of psychotherapy and politics interacted. He outlined the history of psychotherapy bodies organising in the UK, and described the discomfort that emerged among some practitioners during the period. He believed that participation in the groupings that had developed was encouraged by making trainees and therapists fearful that they may not be able to practice without being members. He described how changes in the European Community in 1972 generated opinions in the UK about restrictions that would come into force after entry into the

EEC occurred. He believed that most of these views were mere rumours but that they helped to push a regulatory agenda. He argued that the UK government avoided involvement due to the complexities of the issue. Totton reported that the UK government saw psychotherapy as an activity that many different professional groupings did rather than being deserving of a separate function. This view was also confirmed from an Irish context by the interview with the HSE official carried out for this research. In looking from within psychotherapy, Totton (2000) challenged the structures that were used to administer and accredit the profession.

This aspect of the literature review suggests a need for a reflective response to how PSP positions itself vis-a-vis the state and client care. The two perspectives may not be wholly reconcilable. It is perhaps a question of ethics to decide where one resides as a practitioner. In terms of the e-Delphi study, this literature may be useful for informing consideration of the outcomes of the study and its findings.

2.10.1 STATUTORY REGULATION

In many developed countries, the practice of psychotherapy outside public health settings is regulated. Van Broeck and Lietaer (2008) contended that regulation occurred in order to protect service users from the possibly harmful effects of psychotherapy and ensure that practitioners undertook appropriate training. However, in Ireland practice in the private sector remains largely unregulated (O'Morain et al. 2012), though practitioners may be members of a self-regulating accrediting body (Boyne 2003). In Ireland, under the Health and Social Care Professionals Act 2005 a number of designated professions were described under law. These professions included psychologist and social worker among others. The term psychotherapist and counsellor are not legally protected. Effectively anyone can use the terms psychotherapist or counsellor to describe the work they do irrespective of qualifications, professional affiliations or insurance cover.

The regulation of psychotherapy in the US began largely as a result of psychotherapeutic malpractice cases taken against psychiatrists there in the 1960s (Freiberg 1978). This regulation coincided with the emergence around that time of alternatives to traditional psychoanalysis and the growth in the numbers of practitioners trained outside medical and psychiatric contexts. Freiberg recalled that the issue of training standards in psychotherapy was connected in law with the concept of standard of care (Prosser 1971) which placed not just an ethical obligation on a practitioner to be sufficiently well trained but also imposed a legal onus in this regard.

Freiberg pointed out that the law required that practice should be grounded in the informed consent of clients and that where there was a conflict of interest between the interests of the practitioner and client, that the client's interest should generally take precedence. Additionally, she reasoned that in law the practice of psychotherapy should be grounded in formal learning.

In comparing the impact of regulation and disciplinary actions taken against doctors, psychotherapists and counsellors in the UK, McGivern et al. (2009) carried out fifty formal and twenty-two scoping interviews with regulatory officials, professional body representatives, GPs, psychiatrists and therapy practitioners. The participants reported the devastating impact of disciplinary undertakings on those who endured these both personally and professionally. It suggested the importance of "formative spaces" such as "supervision or reflective practice groups" for psychotherapists that could accommodate error and openness (p.5). They recommended that psychotherapists be more supported in the event of disciplinary actions being taken. They referred to the possibility of mediation to prevent client issues escalating to law, especially given that it was believed that in many cases complainants simply wished to be heard. They also warned against over-reactions to media scandals arising from individual cases of poor practice.

Their report recorded that independent psychotherapists reported less awareness in relation to the impact of regulation compared to public sector employees. Concern was again expressed with the state's need to measure outcomes, for fear that the measurement could become the focus of therapy with a detrimental impact on the nuances of being in a therapeutic relationship. However, the report observed the need for psychotherapists to recognise the importance of evidence and claimed that psychotherapists and counsellors were too "insular" in this regard (p.9). Psychotherapists also reported a fear that clinical psychologists were becoming the most dominant grouping arising from National Institute of Clinical Evidence (NICE) guidelines and IAPT policies.

McGivern et al. (2009) reported that there was no overriding political agenda driving development and implementation of regulation but rather that "a far wider process of regulatory assemblage is taking place, in which governmental organisations, professional groups, and a range of interested stakeholders are competing for position and influence." (p.8). Briefly, they described the recognition in the UK of a difference between psychotherapy and counselling in

2009. Importantly, they questioned whether state regulation was the appropriate route given the difficulty of regulation capturing the subtleties of practice saying:

> But our data leads us to ask whether mandatory professional regulation, owned by the profession(s) of psychotherapy and counselling, in practice, may be a more effective way to protect the public than statutory regulation by a quasi-governmental body. (p.9)

Reeves and Mollon (2009) observed critically, that rather than being described as statutory regulation, the process of overseeing psychotherapy should be described as state regulation. In exploring the emergence of Empirically Supported Treatments and in supporting a principle-based rather than rule-based approach to regulation, Heidi, Neimeyer and Williams (2005) observed the difference between the US and European approaches to regulation in many economic spheres. They observed that the US approaches tended to be rule-based and somewhat prescriptive while European and Australian oversight tended to be more principle focused. They made an argument for principle-based approaches based on this cultural difference that was also grounded in the complexity of therapy.

Lees and Cleminson (2013), in discussing the common issues affecting psychotherapy and complementary and alternative medicine (CAM), proposed that there were critics of government proposals for regulation of psychotherapy among psychotherapists. They contended that therapists opposing current efforts to regulate saw this as an infringement of individual rights that externalised control and that was based on a consumerist perspective of therapy. They maintained that over-centralised power had been challenged by those who stand outside or apart from that power and that these kind of groupings were important in challenging prevailing ideas. They believed that psychotherapy contained two inherent contradictions "between radicalism and conformism" (p.203) and between political involvement and being detached or uninterested in political issues. The authors wondered whether contemporary psychotherapy and CAM would continue to offer the potential for a challenging position in light of legal requirements and what they perceived as the selfish dynamics of regulation.

Foisy et al. (2001) suggested that how psychotherapy is seen in different countries is dependent on a number of factors, including historical national and organisational factors, mental health priorities in national contexts, cultural issues, economic factors and social pressure. All of these

factors may be at play in the Irish context. Foisy et al. also found that these elements were interlinked and generate complexity.

Though they do not clearly differentiate between the terms psychology and psychotherapy Van Broeck and Lietaer (2008), in their review of European regulation of psychotherapy and psychology, asked if there is an ongoing need for psychotherapy, as other professionals in the health care field utilise EBP interventions. Strategically the IACP foresees that it will be able to participate in the debate about the dynamics of mental health issues with more assertiveness and credibility if and when statutory regulation is introduced. The IACP sees this as an essential step in improving its standing among the other professions who also lay claim to the title of Psychotherapist (personal communication with IACP official).

Again, this literature appears to speak to an inherent risk of practitioners being overly beholden to state perspectives (and productivity goals) in relation to treatment and the dangers of this contradicting the need for care of the individual presenting for therapy. That is not to say that PSP should be outside or beyond the law. However, it suggests the need for another voice, somewhat independent of, while necessarily interlinked with, the goals of the state and the perspective of research (including the use of medication). It would seem that the state cannot guarantee the prizing of the individual experience in its response to distress. At the same time, research is necessarily limited in its application to the individual lived experience. Perhaps this leaves the PSP practitioner as a necessary treatment option that seeks to support the client, at an appropriate distance from the state, albeit having to consider the complexity of the implicit and explicit demands and expectations of the client and the state. In considering this position, the outcomes of the e-Delphi study might be reflected upon.

2.10.2 ACCREDITATION AND PROFESSIONALISATION

The future statutory regulation of psychotherapy in Ireland raises issues related to professionalization into focus. House (2006) reminded us of the George Bernard Shaw quote "All professions are conspiracies against the laity" and reasoned against what he describes as old fashioned hierarchical frameworks for psychotherapy in a postmodern world. Speaking in relation to the evolving regulation in the UK at the time, House believed that sound arguments against professionalization had never been adequately rebuffed. He also maintained that there seems to be an "inexorable and inevitable" (p.384) move towards professionalization with no grounding in logical argument. He presented the academicization of psychotherapy via

university settings as giving adherents social standing, in contrast with what he described as the possibility of a vocational, craft-based practice grounded in practical skills and the ability to respond to intimacy, but which he believed also has low social standing.

Strawbridge (2010) contended that professionalization relates to the status claims and regulation of groups. She also outlined how professional power can be seen in the context of social control and referred to Foucaultian ideas of disempowering the individual that may ensue from professional status. She stated that "power struggles characterize the process of professionalization and emerging professions" (p.3). She pointed out that in contrast to the pursuit of power there were also the claims of altruism made by professions. From this, it may be seen that the realities of the dynamics between competing organisations that comprise the business of mental health should not be ignored as they act partly from self-interest while implementing delivery of altruistic activities. This aspect of the dynamics of mental health services seems to generate little comment in the review of literature in the Irish context with the notable exception contained in the book edited by Higgins and McDaid (2014).

Davies (2009) pointed out that professionalization had been a consideration for psychotherapy since its beginning, in that a difference between those who had been trained and not trained was created. Professional organisations with oversight were also a part of this impetus. In relation to the UK, he believed that three periods of professionalization had been experienced by psychotherapy. The first was the establishment of training up to the mid-1970s, the second was as a result of the establishment of accrediting bodies thereafter and the third was the wave of state regulation and ratification in the 21st century. He reasoned that professionalization gave standing and kudos to the professional. However, he claimed that psychotherapy was relatively young as a profession and stood on the outside asking to get in rather than being on the inside. He argued that the pursuit of state approval and regulation presented a risk to psychotherapy in that it may become more involved in promoting its interests as it became more regulated.

In 1999, Kaye wrote about the possibility of practice that was not dependent on a hierarchical approach to therapy. As we have seen in the literature above, Kaye contended that the act of providing psychotherapy was potentially supportive of the status quo in that it might normalise behaviour. He believed in the importance of a position that derives from the client rather than from an authoritative position of the therapist. He believed therapists were able to help create

a dialogue in a structured way. He reasoned that therefore they could not un-know that there is some expertise involved, but that this knowledge must not be used to normalise the client. While not specifying how this could be achieved, he believed in a socially critical psychotherapy which facilitates a client in locating their position in the social landscape. This argument, the need and possibility of maintaining a socially critical client-focused perspective in the provision of therapy, might be used in support of the view of PSP offering a different perspective to science and state provision while at the same time being somewhat interlinked with these.

In an article published in the British Journal of Guidance & Counselling in 1999, Totton described some dangers inherent in the process of professionalization. He reminded us that Carl Rogers was unable to get certification as a psychotherapist and consequently developed the term counselling which may account for some of the historical and contemporary confusion around the differences between the terms counselling and psychotherapy (Department of Health and Children 2006, Annex 11, p.246). Totton described training in the UK as "close to being a bubble" and outlined what appears to be a self-feeding loop occupied by therapists, trainees and supervisors which was fuelled by therapy and supervision requirements for practitioners (p.315). Issues such as those raised by Totton are valid as to the ability of the market in Ireland to provide sufficient client numbers for qualified therapists. Totton suggested that the supply of client's needed to be fifteen to twenty for each newly qualified trainee, that being the approximate number he believed that a practice would require to be full. While this is perhaps a simplistic view of professional destinations for qualifying therapists, it does illustrate a real difficulty arising from increasing numbers of qualified therapists issuing from the colleges. The above analysis suggests that Ireland has a relatively high number of therapists per capita (Table 1). In training, the question of post-qualification employment is often avoided, as is discussion of the difficulty of establishing a private practice (Grodski 2000). Totton (1999) implied that an observed change from introspective motivations on the part of trainees to a focus on others in need of help was as a result of a reduction in cultural stigma associated with psychotherapy. However, he warned that the danger inherent in this occupation of the profession by the "normal practitioner" was connected to the "remedicalisation of therapy" (p.316).

Davies (2009) was concerned about the possibility of professionalization as generating a legalistic dynamic threatening the existing discourse between therapist and client. He also saw

this as a threat to the way in which changes took place in culture and that those deemed to infringe the legal burden placed on practitioners would be punished. Davies reminded us that Freud accommodated the variation that existed among practitioners in practice and that each should be allowed to work in a way that suited their character and temperament. He recalled that Freud and Jung were aware of the dangers of rigidity and of the absence of any structure. Davies described a balancing act between creativity and a technical demand. He warned against the proceduralisation of practice which he believed could reduce creativity and innovation. His concern was that the rigidities of professionalization could wipe out the benefits of clinical knowledge and skill. He was concerned that the practice of therapy could become overly objectified.

In 1984 (Feldstein 2011), the accreditation requirements for full membership of the Irish Association for Counselling and Psychotherapy (IACP) were one year's experience of providing counselling with an average of six hours supervised practice per week, or training that was regarded as acceptable by the Executive Committee of the IACP. An accreditation committee was established in 1986. As of 2014, the accreditation requirements included completion of an accredited or approved training, four hundred and fifty hours client work after completion of training, a ratio of ten hours client work to one hour of approved supervision during a minimum two-year period after training and a quarter of accreditation work in group, family or couple contexts (IACP website). The earlier accreditation arrangements may be causing difficulty for the IACP in attaining state recognition, as the relatively lower historical accreditation standards are difficult to support in a regulatory context, where accrediting bodies are hoping to have their existing members accepted without additional or enhanced credentials in a new framework (personal communication with HSE official). These accreditation requirements appear to be arbitrary and may be connected to a desire for professionalisation among practitioners.

2.11   FUTURE DIRECTIONS IN PSYCHOTHERAPY

Norcross, Pfund and Prochaska (2013) used a Delphi study to consider what possible changes might take place in the decade ahead in the field of psychotherapy in the US. Their study, a version of which had been carried out every ten years beginning in 1980, explored what areas of practice might expand and contract, and how practitioners could be prepared for the developments that may occur. From their study, it was clear that the technological age had arrived and its impact was now being experienced in psychotherapy.

Norcross and his colleagues recorded that the earlier studies in the series of Delphi studies accurately predicted the move in popularity from psychoanalysis to the cognitive behavioural therapies and the reduction in time spent by clients in therapy. These earlier studies also correctly forecasted increases in female therapists and practitioners from ethnic backgrounds. They acknowledged error in predicting the timing of a nationwide health insurance programme. The findings of the 1990 group of seventy-five experts participating in that Delphi study predicted an increase in self-help groups and a reduction in the ratio of psychotherapy provided by psychiatry. The 2001 cohort of experts predicted ongoing enlargement and expansion of standards in treatment, medicines for behavioural issues and the use of pharmaceuticals in mental health applications. In their 2013 study, Norcross, Pfund and Prochaska considered the future of different modalities and predicted the greatest increases in usage for mindfulness, cognitive-behavioural and integrative approaches while transactional analysis, Jungian therapy, Adlerian therapy and classical psychoanalysis were predicted to show the biggest reductions in use. The authors reported that there was a modest bias level measured for the study, in respect of participant's preferred theory.

In terms of interventions used, the study predicted increases in the use of computer technology and self-help techniques (including bibliotherapy) and skill building approaches (such as cognitive restructuring and relapse prevention). In outlining the study predictions, they predicted that the use of techniques such as aversive conditioning, free association and dream interpretation would decrease (Norcross, Pfund and Prochaska 2013). Looking at the provision of therapy over the next decade, the report predicted an increase in provision via internet programmes and by master's level practitioners (Norcross, Pfund and Prochaska 2013). The forecast also predicted a decline in one format for therapy, that of long-term therapy.

Walsh (2011) in writing about lifestyle modifications that may be therapeutic believed that such interventions were under appreciated, arguing that these were often as effective as psychological or medication-based interventions. He used the term "therapeutic lifestyle change (TLCs)" and listed these as "exercise, nutrition and diet, time in nature, relationships, recreation, relaxation and stress management, religious or spiritual involvement, and service to others." (abstract). He believed that there was no guarantee that psychotherapy might be the most eminent intervention for mental distress and that other professions and approaches can be utilised. The boundaries of psychotherapy technique are porous (Van Broeck and Lietaer 2008), in addition to growing expectations for psychotherapy to absorb emerging interventions

that are empirically grounded. It may be of interest to see how Delphi participants see the future of PSP developing in the Irish context.

2.12 TECHNOLOGY IN PSYCHOTHERAPY

Norcross, Pfund and Prochaska (2013) reported a forecast that is different from findings of the previous Delphi studies in the series, predicting that technology would be the more highly rated driver of change rather than economic forces, which had been the more highly rated driver of change in previous studies. Norcross, Pfund and Prochaska referred to Kazdin and Blasé (2011) and forecasted a "disruptive" (p.369) period of change for psychotherapy arising from new technology. They also suggested that providers of therapy in the future may be working via digitised interactions rather than through face-to-face services. They also maintained that economic dynamics were encouraging the spread of digitised provision and were an important influence on change. Predictions were included that suggested the increased offering of psychological services in medical homes (multi-disciplinary centres similar in practical terms to primary care centres) and treatment of behaviour aspects of illness and health.

In 2011, Kazdin and Blasé reported on significant changes in the development of mental health interventions. They believed that these changes had as a key objective the reduction in the difficulties caused by mental health problems. They observed that demand was significantly higher than supply. They believed that one-to-one therapy would not be able to meet this need. Irrespective of the important changes that have taken place, they argued, without changes in clinical and research interventions is it unlikely that the overall impact of mental health issues would be reduced. Because of this, they reasoned, a new set of delivery methods would be needed. Given the significant predictions of Kazdin and Blasé, in addition to those of Norcross and his colleagues, further exploration of research relevant to the use of technology in psychotherapy and mental health interventions may be of relevance.

In a 2007 review article, Spek et al., in examining the effectiveness for the use of internet-based CBT interventions for depression and anxiety, carried out a meta-analysis of eleven randomised control trials (RCTs). Their study found that the six anxiety treatment studies analysed had a large effect size of .96 (95% CI = 0.69–1.24) while the treatments for depression had a low mean effect size of .32 (95% CI = 0.08–0.57). In addition, of the five of the eleven treatments that included therapist online intervention or feedback, these had a higher effect size than those that did not (an effect size of 1.00 (95% CI = 0.75–1.24)), compared to an effect size of .26 (95% CI = 0.08–0.44). While this study is not supportive of the use of online interventions for

depression, Andrews et al. (2010) in carrying out a meta-analysis of twenty-two RCTs for depressive and anxiety disorders found that (conclusion):

> Computerized CBT for anxiety and depressive disorders, especially via the internet, has the capacity to provide effective acceptable and practical health care for those who might otherwise remain untreated.

Barak et al. (2008) carried out a study of internet-based therapy interventions. The study was a meta-analysis of niney-two studies covering 9,704 patients. Clients demonstrated effect sizes similar to face-to-face therapy. However, in a 2013 study of fourteen RCTs using sixteen comparisons, So et al. questioned the efficacy of computerised CBT (cCBT) saying that dropouts were significantly high and that the long-term follow-up of depressive patients showed effects that were not significant, which in respect of depression efficacy echoed the Spek et al. study above. Taken with the possibility of bias in the studies reviewed, they urged caution and suggested that the use of cCBT for depression among adults may not be as clinically beneficial as had been thought. Waller and Gilbody (2009) completed a systematic review of qualitative and quantitative research studies of computerised anxiety and depression treatments. They reported high pre-treatment dropout rates and a treatment completion rate of 56% for cCBT, which was lower than for other interventions included and they believed that therapists had a more negative view of cCBT than patients. They suggested the need to investigate the reasons for the high dropout rates. On reflecting on these findings, it may be that therapist resistance to technology could play a part where they are involved in the treatment.

Confirming issues with dropout rates, a 2013 Irish study by Twomey et al. used a sample of 149 (n=149) adult mental health service users across Ireland to evaluate the use of the Australian online software programme Moodgym (moodgym.anu.edu.au). This programme was designed to help users learn about cognition skills for depression. Twomey et al. found that 56.3% of users dropped out of the study, and of these 85% of males discontinued. Of those who did complete most found it useful; however, 73% of users included in the final analysis did not complete the scheduled number of five sessions. While the Moodgym programme may be of benefit to some users, the authors did not recommend it as a primary treatment.

In considering the apparently high dropout rates reported in many of the computerised interventions, a 1993 study on dropout rates for face-to-face therapies carried out by Wierzbicki

and Pekari reported dropout rates in the range of 30-60%. It would appear that the computerised dropout rates reported by Twomey et al. (2013), while at the higher end of the range, are not outside some of the ranges reported for more traditional approaches to delivery. Sharf, Primavera and Diener (2010) reported therapeutic alliance as being one of the most important factors associated with dropouts in face-to-face contexts. The establishment of a therapeutic alliance in the context of a computerised intervention is perhaps not of relevance; however, these dropout rates may also be a factor of an awareness and general acceptance of technology-based interventions (both by therapist and client), rather than a permanent difficulty with such treatments (Donovan, Spence and March 2013).

In support of this possibility, Gaggioli 2012 (p.184) published an article in Cyber and reviewed the use of new technologies by psychologists. He believed that the use of digital applications in the clinic had not yet become prevalent. He discussed what he characterised as the two main technological developments in "cyberpsychology" in the past two decades: "online therapy and virtual reality therapy". Virtual reality therapy involves providing an intervention in which enhanced online environments are used to provide therapeutic experiences for users. In defining online therapy he also called it "e-therapy" saying that this "concerns the use of internet-based technologies (e.g. e-mail [sic], chat, video-conferencing systems) to provide evaluation and treatment services at a distance."

He observed that there were an insufficient number of studies related to the use of these technologies by clinicians. However, he believed that these approaches had been tested in a significant number of studies and concluded that evidence confirmed that online delivered CBT and virtual reality therapy was at least as effective as one-to-one therapy. He asked, given these findings, and what he believed was the unquestionable advantages of online provision, what was preventing a more widespread use of online provision. In exploring the delay in take-up of the technology Lovejoy et al. (2009) reported that the general population had taken to using technology but that this had not yet been reflected in psychological treatments. Again, this may point to practitioner resistance to change rather than an inherent problem with the technology (Donovan, Spence and March 2013). Lovejoy et al. (2009) also contended that issues around complexity, the law, risks of dehumanising the therapeutic space, regulation and jurisdiction, insurance reimbursement, high costs of training and implementation were retarding the adoption of new technologies. Also, they believed that ethical concerns, client and clinician

suitability, privacy and safety and a concern among practitioners about a risk to their reputation were factors slowing the introduction of new technologies.

Virtual reality therapy (Gaggioli 2012) may involve the use of an avatar and an artificial intelligence program to respond to user interactions. Gaggioli noted that the number of published studies in this area had gone from n=26 in 1996 to n=166 in 2011. Gaggioli (2012) believed that the relatively slow pace of the introduction of virtual reality therapies may be due to a number of factors, including the cost of developing these treatments, in addition to the complexity of the technology and the complexity of the issues involved for users and delivery of virtual reality treatments. He found that, though the adoption of this approach was very low, the efficacy of it appeared to be at least the same as traditional face-to-face CBT.

The stepped care approach in the IAPT model included the provision of computer-based psychotherapy treatments. Computer-based treatment used in the IAPT approach were reviewed by Marks and Cavanagh. In their 2009 analysis of what they called computer-aided psychotherapy (CP), the authors suggested that the use of CP could be more acceptable to clients due to the privacy and reduction in stigma associated with the use of this resource that contrasted with the confidentiality concerns of practitioners noted in the Lovejoy (2009) study above. It may be that users have a more accepting view of technology than practitioners. The CP model combined internet-based software with brief support via telephone. Marks and Cavanagh reported that the model had increased access in a number of countries including the UK, Australia and the Netherlands. Interestingly, such was their perception of the speed of development in this treatment sphere, the authors believed that their report would be out of date by the time it was published. They concluded that CP was clinically effective.

In reading their report it must also be acknowledged that political, cost and stakeholder pressures have a part to play in the ongoing development of this approach. Nowhere in their report is there a reference to how important face-to-face therapy might be as part of a need to encourage interpersonal connections, rather than one which lauds the cost-effectiveness of this way of dealing with mental distress. The authors acknowledged the lack of a body of Randomised Control Trials (RCTs) for the CP model. In addition, the authors had connections with one or more organisations that licenced this kind of software which might indicate a bias favourable to the model. Learmonth et al. (2008) explained that the use of CP can be useful in response to long waiting lists for treatment as well as being clinically and cost-effective. Their study of 555 users of a CBT-based treatment found the approach to be clinically effective and,

given the need for less face-to-face interaction between therapist and patient, one that increased the capacity of the service by 50%.

It is evident from the above that new technology is having an impact on PSP. It would seem certain that new technology will be an increasingly important factor in the provision of mental health interventions, especially given cost and therapist availability issues. For the purposes of the Delphi study, it would be of interest to see how participants perceive technology and also to establish their views on whether a technological context can replace or equate with a face-to-face therapeutic intervention, and how aware participants are of the technological disruption coming to PSP practice.

2.13 SUMMARY

This chapter has traced the evolution of psychotherapy in general and its development in Ireland. In exploring this history, it is clear how important research has been since the 1950s in developing and promoting psychological interventions as well as offering alternatives for biomedical approaches to mental health. The literature review has shown that psychotherapy is an effective intervention for mental health difficulties. The increasing use of EBP is apparent but there are challenges posed by the power of biomedical stakeholders in promoting research into biological indicators. Within psychology, there is somewhat of a disconnection between the research being produced and the application of this in the clinic. The recording and research of outcome measures in the clinic may be an important bridge to research. In the context of PSP, it seems that the sector is not well covered in the literature. Issues around the availability of low-cost services and other issues of access and equity have been discussed and these are of relevance to the Irish context and PSP also. In the Irish context, the issue of GP referral practices, which demonstrate complexity, has been explored. Collaboration and links between PSP practitioners and other professions may be important. In relation to referrals, it is not only an issue of psychotherapists being available to GPs, there are also many other pathways to receiving care for clients. It cannot be assumed that GPs have sufficient regard for PSP in Ireland to make referrals at the levels that might be hoped for. Additionally, there is no reason why an effective intervention should belong to psychotherapy alone and it is clear that other professional groupings are able to absorb evidence-based interventions. Related to the issues around GP referrals, are the evolving practices of psychiatric responses to mental health. The literature suggests a rigidity in psychiatric responses that are focused on what some believe is an out-of-date taxonomy. There are significant changes in progress, including RDoC, which

may challenge the power base of psychiatry by insisting on a more subjectively grounded appreciation of mental distress. While the availability of medications has undoubtedly had a beneficial impact on the care of many patients, there remains a question around what appears to be a medication-focused, rather than the recovery-focused practice of psychiatry in Ireland.

The literature review has included reference to the critics of the over-use of medication and in a number of instances the benefits of psychotherapy over medication. Despite this, treatment choices are not always made in administering care based on contemporary EBP. Instead, it would seem that treatments are often grounded in historical power dynamics and resource limitations rather than in evidence. In considering the political perspectives in the review, it would suggest a confirmation of this view in the Irish context. Related to this, the lack of domestic data as a basis for arriving at policy positions is evident. Higgins and McDaid (2014) described the field of mental health in Ireland as "highly contested" (p.2) with many interests competing for influence and policy input. They presented psychiatry in Ireland as having the most powerful position in the field, while noting that other groupings have increasingly challenged this status. In addition, MacGabhann (2014) acknowledged the need for recognising user perspectives in treatment.

Relevant to the Irish context, a review of the introduction of the IAPT model in the UK has shown some of the outcomes associated with its large datasets and productivity driven model of care. Consideration of this has led to a review of some aspects related to the politics of psychotherapy and how historical issues have impacted on the current stakeholders in the field. The exploration of the political aspect has also entailed a discussion of statutory regulation, accreditation and professionalization. There would appear to be a friction between what might be described as state-led, productivity focused interventions and the potentially more subjective focus of PSP. Finally, references to some recent developments in Ireland have been presented which appear to confirm views related to the excessive power of psychiatry, the lack of a domestic evidence base for policy and the dynamics of power that prevail in the Irish context. In considering all of these complex issues, an effort has been made, within the limitations of the study, to incorporate relevant items in the e-Delphi questionnaire.

It is clear that technology will have a significant impact on PSP. This impact may be driven by a number of factors including resource and efficacy. Resistance among users and practitioners has been observed, but is not well understood. Assumptions about the importance of relationality in psychotherapy may not stand up to the benefits of, and increasing familiarity

with, emerging technologies. While drop-out rates appear high for many of the electronically derived approaches, some of the research is suggesting that this might not be worse than existing approaches.

By way of encapsulating many of the issues raised by this literature review, Gaudiano and Miller wrote (2013, para.1):

> Historically, psychology as a profession has had difficulties differentiating between true compromise and mere acquiescence to opposing influences outside the field. Psychologists often focus too much on "getting along" instead of advocating strongly for their interests and perspectives. At the same time, there has been considerable difficulty finding ways for psychology to speak as one voice given the diversity of traditions within the field itself. This tendency within psychology to fail to put forward a unified front has left room for other professions to wage aggressive media campaigns to change public thinking in ways that argue against psychology and ultimately do a disservice to consumers and their families.

In terms of identifying the perspectives and issues identified in the literature review, a number of issues that may be of relevance to the Delphi study. These include:

The possible place of Irish PSP in current and future policy.

The numbers of available therapists and their accreditation.

The perceived value of PSP in an Irish context.

The establishment of links with referral sources and other professions.

Perspectives on training and academic requirements.

The use or overuse of medication in response to mental distress.

The appropriate use of psychotherapy as an alternative response.

The risks of a quick-fix and overly prescriptive approaches to interventions.

The possibly disruptive impact of technology on the future of PSP.

The impact of low-cost therapy on PSP.

The perceived benefits of using outcome measures in PSP.

These issues will be incorporated into the questions in Round 1 of the Delphi study in addition to posing a broad, open question seeking to establish the views of the participants. In the discussion of the findings of the e- Delphi study, reference will also be made to the political and cultural contexts identified above.

CHAPTER 3   METHODOLOGY AND METHODS

3.1   INTRODUCTION

The purpose of this research was to explore factors that may influence the future of private sector psychotherapy in the Republic of Ireland. It utilised an e-Delphi method that sought to elucidate the views of key stakeholders such as practitioners, policy makers, educationalists and key referrers.

In this chapter a rationale for the use of a Delphi study followed by an explanation of the methodology will be provided. The participant profiles and process of participant recruitment will be discussed. This will be followed by a discussion of the sample size attained. Ethical considerations will also be explored, including discussion of consent and any risks to participants. Confidentiality and anonymity will be considered. The methodology used for analysis of the data generated will be explained, followed by reference quality and rigour in the Delphi method. The method used for the study carried out will be described. This will be followed by a summary of the chapter.

3.2   WHY A DELPHI STUDY?

A Health Research Board report (2010) observed that many therapeutic approaches in Ireland lack a history of research. In considering what type of research to use for this study, it was hoped to add to the body of psychotherapy knowledge and conduct research that has relevance to mental health policy in Ireland. Training and working as a psychotherapist has led me to adopt a post-modernist worldview, which aspires to a collaborative stance in relation to encountered phenomena. A post-modernist, collaborative stance might suggest a more qualitative perspective (Angrosino and Rosenberg 2011).

Babbie and Mouton (1998) contended that qualitative research was not about capturing a fixed reality but related to capturing a changing reality with a focus on related phenomena rather than acquiring universal truths. McLeod (2003) wrote about the evolution of non-positivist research in human science approaches. He reasoned that qualitative research involved placing text in an interpreted structure of meaning. He argued that in carrying out counselling research it should make a contribution to the clinic. McLeod also maintained that qualitative research was often described as being what quantitative research was not. He believed that qualitative research was more diffuse and fragmentary than quantitative approaches.

In considering an approach to this research, resource and time limitations had also to be contemplated. Bearing in mind McLeod's themes above, and in wanting to survey those with an interest in psychotherapy, particularly those working at least partly in private sector contexts, a potential difficulty in getting potential participants to travel to one location at one time was considered. In responding to this, online or electronic means of canvassing opinion were the most efficient and potentially most effective way of recruiting participants (Donohoe et al., 2012). Another consideration was trying to minimise researcher bias in the execution of the research. Babbie and Mouton (1998) believed that this was a problem implicit in qualitative approaches, in that the researcher was in danger of only seeing what supported his/her conclusions. Agrosino and Rosenberg (2011) contended that this was a reality that must be acknowledged in research.

In consultation with colleagues and on reflection it was decided that an e-Delphi study (McEachran et al. 2006) would optimally accommodate the above considerations, a post-modernist research position and practical resource limitations. The Delphi process may be used in reaching a consensus (though a consensus may not be possible) and or agree on priorities such as in health research (von der Gracht 2012; Keeney et al. 2011). Murry and Hammons (1995) described the Delphi study as a qualitative approach. Stewart (2001) supported this view, saying that the Delphi approach was qualitative, as the method involves interpretation in progressing through the process rather than a statistical examination of cause and effect. McLeod (2003) presented a synthesis of themes that were of particular relevance to qualitative research. These included: the study of events in the real world, "inductive analysis", "keeping the larger picture in mind", "personal contact and insight", observation of the process, appreciation of the contextual meaning of the data, reflexivity, benefiting the participants and a constructionist approach (pp.72-73). All of these are elements of the Delphi approach (Donohoe et al. 2012).

3.3   METHODOLOGY

In this section, a background and explanation of the Delphi methodology will be provided.

3.3.1   OVERVIEW

Dalkey (1969) recommended the use of the Delphi approach to research for formulating wide-ranging, long-term policy approaches, including social policy. Though the Delphi approach is increasingly used in health research (Norcross, Pfund and Prochaska 2013; Keeney et al. 2011; Health Research Board 2010), Dallos and Vetere (2005) believed that the Delphi approach was

underused in psychotherapy research. Keeney et al. (2011) maintained that the Delphi method was based on the idea that group knowledge was more valuable than individual opinion. The higher accuracy of this approach compared to other predictive approaches was confirmed by Norcross, Pfund and Prochaska (2013). Dalkey described the Delphi method as an approach in which the assumption "two heads are better than one" was applied (1969, p.v). Dallos and Vetere (2008) described it as a method in which knowledge was sought from experts about issues of complexity and Hsu and Sandford (2007) described it as a helpful means of collating and analysing data from respondents within their realm of knowledge. Dalkey (1969) and Donohoe et al. (2012) recorded that the Delphi approach was derived through experimentation at the Rand Corporation for use in military applications. Keeney et al. listed 10 different types of Delphi study (2011, p.7):

TABLE **2** : TYPES OF DELPHI STUDY

Classical Delphi	Uses an open first round to facilitate idea generation to elicit opinion and gain consensus Uses three or more postal rounds Can be administered by email
Modified Delphi	Modification usually takes the form of replacing the first postal round with face-to-face interviews or focus group May use fewer than three postal or email rounds
Decision Delphi	Same process usually adopted as a classical Delphi Focuses on making decisions rather than coming to consensus
Policy Delphi	Uses the opinions of experts to come to consensus and agree future policy on a given topic
Real Time Delphi	Similar process to classical Delphi except that experts may be in the same room Consensus reached in real time rather than by post Sometimes referred to as a consensus conference
e-Delphi	Similar process to the classical Delphi but administered by email or online web survey
Technological Delphi	Similar to the real time Delphi but using technology, such as hand held keypads allowing experts to respond to questions immediately while the technology works out the mean/median and allows instant feedback allowing experts the chance to re-vote moving towards consensus in the light of group opinion
Online Delphi	Same process at classical Delphi but questionnaires are completed and submitted online
Argument Delphi	Focused on the production of relevant factual arguments Derivative of the Policy Delphi Non-consensus Delphi
Disaggregative Delphi	Goal of consensus not adopted Conducts various scenarios of the future for discussion Uses cluster analysis

3.3.2 ROUNDS

The Delphi method involves a number of rounds for gathering data (von der Gracht, 2012; Dallos and Vetere, 2005; Dalkey, 1969). The rounds incorporate responses from previous rounds to "provide feedback to participants" (Keeney et al. 2011, p.73).

3.3.3 E-DELPHI

This study used an e-Delphi approach delivered using online survey tools and emails to communicate with participants and provide feedback for the rounds. Donohoe et al. (2012) discussed the development of the e-Delphi which they observed had been made possible by the arrival of the internet. Chou (2002) in conducting an e-Delphi found that it was more effective than manual, mail based methods in reducing response times and in encouraging continued participation of panel members.

3.3.4 ANONYMITY AND FEEDBACK

According to Dalkey (1969) and Turoff (1970), confidentiality in the use of a Delphi study allowed participants to emerge from their professional stances and incorporate other perspectives. It also prevented strong personalities dominating the process. Dalkey (1969) explained that the process involved "controlled feedback" through reporting back information to participants through a series of rounds. He said that because of the way in which the process operated, it generated a higher group acceptance on the part of participants and that it "releases from the respondent's inhibitions" (p.17). Donohoe et al. (2012) confirmed the benefit of anonymity in facilitating uninhibited participation.

The Delphi method involves four aspects, which are used in order to minimise bias arising from irrelevancy, domination by individuals and pressure to conform (von der Gracht 2012; Dalkey 1968) and these are:

1. Anonymous response

2. Iteration

3. Controlled feedback

4. Statistical group response

3.3.5 FORECASTING

In discussing the use of Delphi in statistical forecasting, Dalkey believed that the process was shown to reduce "noise" generated by extraneous or irrelevant inputs (1969, p.4). Studies sometimes (p.22) asked participants to rate their competence on the subject being discussed and these weightings were incorporated into the subsequent analyses. He described the presence of "holdouts" and "swingers" in the process with holdouts being participants whose inputs tended towards the median results while swingers provided inputs further away from the norm (p.40). However, he also maintained that due to the way in which the process operated, over the course of the rounds the performance of the group overall can improve (p.42) though he also warned of the possibility of "diminishing returns" as the process was repeated (p.76). He also referred to the difficulties of face-to-face discussions in which interpersonal factors can have a detrimental impact on openness and outcomes (p.14). In explaining the future focus of the approach, Dalkey (p.4; p.73) discussed the differences between "factual" versus "value" statements and described the difference between "knowledge" (empirical or fact based), "opinion" (expert opinion) and "speculation" (neither of the previous positions) predicting that each of these terms was progressively less accurate in forecasting outcomes, while acknowledging that he had no scientific basis for this assumption (pp.2-4). In relation to this admission, it can be noted that some years later Norcross, Pfund and Prochaska (2013) confirmed the relative predictive accuracy of this group approach as superior to other predictive methods, and that it performed better than individual prognostic expertise.

3.3.6 EXPERT OPINION

Keeney et al. contended that "The Delphi technique does not produce any right or wrong answers; instead, it produces valid expert opinion" (2010, p.9). Dallos and Vetere (2008) picked up elements of this theme in their views on the Delphi method, saying that its purpose was more focused on the possible use of beneficial understanding, rather than being concerned with what the truth was. Keeney et al. stated that the method was in danger of having more reliance placed on it than is appropriate (2011, p.13).

Though the use of expert opinion is a core element of the Delphi approach, the definition of what is an expert may be problematic. Keeney et al. (2011, pp.7-8) pointed out that in the discussion of Delphi studies, what constituted an opinion generated much debate and the approach did not always use a random sample from a population. Powell (2003) recommended that experts should be chosen for their experience in the area of study and that they should have

standing among those who would use the study. Participants in a study by Avery et al. (2005) were recruited with a "breadth of expertise and perspective" (p.4) relevant to the specific study. Powell (2003) reasoned that heterogeneous rather than homogeneous combinations in groups were more likely to generate studies that were of higher quality and referred to Rowe (1994) and Delbecq et al. (1975) in support of this belief. Powell (2003, p.378) argued that the focus in the Delphi method was on "representativeness" rather than a "representative sample".

3.3.7 EXPERT INTERVIEW

Though not a usual element of Delphi studies, towards the end of the study an opportunity arose to interview a senior health official in the Irish Health Service Executive (HSE). This official was involved with the development and implementation of policy in respect of mental health. Given the lack of literature on PSP in Ireland, it was considered that this interview gave a context (Harte 1998) and perspective that would have been otherwise unavailable. The comments of the official also offered some triangulation and realism (Golafshani 2003) for the study, again in the context of scant literature available on PSP in Ireland. As a result of these considerations, it was decided to incorporate elements of this interview in this study. While the interviewee gave permission for publication of their name, it was decided in line with the anonymity of the Delphi approach used, and given ethical considerations, that the name of the interviewee should not be included.

3.3.8 CONSENSUS AND DISSENSUS

The objective of reaching a stable consensus has been a historical focus of Delphi studies. However, the Delphi method has been criticised as an exercise in forcing agreement which does not facilitate discussion of issues arising (Keeney et al. p.13). Graham et al. (2003) believed that it was possible for the researcher to impose restrictions on the scope and content of the study. Powell (2003) reported that there was no definitive guideline for deciding on consensus.

In recent years studies that incorporate the consideration of stable dissent or dissensus have become more popular (von der Gracht 2012). Von der Gracht also discussed that there was a difference between stability and consensus, saying that stability of responses across rounds was more appropriate to the Delphi method. Related to this, he believed that there was an erroneous focus on specified consensus levels. Steinert (2009) proposed that as a tool of exploration the Delphi could also be used to generate dissensus, which may help with producing a more varied outcome in exploring an issue that is not yet well understood.

The consensus level in a Delphi study refers to the cut-off point or percentage of one type of response that is required for a given item to reach consensus for that particular study. However the definition of what consensus means has been problematic and variable (von der Gracht 2012; Powell 2003). Given the higher number of recruits from the field of psychotherapy, who might be more likely to agree on issues, it was decided that a higher consensus level could be more appropriate than a simple 51% majority. A consensus level of 60% was selected for use after Round 2 results had been received (Powell 2003). Furthermore, if the panellists reached consensus above 60% in Round 2, then this was considered to indicate a stable perspective within the sample. The percentages of combined Strongly Agree plus Agree, Don't Know, and Agree combined with Strongly Agree were be compared and considered by reference to the consensus level of 60%.

3.3.9   VERSATILITY

Mullen (2003) warned against an overly prescriptive description of what a Delphi should be describing it as a "versatile approach" (para.3). The versatility of the approach was also espoused by Powell (2003) and Lewy and Anderson (1975), meaning that it could be used in the context of many different contexts and applications.

3.3.10   SUMMARY

In this section 3.3 on Methodology a rationale for the use of an e-Delphi study and description of this method, by reference to relevant literature, has been included. The history of the Delphi study, including discussion of issues related to anonymity and feedback, the predictive nature of the approach, issues and decisions around consensus and dissensus, the versatility of the approach and the manner in which the rounds of the study are carried out have been reviewed. An explanation of the inclusion in the study of an interview with an official of the HSE has also been provided. Discussion about consensus and dissensus, and the versatility of the method were presented.

3.4   PARTICIPANT PROFILE

The panel for this and the subsequent Delphi element of the research was chosen based on the members' expertise (Dallos and Vetere 2005, p.188). The meaning of the term expert is not pre-defined in the Delphi approach and the reported selection criteria for participants in the method is varied and complex (Keeney et al. 2011). However Keeney et al. (2011, p.25) believed that two key elements have been identified: self-assessment and sample criteria.

Despite this, they confirmed that there remained philosophical and methodological debates about the idea of what constituted an expert.

For the purposes of this study the following criteria for participation were outlined:

All participants must be over eighteen years of age and have a good working knowledge of the field.

For mental health service delivery participants (including psychotherapists), key referrers to psychotherapy (including psychiatrists and GPs) and educationalists (including those involved in training psychotherapists) participant criteria are as follows:

Three or more years post-training membership of an accrediting body or statutory organization.

Self-assessed as adequately informed in responding to the questions asked.

For policy participants (including politicians) the criteria are as follows:

Two or more year's involvement with health policy.

Self-assessed as adequately informed in responding to the questions asked.

Of the twenty-six participants, twenty-two were involved in mental health delivery, four were key referrers (including GPs and psychiatrists), ten were educationalists and one was a policy professional. The total of these sums to greater than the sample size because a number of participants had overlapping roles. There were ten mental health delivery participants who were also educationalists and one participant who was both a mental health delivery participant and a key referrer. This sample represents a less than planned for number of participants. As such, it may be that the sample generated data that was more reflective of mental health delivery biases and the interests of these participants.

There were twelve male and fourteen female participants. The average age of the Round 1 participants was fifty-one years, with seventeen participants responding to the age question. The first round of open questions generated responses containing fifteen thousand words.

3.5 SAMPLE SIZE AND PROCESS OF PARTICIPANT RECRUITMENT

There is wide variation in the sample size that can be used for the Delphi method (Keeney et al. 2011). Given the limited resources of this study, it was decided to select a target sample of up to forty participants. This was within the sample range of most Delphi studies (Akins et al. 2005; Keeney et al. 2005). Given resource constraints, it was considered difficult to collate and analyse data from a larger sample. This participant sample size may be a potential limitation of the study; however, it may be that small numbers of participant members may be adequately representative of the population as a whole (Keeney et al. 2005, p.53). In keeping with the Delphi approach, Keeney et al. (2011, p.47) observed that, "many Delphi studies have employed non-probability sampling techniques, used individually or in combination such as convenience and snowballing to recruit the sample". They also referred to Gordon (1992) who stated that panel members may be recruited through recommendations by other experts.

For Round 1 of this study, experts were recruited via a non-probability sample consisting of a purposive sample (Babbie and Mouton, 1998) from my professional network among those who meet the selection criteria above. A snowballing method was used (McLeod 2008; Babbie and Mouton 1998) to recruit additional experts, wherein recommendations made by the participants facilitate introductions or contacts with other participants who also meet the selection criteria.

For the Delphi phase the intention was to recruit a broadly equal number of expert participants (10) from each panel of: those involved in mental health service delivery (including psychotherapists), key referrers to psychotherapy (including psychiatrists), educationalists (including those involved in training psychotherapists) and policy professionals (including politicians) taking part in the Delphi phases.

Attempts are made to acquire a list of psychiatrists through the accessing of psychiatrist listings available via the HSE website. Recruitment of educationalists was planned through the listing of educational organisations validated for training on the IACP website. Contact details for politicians could be acquired from online Oireachtas listings. Psychotherapists were recruited from the online listing of the IACP. All of these are supplemented by the snowballing approach referred to above.

3.6 ETHICAL CONSIDERATIONS AND APPROVAL

McLeod (2003, p.167) believed that attention to ethical issues during all stages of research was essential. He referred to the ethical principles of "beneficence", "non-maleficence",

"autonomy" and "fidelity". He also discussed that it could be difficult to follow these principles in everyday realities. However, these were principles that it was intended would be adhered to in this research project.

Baumrind (1964, p.421) suggested that in participating in research, "the subject agrees implicitly to assume a posture of trust and… the subject has the right to assume that his security and self-esteem will be protected." This statement incorporates aspects of all the above ethical principles. It was not believed that there were significant ethical difficulties or risks of taking part in the study for participants, the design of which took account of considerations related to beneficence and non-maleficence referred to above. Participants were reminded that their participation was voluntary and that they could withdraw from the study at any time (see Appendix 1) which affirmed the participant's autonomy. Guillemin and Gillam (2004) discussed reflexivity in the context of ethics in research. They claimed (pp.263-265) that there were two kinds of ethics involved in research, "procedural ethics" and "ethics in practice". Procedural ethics relate to the process of acquiring approval from one's school or department while ethics in practice relates to the daily encounter with ethical questions in carrying out research. In supporting the need for reflexivity in research, they believed that this reflexivity involved ensuring the informed consent of respondents, with those contributing to the research being treated as participants rather than as subjects. This affirms the concept of fidelity in the research process. They described reflexivity as facilitating a process of sensitisation to the experience of participants rather than as a predefined method of engaging ethically. They believed that this reflexivity facilitated an ethical encounter with qualitative research and not merely a traditional route to rigour. In carrying out this research the intention was to keep participants informed and safe (autonomy, fidelity and non-maleficence) while engaging in an ethical experience that also adhered to the basic procedural principles that guide ethical research (beneficence). This ethical stance included facilitating the views of participants and their voice in the data generated to emerge in the process while acknowledging the practical limitations of time, resources and interpretation.

Ethical approval for this study was received from the DCU Research Ethics Committee (Appendix 5).

3.7   PARTICIPANT CONSENT

An information sheet was provided via email for e-Delphi participants (Appendix 1). This information sheet explained the study in line with DCU ethical guidelines. It was made clear

to all participants that they had the right to not participate or withdraw from the study at any point. Consent information included with emails incorporated permission to record, transcribe and report on and publish findings related to the study. Participants had to confirm that they had read and understood the information sheet and that any questions had been adequately answered before being allowed to participate in the online survey.

3.8   RISKS TO PARTICIPANTS AND SUPPORT

It was not envisaged that there would be significant risks to participants and the survey was considered unlikely to cause any level of distress. The study was not asking respondents about personal circumstances. Information was given on the information sheet (Appendix 1) so that participants were informed of the purpose, structure and content of the study. It was considered to be a low-risk project.

In the event that participants would have become passionate in their responses, they would have been debriefed by a qualified psychotherapist in relation to the material and the study.

The principal investigator was responsible for carrying out all of the data gathering and collation work of this study. The principal investigator discussed the study with the DCU appointed research supervisors in order to monitor the research.

Participants were informed of the process involved in the research. In the event that participants wished to discuss any issues related the research with another person they were advised to contact Dublin City University.

3.9   CONFIDENTIALITY AND ANONYMITY

For the Delphi study, the anonymity of participants was maintained in distributing questions and data related to each round of the study. Only the principal investigator had access to Delphi responses and was able to identify the contributions of individual focus group participants. Only research supervisors and the principal investigator had access to anonymised and unanalysed data arising from the panel rounds and focus groups.

No information was included on completed research that could identify individual participants. All identifying information (such as name and address) was separated by the principal investigator from returned responses before collating and analysing the material. In relation to the Delphi, only the principal investigator knew which response belongs to which participant.

When data were received via email or electronically, only the principal researcher had access to the data. The data was marked with a confidential code for each participant before further downloading or processing of the data. The confidential code list was retained in a password-protected spreadsheet accessible only by the principal researcher. The coded, anonymised data were discussed with the research supervisors.

3.10   DATA ANALYSIS

Thematic analysis was chosen as a method for analysing the data generated by the Delphi study first round. Boyatzis (1998) described thematic analysis as useful for qualitative data (p.4) and that it could be applied during different phases of research. He also reported that "the interpretation phase of research follows development and use of a thematic code" (p.5). He described three separate phases to the analysis (p.29):

Stage I, deciding on sampling and design issues;

Stage II, developing themes and a code;

Stage III, validating and using the code.

In discussing Stage II, Boyatzis offered three possible ways in which to develop a coding for the emergent themes. These were "(a) theory driven, (b) prior data or prior research driven, and (c) inductive or data driven" (p.29). Given the future-based context of this study and in the hope of identifying a new understanding of participant perspectives, it was decided to adopt the inductive approach which Boyatzis (1998) suggested was more difficult than the other approaches in that it involved developing a code from a new theory. However, it was not envisaged that a new theory was essential for this study, but rather an interpretation of the views espoused by the participants. Boyatzis also warned about "obstacles" (p.12) to the approach, including "projection" or interpreting the data in light of one's own biases or experiences (p.13); "sampling" or "garbage in, garbage out" (p.14); and the "mood and style" of the researcher, including tiredness and boredom with the data (pp.15-16). He advised the researcher to be rested and "go with" the data (p.16).

In terms of using the inductive method, Boyatzis referred to three steps within Stage II of the analysis phases above. Step 1 of this development phase was to integrate the basic data internally as much as was practical and to make the data more "manageable" for analysis while paying attention to fatigue and premature identification of themes (p.69). Step 2 in this phase was "to sense and articulate potential themes in a subset" of the outlines created (p.86). Step 3

was for "comparing themes across subsamples" (p.87). Step 4 was for "creating a code" (p.90), and Step 5 was for "determining the reliability of the code" (p.94). In completing Stages I to III, the process also involved, "scoring, scaling and clustering themes" (p.128).

In generating a code book as part of the thematic analysis used in this research, Boyatzis (1998, p.xiv) claimed that:

> Regardless of ontology or epistemology, a code or codebook and assessment of consistency of observation provide (a) reliability for the positivist or postpositivist; (b) dependability for the postmodernist; (c) ability to communicate with others (i.e. to engage in social construction) for the hermeneutic, interactionist or relativist; and/or ability to interact with others about observations (i.e. dialogue or conversation) to the relationist.

In addressing an array of philosophical and scientific positions, Boyatzis claimed to offer some assurance for the consumer of this research whatever their philosophical or theoretical stance. The analysis method used in carrying out this study is discussed in section 3.14 below.

3.11   CRITERIA FOR ASSESSING QUALITY

The question of quality is challenging for qualitative studies and is one that generates debate. In writing a Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions, Hannes (2011) acknowledged the difficulty of establishing reliability and validity criteria for qualitative studies. In addressing participants in Cochrane reviews, Hannes believed that a "critical appraisal" (p.1) would be important for addressing the questions under consideration by the review. In respect of this position and in relation to this Delphi study, Diamond et al. (2014) proposed quality criteria to assess Delphi studies. These criteria are included below and consideration of how these issues have been addressed in this study is provided:

Assessment of Methodological Criteria based on Diamond et al. (2014)

1. Does the Delphi study aim to address consensus?

   Yes, the study involved consideration of whether or not consensus had been reached and what this means. The study included a cut-off point of 60% for inclusion of Round 2 results in Round 3.

2. Is the objective of the Delphi study to present results (e.g., a list or statement) reflecting the consensus of the group, or does the study aim to merely quantify the level of agreement?

The study presented a list of items made up of Likert scale statements and multiple choice items. The study reflected a consensus as the results were considered to be stable after the consensus level had been reached in Round 2 and after participants had been given the opportunity to consider their responses to Round 3.

3. How will participants be selected or excluded?

The participant criteria included reference to the length of time participants have had experience in the field, their accreditation or professional standing and whether they self-selected as having expertise in the field.

4. How will the consensus be defined?

The consensus was defined for Round 2 at the 60% cut-off point and in Round 3 stability will be presumed to have been achieved.

5. If applicable, what threshold value will be required for the Delphi to be stopped based on the achievement of consensus?

Not applicable; a 3 Round Delphi was used.

6. What criteria will be used to determine when to stop the Delphi in the absence of consensus?

Not applicable; a 3 Round Delphi was used.

7. Were items dropped?

Yes. Given resource limitations and considerations of the risk of participant fatigue, the number of items used in the instrument was restricted in each round.

8. What criteria will be used to determine which items to drop?

   N/A

9. What criteria will be used to determine to stop the Delphi process or will the Delphi be run for a specific number of rounds only?

   The Delphi ran for three rounds.

The Diamond et al. (2014) criteria above may benefit from the inclusion of explicit consideration of stability and dissensus factors (von der Gracht 2012; Steinert 2009).

3.12 RIGOUR

According to Dallos and Vetere, rigour was "equated" with the scientific method which in turn was "widely regarded as an approach to rigorous and systematic investigation that involved the process of hypothesis testing" (2005, p.11). Fox et al. believed that "researchers must ensure that their research methods are logical, rigorous and open to public and academic scrutiny." (2010, p.57). As part of this scrutiny, it was envisaged that this research would be available to academic and policy forums.

In considering rigour in qualitative research it was planned to adhere to the strategy referred to by Mays and Pope (1995) who observed, "As in quantitative research, the basic strategy to ensure rigour in qualitative research is systematic and self-conscious [sic] research design, data collection, interpretation, and communication." (p.110)

There has been considerable criticism of the Delphi approach. There has been a significant level of variability reported within the approach in relation to what practices have been acceptable in carrying out this type of research. It has been criticised for not meeting the standards of the scientific method, while issues around procedures, panel size, anonymity, the meaning of expertise and consensus levels have been debated.(Keeney et al. 2011, pp.20-30). However, as has been seen above, it is a popular method and has been used in many health care contexts.

3.13   SUMMARY

In this chapter, an outline of a rationale in relation to the choice of qualitative research and the use of an e-Delphi study has been given. An explanation of the approach has been outlined. This research was designed to explore a how the future of private sector psychotherapy in Ireland might look. The method of sampling, collating and analysing data has been examined. Specific issues related to ethical considerations, consent and confidentiality have been considered. The approach to data analysis has been reviewed and criteria for assessing quality and rigour considered. Problems arose in recruiting the planned cohort of forty participants which would have made up four panels. These panels were designed to facilitate an inter-panel comparison of perspectives. However, this was not possible and most panellists who were recruited were working in the field of psychotherapy. A sample of 26 (n=26) was recruited. Due to an unexpected opportunity, agreed extracts of an interview with a senior official of the HSE involved in mental health policy have been included.

3.14   METHOD USED IN THE E-DELPHI STUDY

The e-Delphi study involved the following steps:

1.   Review of literature and discussion with relevant experts.

2.   Gaining ethical approval from Dublin City University for the study.

3.   Development and distribution of Round 1 questionnaire.

4.   Thematic analysis of Round 1 responses.

5.   Development and distribution of Round 2 questionnaire.

6.   Analysis of Round 2 responses.

7.   Distribution of Round 3 questionnaire (non-consensus items).

8.   Analysis of Round 3 responses.

9.   Interview with a senior official of the Irish Health Service Executive.

For the literature review stage, I met with a number of experts in the field of psychotherapy in Ireland and discussed the Delphi study and its initial content.

3.14.1 ROUND 1 PROCESS

For Round 1 (n=26) the aim of the e-Delphi study was to ask a series of open-ended questions in order to generate data for developing the Round 2 questionnaire. The questions posed in Round 1 were informed by the literature review. A questionnaire was developed containing nine questions. One question was included as a general, more open question, to facilitate the unique views of participants to emerge (Appendix 1). In relation to the future of PSP, questions included in the Round 1 questionnaire asked participants to identify and outline their views on the impact of key issues effecting the future of PSP, including: mental health policy, training standards and accreditation, competitive forces, the medical model, existing responses to mental health, low-cost counselling and technology. Participants were also asked to outline what changes they would like to see that would have an effect on PSP.

The purpose of the Round 1 and this questionnaire was to establish what participants thought about the questions posed and also to ascertain what other issues respondents considered

relevant to the future of private sector psychotherapy in Ireland in order to produce a questionnaire for Round 2

Care was taken to ensure that participants were not able to identify other participants. This was not always possible as some participants introduced other participants in line with the methodology above. However, during communication with participants, efforts were made to ensure that no acknowledgement of other participant names was given.

Participants were informed via email of ethical considerations related to the study and options for action in the event of any ethical or other issues arising (Appendix 1). The Round 1 questions are included in Appendix 1, although it should be noted that the format is not exactly the same as that which appeared in Google Forms.

For the purposes of Round 2, the responses given in Round 1 were analysed using an approach based on Boyatzis (1998). A codebook was used to perform the initial analysis. In performing this analysis, key phrases were highlighted on printouts of the Round 1 responses and then written manually in the code book. Each of these elements was then coded thematically: for each of the responses so written a code theme was written in the right-hand column of the coding book. Hierarchical or metathemes were identified which summarised the included code themes identified.

These metathemes and code themes were then entered into a spreadsheet for sorting by theme. Frequencies for each code theme within the dataset were calculated and included in the spreadsheet. Code themes with similar meanings were reviewed and the theme title standardised where it was considered that this was appropriate, in order to use the consistent code theme description across the data. The data was then discussed and reviewed with another researcher and amended by agreement. As a result of this exercise, some codes were amended or joined with other codes as they were essentially equivalent to the code content generated by other questions in the questionnaire.

From these key themes, eighty codes were identified and the frequencies associated with these were established (see Table 3). The themes were sorted in order to establish the ranking of the frequencies with which they occurred in the responses. The themes were further reviewed and concentrated in order to reduce the overall number of themes (see Table 4 and Table 5).

Sixteen initial items were generated based on this analysis (see Table 6). In relation to Regulation and Recognition, it appeared that there were fewer responses concerning difficulties

with regulation and more concerned with recognition of private sector psychotherapy and the profession. There appeared in the data to be an assumption that regulation will happen and little questioning about this. Issues raised appeared to be more focused on the place of PSP in regulation rather than the fact of regulation. Therefore, an item in relation to regulation was not generated. Though the potential value of a survey questioning regulation would appear obvious, this questioning did not emerge in the original data. Items related to Economy and Cost of Therapy and Need for Funding themes were excluded as on review of the responses to these it was decided that the theme Low-Cost Therapy could address these themes. The theme Promotion of PSP (Private Sector Psychotherapy) was considered to be covered by the Regulation and Recognition and Collaboration and Links themes and related items. The theme Evidence-Based Practice was considered to be covered by Regulation and Recognition items. The Oversupply theme was excluded due to its low frequency as an issue and bearing in mind that it was considered that this had been adequately addressed in the literature review. In doing this, consideration was given to avoiding repetition and minimising the burden on participants. As a result of this distillation, the number of metatheme items was reviewed and reduced to twelve (see Table 4 and Table 5 below).

The responses given by participants in Round 1 (n=26) demonstrated variability in the perspectives held by the study participants, though overall themes could be established by way of the thematic analysis. Given this variability, it was considered whether consensus could be reached, though the possibility for a consensus or dissensus resulting from the study was also contemplated.

3.14.2 ROUND 2 PROCESS

The purpose of Round 2 was to establish consensus levels for the items generated in Round 1 and elicit comments from participants about Round 2.

For Round 2, a set of sixteen draft items had been generated for inclusion in the instrument. On review of these, it was decided that these should be reduced, so as to minimise the burden on participants. Therefore, four items were removed which were deemed relatively unimportant or duplicates. The remaining twelve items were taken and reviewed again to ensure that they were sufficiently clear for inclusion in the instrument and some small amendments were made to the wording for clarity. An open question was added to facilitate further comment by participants leaving thirteen items in total (see Appendix 2).

For Round 2 the items generated by the analysis of Round 1 responses were distributed to participants via email communication using Gmail, Google Forms or Linkedin, which included a link to the Google Forms Round 2 Questionnaire (Appendix 2). Email reminders were sent to participants to ask them to complete the Round 2 questionnaire. Twenty-three responses were received between May 18th and June 3rd 2014 (n=23) after which access to the questionnaire was closed. For Round 2 it was not possible to get responses from three participants. Of these, contact with one participant was not possible to re-establish in the time available and two participants did not respond in time.

The Round 2 questionnaire also included an item (Appendix 2, item 13) to facilitate additional comments from participants. It was possible to incorporate some of these comments into the Round 3 (Appendix 3) process. However, some comments were not incorporated as they were not considered relevant to the Round. The retention rate of 88% of participants from Round 1 to Round 2 was considered satisfactory, especially in light of the lengthy delay between Round 1 and Round 2.

In summary, for Round 2 (n=23), the information generated in Round 1, which had been analysed and organised into themes, was then used as the basis for a Likert scale questionnaire. This Likert questionnaire was distributed to participants and the data collated. The Round 2 data generated was then reviewed and analysed to see if consensus had arisen. A graphical and statistical analysis of the Round 2 results was completed and is shown in Section 4.3 below. This consisted of constructing a graph for each of the twelve items and calculation of mode, mean and standard deviation for each item. In addition, percentages were calculated for each of the responses to the items.

Despite the variability apparent in Round 1 responses, Round 2 resulted in the consensus level of 60% being reached for eight out of the relevant twelve items (n=23 participants), excluding the open question contained in item 13. Eight of the twelve items were at the 65% level or above. In considering the process, this may indicate that many of the themes generated as a result of Round 1 responses were appropriately captured in the Round 2 questionnaire item statements.

3.14.3 ROUND 3 PROCESS

For Round 3, the aim was to establish if consensus could be reached for those items which had not yet reached consensus.

On reviewing the Round 2 responses, it was found that the Round 2 responses had resulted in consensus for eight of the twelve items. The remaining four items for which consensus had not been attained were reviewed. An email was created (Appendix 3) and issued to each participant containing the following information for each of the four items: frequency of each category (Strongly Agree, Agree, Neutral / Don't Know, Disagree or Strongly Disagree), the percentage of each category, mode, mean and standard deviation. An information sheet containing edited extracts from Round 1 participant responses was also included (Appendix 4). The email was constructed to optimise the amount of information provided and minimise confusion and burden for participants. As a result of this consideration, a table containing the mode, mean and standard deviation data was included at the bottom of the email rather than alongside the main data. The email also included brief clarification (based on Round 1 and Round 2 participant comments) of the consensus/dissensus aspects and speculative nature of the Delphi approach. In addition, a definition of PSP was included (see Appendix 3 and Appendix 4).

Nineteen (n=19) respondents replied to the round. This was a reduction of four participants from the previous round. Just one respondent changed one response out of the four items distributed for the third round: for item 11 which was one of the four items redistributed in Round 3 "The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy" this respondent changed from Agree to Neutral / Don't Know.

Round 3 confirmed the presence of a stable consensus and dissensus for most of the questions. As one of the objectives of the Delphi method is to reach stability in consensus or dissensus (von der Gracht 2012; Steinert 2009) it could be said that, while Round 3 did not generate significant additional data, it was valuable in that it demonstrated stability in the participants' views.

In summary, for Round 3 items which had not attained the predetermined consensus level of 60%, were redistributed to the participants. These items were sent to all participants and included the overall response percentages given in Round 2 by the sample panel in addition to an information sheet giving feedback containing selected Round 1 responses. The purpose of Round 3 was to establish if consensus and stability could be achieved for those Round 2 responses where no consensus had emerged. In order to achieve this, Round 3 participants were given the opportunity to change their previous responses.

3.14.4 INTERVIEW WITH SENIOR OFFICIAL OF THE HSE

As has been outlined above, in June 2014 an opportunity arose to interview a senior official of the HSE. Extracts from the interview were transcribed and approved for inclusion by the official. A wide range of issues were discussed in the interview. A summary of these extracts is included in section 4.5 below. A more extensive analysis of these comments is included in Appendix 6. The themes arising from the data generated by this interview were analysed and compared to the literature review and results of the e-Delphi study in the Discussion chapter.

These extracts were analysed on the same basis of the e-Delphi Round 1 results (Boyatzis 1998). Only themes, and related content, of the interview that were the same or broadly similar to those themes that had already been generated by the study were included in the extracts. This was done to not override the Delphi and literature findings with the opinions of an influential individual (von der Gracht 2012; Dalkey 1968) and to avoid using data that was extraneous to the literature review and e-Delphi. Where the themes overlapped but were described differently, the themes used in the literature review or in the e-Delphi were used in the interview analysis.

CHAPTER 4   <u>RESULTS</u>

4.1   <u>INTRODUCTION</u>

There appears to be a gap in information related to the understanding of PSP in Ireland. This study was designed to explore, by use of an e-Delphi study in conjunction with a literature review, what factors may impact on the future of PSP in Ireland and offer some feedback and context from participants with expertise in the field, in relation to their views on PSP. In this chapter, results of the study over the three rounds of the e-Delphi are presented. The frequencies of the results are reported and selected participant responses are presented.

4.2   <u>ROUND 1 RESULTS (CODED RESPONSE FREQUENCIES)</u>

Round 1 was designed to establish a starting point for subsequent rounds by using data generated by asking participants general questions about PSP, in order to establish themes for the Round 2 questionnaire. Table 3 below shows a thematic analysis (Boyatzis 1998) of the responses given in Round 1. To arrive at this analysis, firstly the responses given by participants in Round 1 (n=26) were reviewed. The first column shows the relevant Round 1 question number from where the theme arises and the second column shows the theme of the Round 1 question. The third column shows the code themes that were identified. The fourth column includes the frequency of occurrence for each of the identified code themes. The final column shows the identified metatheme for the dataset:
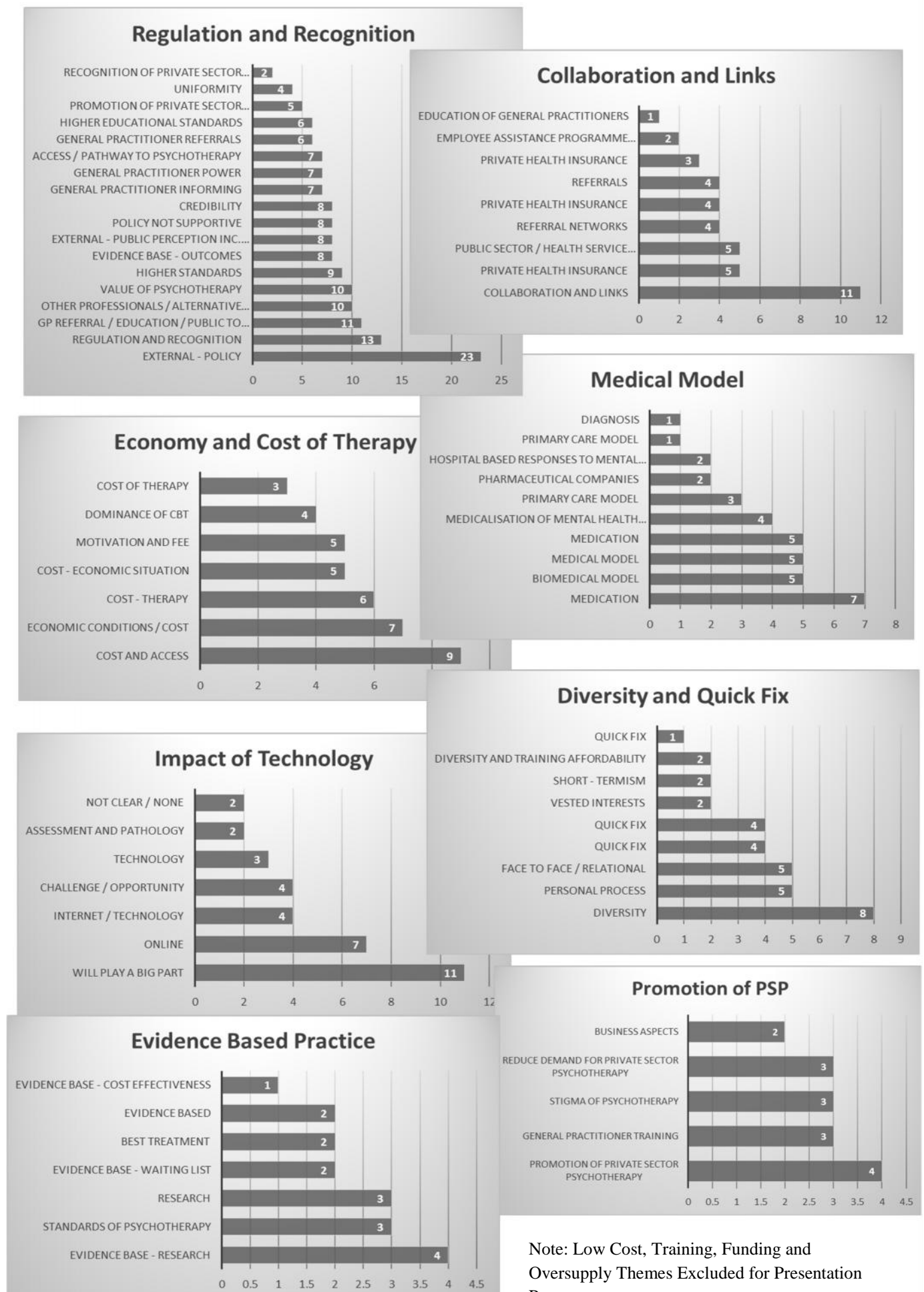
TABLE 3: ROUND 1 CODE THEMES, FREQUENCIES AND METATHEMES

R1 Question	Question Theme	Code Theme	Frequency (f)	Hierarchical Theme (Metatheme)
Q9	Changes You Would Like	**Collaboration and Links**	11	**Collaboration and Links**
Q1	Key Issues in Future of PSP	Private Health Insurance	5	**Collaboration and Links**
Q4	Competitive Forces	Public Sector / Health Service Executive	5	**Collaboration and Links**
Q1	Key Issues in Future of PSP	Referral Networks	4	**Collaboration and Links**
Q4	Competitive Forces	Private Health Insurance	4	**Collaboration and Links**
Q6	Existing Responses to Mental Health	Referrals	4	**Collaboration and Links**
Q9	Changes You Would Like	Private Health Insurance	3	**Collaboration and Links**
Q4	Competitive Forces	Employee Assistance Programme Provision	2	**Collaboration and Links**
Q6	Existing Responses to Mental Health	Education of General Practitioners	1	**Collaboration and Links**
Q9	Changes You Would Like	**Diversity**	8	**Diversity and Quick Fix**
Q3	Existing Mental Health Policy	Personal Process	5	**Diversity and Quick Fix**
Q8	Impact of Technology	Face to Face / Relational	5	**Diversity and Quick Fix**
Q4	Competitive Forces	Quick Fix	4	**Diversity and Quick Fix**
Q6	Existing Responses to Mental Health	Quick Fix	4	**Diversity and Quick Fix**
Q1	Key Issues in Future of PSP	Vested Interests	2	**Diversity and Quick Fix**
Q1	Key Issues in Future of PSP	Short – Termism	2	**Diversity and Quick Fix**
Q3	Existing Mental Health Policy	Diversity and Training Affordability	2	**Diversity and Quick Fix**
Q8	Impact of Technology	Quick Fix	1	**Diversity and Quick Fix**
Q8	Impact of Technology	Cost and Access	9	**Economy and Cost of Therapy**
Q4	Competitive Forces	Economic Conditions / Cost	7	**Economy and Cost of Therapy**
Q1	Key Issues in Future of PSP	Cost - Therapy	6	**Economy and Cost of Therapy**
Q1	Key Issues in Future of PSP	Cost - Economic Situation	5	**Economy and Cost of Therapy**
Q7	Impact of Low Cost Counselling	Motivation and Fee	5	**Economy and Cost of Therapy**
Q5	Medical Model Impact	Dominance of CBT	4	**Economy and Cost of Therapy**
Q6	Existing Responses to Mental Health	Cost of Therapy	3	**Economy and Cost of Therapy**
Q1	Key Issues in Future of PSP	Evidence Base - Research	4	**Evidence- Based Practice**
Q5	Medical Model Impact	Standards of Psychotherapy	3	**Evidence- Based Practice**
Q9	Changes You Would Like	Research	3	**Evidence- Based Practice**
Q1	Key Issues in Future of PSP	Evidence Base - Waiting List	2	**Evidence- Based Practice**
Q3	Existing Mental Health Policy	Best treatment	2	**Evidence- Based Practice**
Q3	Existing Mental Health Policy	Evidence Based	2	**Evidence- Based Practice**
Q1	Key Issues in Future of PSP	Evidence Base - Cost Effectiveness	1	**Evidence- Based Practice**
Q8	**Impact of Technology**	Will Play a Big Part	11	**Impact of Technology**
Q8	Impact of Technology	Online	7	**Impact of Technology**
Q4	Competitive Forces	Internet / Technology	4	**Impact of Technology**
Q8	Impact of Technology	Challenge / Opportunity	4	**Impact of Technology**
Q1	Key Issues in Future of PSP	Technology	3	**Impact of Technology**
Q8	Impact of Technology	Assessment and Pathology	2	**Impact of Technology**
Q8	Impact of Technology	Not Clear / None	2	**Impact of Technology**
Q7	**Impact of Low Cost Counselling**	Erosion of Private Sector Psychotherapy	8	**Low Cost Therapy**
Q7	Impact of Low Cost Counselling	Good Effect	7	**Low Cost Therapy**
Q4	Competitive Forces	Low Cost / Free Therapy	4	**Low Cost Therapy**

Q	Question Theme	Code Theme	(*f*)	Hierarchical Theme (Metatheme)
Q5	Medical Model Impact	Medication	7	**Medical Model**
Q1	Key Issues in Future of PSP	Biomedical Model	5	**Medical Model**
Q4	Competitive Forces	Medical Model	5	**Medical Model**
Q6	Existing Responses to Mental Health	Medication	5	**Medical Model**
Q6	Existing Responses to Mental Health	Medicalisation of Mental Health Issues	4	**Medical Model**
Q6	Existing Responses to Mental Health	Primary Care Model	3	**Medical Model**
Q4	Competitive Forces	Pharmaceutical Companies	2	**Medical Model**
Q6	Existing Responses to Mental Health	Hospital Based Responses to Mental Health	2	**Medical Model**
Q1	Key Issues in Future of PSP	Primary Care Model	1	**Medical Model**
Q5	Medical Model Impact	Diagnosis	1	**Medical Model**
Q1	Key Issues in Future of PSP	External - Funding	7	**Need for Funding**
Q2	Existing Mental Health Policy	Mental Health is under resourced	3	**Need for Funding**
Q3	Existing Mental Health Policy	Oversupply	3	**Oversupply**
Q4	Competitive Forces	Oversupply	2	**Oversupply**
Q1	Key Issues in Future of PSP	Oversupply	1	**Oversupply**
Q9	Changes You Would Like	Promotion of Private Sector Psychotherapy	4	**Promotion of PSP**
Q5	Medical Model Impact	General Practitioner Training	3	**Promotion of PSP**
Q6	Existing Responses to Mental Health	Stigma of Psychotherapy	3	**Promotion of PSP**
Q7	Impact of Low Cost Counselling	Reduce Demand for Private Sector Psychotherapy	3	**Promotion of PSP**
Q9	Changes You Would Like	Business Aspects	2	**Promotion of PSP**
Q1	Key Issues in Future of PSP	External - Policy	23	**Regulation and Recognition**
Q9	Changes You Would Like	**Regulation and Recognition**	13	**Regulation and Recognition**
Q9	Changes You Would Like	GP Referral / Education / Public to Private Referral	11	**Regulation and Recognition**
Q4	Competitive Forces	Other Professionals / Alternative Therapies	10	**Regulation and Recognition**
Q6	Existing Responses to Mental Health	Value of Psychotherapy	10	**Regulation and Recognition**
Q3	Existing Mental Health Policy	Higher Standards	9	**Regulation and Recognition**
Q1	Key Issues in Future of PSP	Evidence Base - Outcomes	8	**Regulation and Recognition**
Q1	Key Issues in Future of PSP	External - Public Perception inc. Stigma	8	**Regulation and Recognition**
Q2	Existing Mental Health Policy	Policy not Supportive	8	**Regulation and Recognition**
Q3	Existing Mental Health Policy	Credibility	8	**Regulation and Recognition**
Q5	Medical Model Impact	General Practitioner Informing	7	**Regulation and Recognition**
Q5	Medical Model Impact	General Practitioner Power	7	**Regulation and Recognition**
Q7	Impact of Low Cost Counselling	Access / Pathway to Psychotherapy	7	**Regulation and Recognition**
Q5	Medical Model Impact	General Practitioner Referrals	6	**Regulation and Recognition**
Q9	Changes You Would Like	Higher Educational Standards	6	**Regulation and Recognition**
Q8	Impact of Technology	Promotion of Private Sector Psychotherapy	5	**Regulation and Recognition**
Q3	Existing Mental Health Policy	Uniformity	4	**Regulation and Recognition**
Q6	Existing Responses to Mental Health	Recognition of Private Sector Psychotherapy	2	**Regulation and Recognition**
Q1	Key Issues in Future of PSP	Training Standards	10	**Training Standards**
Q1	Key Issues in Future of PSP	Training Standards - CPD	3	**Training Standards**
Q1	Key Issues in Future of PSP	Training Standards - Accreditation	3	**Training Standards**

The following Table shows the above data in graphical form. The themes Low-Cost, Training, Funding and Oversupply Themes from above have been excluded, as some of the code themes are repetitive within the metatheme. In addition, these themes have been excluded in order to optimise presentation:

TABLE 4: SELECTED ROUND 1 METATHEME CODE FREQUENCIES

Regulation and Recognition

Code	Frequency
RECOGNITION OF PRIVATE SECTOR...	2
UNIFORMITY	4
PROMOTION OF PRIVATE SECTOR...	5
HIGHER EDUCATIONAL STANDARDS	6
GENERAL PRACTITIONER REFERRALS	6
ACCESS / PATHWAY TO PSYCHOTHERAPY	7
GENERAL PRACTITIONER POWER	7
GENERAL PRACTITIONER INFORMING	7
CREDIBILITY	8
POLICY NOT SUPPORTIVE	8
EXTERNAL - PUBLIC PERCEPTION INC...	8
EVIDENCE BASE - OUTCOMES	8
HIGHER STANDARDS	9
VALUE OF PSYCHOTHERAPY	10
OTHER PROFESSIONALS / ALTERNATIVE...	10
GP REFERRAL / EDUCATION / PUBLIC TO...	11
REGULATION AND RECOGNITION	13
EXTERNAL - POLICY	23

Collaboration and Links

Code	Frequency
EDUCATION OF GENERAL PRACTITIONERS	1
EMPLOYEE ASSISTANCE PROGRAMME...	2
PRIVATE HEALTH INSURANCE	3
REFERRALS	4
PRIVATE HEALTH INSURANCE	4
REFERRAL NETWORKS	4
PUBLIC SECTOR / HEALTH SERVICE...	5
PRIVATE HEALTH INSURANCE	5
COLLABORATION AND LINKS	11

Economy and Cost of Therapy

Code	Frequency
COST OF THERAPY	3
DOMINANCE OF CBT	4
MOTIVATION AND FEE	5
COST - ECONOMIC SITUATION	5
COST - THERAPY	6
ECONOMIC CONDITIONS / COST	7
COST AND ACCESS	9

Medical Model

Code	Frequency
DIAGNOSIS	1
PRIMARY CARE MODEL	1
HOSPITAL BASED RESPONSES TO MENTAL...	2
PHARMACEUTICAL COMPANIES	2
PRIMARY CARE MODEL	3
MEDICALISATION OF MENTAL HEALTH...	4
MEDICATION	5
MEDICAL MODEL	5
BIOMEDICAL MODEL	5
MEDICATION	7

Impact of Technology

Code	Frequency
NOT CLEAR / NONE	2
ASSESSMENT AND PATHOLOGY	2
TECHNOLOGY	3
CHALLENGE / OPPORTUNITY	4
INTERNET / TECHNOLOGY	4
ONLINE	7
WILL PLAY A BIG PART	11

Diversity and Quick Fix

Code	Frequency
QUICK FIX	1
DIVERSITY AND TRAINING AFFORDABILITY	2
SHORT - TERMISM	2
VESTED INTERESTS	2
QUICK FIX	4
QUICK FIX	4
FACE TO FACE / RELATIONAL	5
PERSONAL PROCESS	5
DIVERSITY	8

Evidence Based Practice

Code	Frequency
EVIDENCE BASE - COST EFFECTIVENESS	1
EVIDENCE BASED	2
BEST TREATMENT	2
EVIDENCE BASE - WAITING LIST	2
RESEARCH	3
STANDARDS OF PSYCHOTHERAPY	3
EVIDENCE BASE - RESEARCH	4

Promotion of PSP

Code	Frequency
BUSINESS ASPECTS	2
REDUCE DEMAND FOR PRIVATE SECTOR PSYCHOTHERAPY	3
STIGMA OF PSYCHOTHERAPY	3
GENERAL PRACTITIONER TRAINING	3
PROMOTION OF PRIVATE SECTOR PSYCHOTHERAPY	4

Note: Low Cost, Training, Funding and Oversupply Themes Excluded for Presentation Purposes

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The twelve summarised metathemes and their frequencies as a result of the analysis of Round 1, and shown in Table 3 and Table 4, above are presented in the table below in rank order and summed by the overall frequency of each metatheme:

TABLE 5: ROUND 1 CODE THEMES FREQUENCIES SUMMARISED

Summary of Theme Frequencies	Frequency
Regulation and Recognition	152
Collaboration and Links	39
Economy and Cost of Therapy	39
Medical Model	35
Diversity and Quick Fix	33
Impact of Technology	33
Low-Cost Therapy	19
Evidence-Based Practice	17
Training Standards	16
Promotion of PSP*	15
Need for Funding	10
Oversupply	6

* PSP refers to Private Sector Psychotherapy.

In determining the frequencies of these metathemes, the original data was again reviewed and possible item statements were derived for use in the Round 2 questionnaire. These are shown in Table 6 below. Given considerations of possible participant fatigue, it was decided to limit the number of questions to twelve items, with one additional open item to facilitate comment by participants, resulting in a total of thirteen items in the Round 2 questionnaire. This necessitated a reduction in the number of possible item statements listed in Table 6 below. The item statements not included related to; diversity in formation, funding, supply and viability. It was decided that these items could be adequately addressed under other items.

TABLE 6. POSSIBLE ITEM STATEMENTS

Metatheme Frequencies	Frequency	Possible Item Statements
Regulation and Recognition	152	Private sector psychotherapy in Ireland is in danger of becoming irrelevant to government policy. Statutory regulation should recognise diversity in therapist formation.
Collaboration and Links	39	Private sector psychotherapy has credibility among referral sources such as GPs and Psychiatrists. Private sector psychotherapy has adequate links with other mental health professionals. Collaboration between diverse approaches to psychotherapy improves the public standing of psychotherapy.
Economy and Cost of Therapy	39	The provision of low cost therapy (excluding medical card holders) is good for private sector psychotherapy.
Medical Model	35	There is too much medication being prescribed for mental health issues. There is adequate utilisation of psychotherapy in response to mental health issues.
Diversity and Quick Fix	33	There is a prevailing quick fix mentality in public sector responses to mental health distress.
Impact of Technology	33	Thinking about technology, face to face therapy will always be better for the client than treatment via technology.
Low-Cost Therapy	19	The availability of low-cost therapy services (apart from medical card holders) is damaging the viability of private sector psychotherapy.
Evidence-Based Practice	17	Therapeutic outcome measures are needed in private sector psychotherapy.
Training Standards	16	The minimum academic requirement for working in private sector psychotherapy should be: (a) Diploma (b) Degree (c) Masters (d) Doctorate (e) other.
Promotion of PSP	15	Private sector psychotherapy needs to be promoted more effectively.
Need for Funding	10	Funding needs to be increased for mental health provision.
Oversupply	6	There is an oversupply of accredited psychotherapists in Ireland.

4.2.1   REVIEW OF ROUND 1 METATHEMES

In this part of the study, the data responses underlying the metathemes identified in Round 1 were reviewed. Items in quotes were taken from the responses of participants. Some editing of these responses was carried out for reasons of spelling, grammar and clarity of presentation in order to avoid repetition of similar or overlapping themes. The letters and numbers in brackets at the end of each quote refer to the questionnaire item or question number (Q) and line of data

(L) from which each quote was included. Some quotations were included in themes other than their originally coded themes for the sake of clarity in presenting the ideas discussed.

4.2.2 REGULATION AND RECOGNITION

The Regulation and Recognition metatheme contained the highest number of coded responses, with 152 in total. In general the responses demonstrated a clear support for regulation or an assumption that regulation would occur. However, there were some concerns raised in the midst of a diverse range of perspectives. These will be discussed below.

One participant questioned the use of the terminology and the related impact of regulation:

> Considering the words 'independent' and 'private', how these are conceptualised with reference to psychotherapy, may be the most significant changes for the future. With increasing regulation, standards and professionalism, the concept of 'independent' practice may become a misnomer? Similarly, with increasing demands for transparency and accountability, 'private' has in many ways become public. (Q1:L10)

There was reference to the possibly poor standing of PSP in connection with policy, with one participant commenting:

> I don't think the psychotherapeutic private sector in Ireland has any significant input into the present mental health policy in Ireland. As a consequence of this position of outsider in terms of mental health policy the future of private practice is questionable. (Q2:L7)

It may be seen from this statement that this participant had a concern about the involvement of PSP in policy and as a result, its future. Related to this was the possible impact of regulation on the field:

> Statutory regulation will have an enormous effect and not necessarily for the better. This will imply minimal training requirements and outside bodies interfering with length and content of therapy. Regulation and the way it is taking shape at the moment through the effect of vested interests will have a serious negative influence on the future of psychotherapy in Ireland as it has done in other countries. (Q1:L20)

Concern for a possible negative impact of regulation was expressed; "I would like to see regulation which does not give inordinate power to one organisation but is inclusive of those who are affiliated to other organisations, or to no organisations at all." (Q9:L11). In considering this possible need for diversity another participant noted, "The most important thing for me is that we rethink statutory regulation and make room for a testimony of one's own therapy or

analysis as a criteria [for] who can practice or not and move away from senseless counting of hours and sessions." (Q9:L20)

Another participant appeared to be supportive of regulation and suggested, "Accreditation, strong informed leadership will be essential in harnessing the profession of psychotherapy, which is; let's face it highly unregulated in Ireland to date." (Q3:L16)

There was also a concern expressed for the idea of practitioners working on their own with one expressed preference for "agency based services, not sole trader's model." (Q9:L17). Related to this, another participant maintained,

> I feel very strongly, that it is not good enough for independent practitioners to work in isolation. There needs to be an increase with [sic] client consent for private therapists to share clinical information with service providers. This is the model used in Scandinavia and is a best model of care with better client outcomes which surely is the aim after all! (Q9:L21)

Somewhat related to this, some participants also discussed themes around referrals to PSP, from GPs among others, and the need to make referrers aware of PSP services. One participant spoke of the need for, "Increasing awareness of psychological therapy as an alternative or adjunct to biological/medical intervention" (L1:Q10). These referral/awareness sub-themes made up thirty-eight of the contributions within this metatheme.

Another viewpoint related to the impact and requirements of regulation and registration was from the participant who reasoned, "I think if accrediting bodies continue in their current trend, it will ultimately become too rigid and restrictive to practice as a private practitioner." (Q9:L6)

Responses related to the code theme "External – Policy" (twenty-three responses were coded under this theme), which was incorporated in the Regulation and Recognition metatheme, included a recognition that the Vision for Change (Department of Health and Children 2006) document represented a move towards an increasingly service-user perspective, and a less medical-model orientation. In relation to this and to PSP specifically, a participant commented, "Existing policy does not have a positive place for psychotherapy even in the public sector, and has little interest in the private sector." (Q2:L3). Supporting this viewpoint, another participant believed that PSP is, "practically invisible to current policy decisions." (Q6:L3)

Commenting on the impact of current policy a participant believed:

A difficult question as current mental health policy is, in my opinion, lacking direction and focus. The 'Vision for Change' recommendations have not been implemented and I do not believe this document was well thought out. (Q2:L19)

Another participant referred to the practical impacts of evolving policies, especially as these related to sexual abuse guidelines, and predicted that shifts, "May put pressure on those in private section [sic] to change how they work, particularly in terms of mandatory reporting of historical abuse." (Q2:L24)

From this, a general consensus is apparent that PSP was not well integrated into policy frameworks. There was an overall assumption of future regulation, while some participants expressed concern about how this regulation would be derived and implemented.

4.2.3 COLLABORATION AND LINKS

In relation to this theme, a total number of code responses of thirty-nine was found. Twelve code or subthemes within this metatheme referred in particular to health insurance providers, and nine code themes referred to referral networks and public health referrals. In relation to this, one participant suggested changes:

More recognition by health insurance and medical card services that this is a valid health option and consequently its cost should be covered rather than borne by the individual. I'd like to see more open dialogue and collaboration with the medical world. (Q9:L6)

The collaboration idea was mirrored in comments by another participant who predicted:

An issue will be whether private sector psychotherapists are included by other players in the mental provision - e.g. doctors, psychiatrists, community psychiatric nurses, social workers. Will psychotherapists in community be included in shared support and care plans? (Q1:L18)

Speaking on what PSP needs to do in order to be a potential referral resource a participant observed, "Private sector psychotherapy probably needs to be similar enough to the medical model to be credible for referrals, and different enough to be useful for referrals" (Q5:L3) One respondent was concerned that existing approaches to mental health care, "… can also mean that existing responses may be referring to un-accredited therapists with poor training." (Q6: L21).

Referring to the implementation of Vision for Change (Department of Health and Children 2006) one participant said that, "Mental health care within the primary [care] setting continues

to be rolled out across the country" and, in speaking of this said that, "… since GPs have traditionally been a significant source of referrals historically, free on-site therapy endorsed by a GP has already begun to erode referrals to the private sector." (Q2:L27). Another participant believed, "I think too that the private sector needs to forge strong links with other professionals that need to refer." (Q9:L4)

Review of this theme suggests a recognition of the need for improved collaboration to encourage referral relationships between different participants in client's care.

4.2.4   ECONOMY AND COST OF THERAPY

Thirty-nine codes or sub-themes were contained in this metatheme. Of these, twenty-eight of the code theme frequencies were focused on the cost of attending psychotherapy. One participant noted, "I think cost is an issue. I notice that clients are beginning to come for just one session, or are not coming for sessions when they feel well. This is a new phenomenon." (Q1:L9) This may be related to general economic difficulties in addition to the actual cost or value of therapy; "The recession forces many people to seek non-fee paying services such as HSE or alternatively to neglect their mental health as private psychotherapy is typically expensive." (Q4:L16). Another participant referred to, "The financial downturn and lack of disposable income." (Q1:L15). A frequency of twelve code themes referred to economic conditions in general. One participant stated:

> Economic realities of providing mental health services, the current economic climate and the seeking of shorter-term, effective interventions. How this may influence the therapeutic approaches that are favoured (e.g. CBT) as cost-effective may be very influential and impact on other therapeutic modalities, including CBT. If the trajectory is to follow the path of the NHS/UK, short-term work may receive greater government investment and public visibility. Clients may preferentially seek such approaches from the independent therapist. (Q1:L10)

This metatheme reveals concerns about the actual cost of attending therapy with PSP and whether this should or could be borne by the state or the individual. Ireland's difficult economic situation is also referred to in this theme.

4.2.5   MEDICAL MODEL

The Medical Model theme generated thirty-five coded comments analysed from the Round 1 data. Medication made up twelve of the sub-code themes and medicalisation was referred to in 4 sub-themes.

Speaking of the impact of medication and the impact of medicalisation a participant claimed that:

> In my experience, the vast majority of clients that eventually present for therapy have ALREADY been prescribed anxiolytics or antidepressants. There is a belief that interventions are developed from a bio-psycho-social model but the reality seems to still be that the 'bio-bio-bio' model is still in force. (Q6:L27).

A highly critical response stated, "Existing responses are: if you are ill mentally take medication, if you're really bad go to hospital where you will be locked up for several days doing absolutely nothing." (Q6:L2).

This participant continued, saying:

> You will stabilized and then discharged to meet up with a psychiatrist who will most likely put you on more meds, if you are public, private is slightly different. Psychotherapy doesn't feature in this scenario for me in my experience. They will also be referred to free counselling or state run service where a waiting list is miles long. (Q6:L2)

One participant was more optimistic and said, "I think the tide is turning and doctors are seeing the benefits of psychotherapy for their patients." (Q6:L9). Another partly contradicts this, in expressing a concern about a "Greater emphasis on medicalisation of fear and sadness (anxiety and depression) and for subsequent treatment." (Q6:L24).

Another believed an issue for PSP to be, "Increasing awareness of psychological therapy as an alternative or adjunct to biological/medical intervention" (Q1:L10). Agreeing with this, another said, "I would like to see the value of longer term therapy being more widely recognised and made more accessible by health insurance companies investing in that rather than relying on medical model." (Q9: L22) A participant was concerned about the increasing medicalisation of problems predicting a "Greater emphasis on medical model in mental health issues." (Q4:L24) while another expressed this concern; "I think it is quite possible that if things continue as they are, the medical model will harm the reputation of independent psychotherapy through scare mongering." (Q5:L6). Speaking of the future impact of the medical model on PSP another reasoned, "Until Counsellor/therapists have a recognised place within mental health care, the medical model will continue to dominate" (Q5:L7).

Looking to the future a participant believed in the impact of the medical model:

It may lead to more referrals to secondary care centres for medical management rather than referral to psychotherapy centres, which may be what patient really needs and lead to delay in therapy and worse prognosis" (Q5:L13).

This theme indicates a clear difficulty with the use of medication. While participants expressed concerns about increasing medicalisation, there were also some more optimistic voices related to the place of PSP within this context.

4.2.6   DIVERSITY AND QUICK-FIX

There were thirty-three code responses recorded under this theme. Speaking of this theme, and in connection with the medical model criticisms in the previous theme, one participant claimed, "There is a strong preference for the 'quick' fix of medication, and statistics show that there is an inordinately large number of people on anti-depressants and anti-anxiety drugs." (Q6: L11)

Speaking of the quick-fix theme and the impact of current policy on the future of PSP a participant predicted that this is leading to:

Creation of a culture where the widespread quick-fix mentality is applied to those with severe emotional trauma and/or disturbance, resulting in totally unrealistic expectations that an individual who was raised during their developmental years in an emotionally deprived, disturbed or abusive environment should recover adequate mental/emotional functioning in...6, 16 or 20 sessions? (Q2:L8)

This idea was partly echoed by the participant who reasoned, "In addition, CBT models have created an expectation from clients that positive gains should be experienced within 3-4 sessions and are more demanding as a result." (Q6:L27) Another participant made the claim that "Health insurance companies [are] only paying for short term therapy" (Q1:L22) and that "Long term therapy now being seen as a luxury." (Q1:L22)

Writing about diversity in approaches to psychotherapy treatments, another participant suggested that "The current debate on statutory registration needs to be aired as registration may not support all current forms of therapy practice in Ireland." (Q1:L25) In relation to the issue of diversity and the potentially prescriptive treatment of clients another participant said, "Health Insurance companies will determine more and more what type of therapy is practised." (Q4:L22)

This theme shows how the quick-fix mentality and a reduction in diversity were concerns for many participants.

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4.2.7   IMPACT OF TECHNOLOGY

The metatheme "Impact of Technology" generated thirty-three comments. Of these, eleven comments were connected to the code theme that suggested that technology will have a significant impact. Two reported that they are not clear on what impact it will have, though one participant offered: "The internet is also likely to be a competitive force in the future in ways that remain to be seen." (Q4 L7).

Another participant observed:

> I think since the invention of the telephone and perhaps even prior to that, technology has been a part of therapy! However, the advent of the internet has brought new opportunities and challenges to the practice of therapy and will bring potentially significant changes to how therapists will work in the future, whether in independent practice or otherwise (Q8:L10).

In addition, the respondent offered a perspective on the impact of technology:

> Internet based therapy certainly challenges the notice of what constitutes therapeutic space as does the ubiquitous nature of social media. In addition, clients are expecting therapist to engage in ever increasing forms of out of office communication (texting appointments/emails etc). (Q8:L10);

One respondent believed that the nature of counselling may change:

> The advent of new technology in the sphere of counselling (skype [sic], telephone counselling and email) will reduce the cost but will change the usual mode of counselling (face to face in a private room)." (Q1:L9).

In contrast to this, another respondent believed that "The essence will always be face to face therapy with someone the patient trusts and admires." (Q8:L5) Another recognised a challenge, saying, "I feel somewhat of a dinosaur in this area." (Q8:L6)

A respondent in support for technology, perhaps taking a realistic perspective, suggested, "There is growing evidence of the benefits of online services, boards and email services along with complete electronic therapy services as being very beneficial and akin to how young people generally communicate all the time." (Q8:L16). While acknowledging the growth of technology, one participant cautioned care and the need for regulation, "I think that online therapy will increase in scale but I fear it will need to be regulated. Already chat room forums are becoming popular and their use in group support situations can be excellent." (Q8:L4).

Another placed this change in a broader context, saying, "But with the advent of new technology counselling will be available from anywhere in the world, with the high costs in Ireland maybe clients will look elsewhere for more competitive rates." (Q4:L9).

Another participant views the Irish context more favourably, "It will lower cost for both the therapist and the user. New technology will make the service available to more users. Therapists will be able to source clients in different countries and different parts of Ireland, not just locally." (Q8:L9).

Yet another participant expressed fear about the impact of technology on the relational and human aspects of therapy believing that it will:

> Reduce it to a computer like science based practice in some cases which will further erode the personal relational nature of the psychotherapeutic relationship, and promote the quick-fix mentality for some persons who would be totally unsuited and thus might dismiss psychotherapy as useless and even dangerous. (Q8:L8)

Overall, participants seemed to recognise the impact of technology as a given while expressing concerns about the impact of technology on PSP in Ireland. There was a concern about technological methods replacing counselling in face-to-face contexts.

4.2.8   LOW-COST THERAPY AND COMPETITION

For this metatheme, there were nineteen coded responses. One respondent said, "It appears as though there is quite a number of low-cost counselling available which is necessary for some people but this may impact established counsellors with years of experience having to reduce their cost." (Q4:L15).

Another participant spoke of the ethical challenge in providing the service while making a living:

> It's a dilemma! As an empathic human being, I would like counselling to be available to all who wish to pursue it. As a private practitioner, it is difficult if a lot of clients are looking for it as it is difficult to make ends meet if you try to meet the financial costs of being self-employed and yet not take on too many clients (which inevitably will reduce the competence of your work) just to scrape by a living. (Q7:L6).

One respondent said that, "Low cost should require a note from social welfare or some official marker to state that you don't have the means. I think the impact on private work will be steady erosion over time" (Q7:L2)

However, another did not support the idea that low-cost counselling had a detrimental impact on PSP:

> I don't believe it has any great affect [sic] because the users of low cost counselling do not have the financial reserves to fund private counselling. If more people have the experience of therapy, when they are in a position to pay for it they will. So low cost counselling can only help the industry." (Q7:L9).

A comment was made on the difficulty of access for those who cannot afford private counselling: "Since the waiting lists for psychotherapy in the HSE are very long, I think that people would like to go private. This could be a problem for people who are not able to pay for it." (Q2:L14). Supportive of this position another predicted, "The public sector services will have an influence but as there is little money heading in that direction it is likely to have the opposite effect."(Q4:L19). Another, speaking of competitive forces in naming possible competitors predicted the impact of, "Private health insurers and how they compete for business through policy provision and what MH options are available to individuals." (Q4:L21)

In respect to the subtheme of competition a participant observed, "I think we are competing with other professionals like psychologists, students, other therapy approaches like massage etc. also those offering low cost and free counselling" (Q4: L2) and another claimed, "For private practice, competition comes from many different sectors, not just the mental health sector but also alternative health practitioners, e.g. Reiki." (Q4 L7). Another participant stated:

> All other mental health professionals are potentially competitors; counsellors, psychologists, psychiatrists as most GP's or lay people know how to differentiate between these roles and titles. Having a clearly stated professional identity which is consensually agreed between psychotherapists is key and may be very difficult to achieve. (Q4:L16)

Another respondent referred to professionalization as a kind of competitive force:

> Professionalization, paradoxically, might also be considered as a competitive force – the costs associated with achieving and maintaining accreditation and an independent practice are high. (Q4:L10).

A respondent referred to the forces impacting from others and wrote of, "Power struggles between different professional groupings including medicine, psychology, psychotherapy and big pharma." (Q4:L17). Perhaps speaking to a societal context, another respondent maintained that the issue of cost was related to "Peoples values: where people do spend their money on. If happiness is equated with material things and house riches, then that is where they will spend their money." (Q4:L18).

This theme introduced the possible difficulties of low-cost counselling for those reliant on PSP for their main income. However, not all participants considered that low-cost counselling was detrimental to PSP. Respondents recognised many different possible sources of competition for those working in PSP.

4.2.9 EVIDENCE-BASED PRACTICE (EBP)

The EBP theme generated seventeen coded responses.

EBP was seen as an influencing factor on PSP by one participant who described it as, "The focus in the field on 'evidence based' practice and what is considered as evidence based within the health sector" (Q1:L10). This participant also recognised the changing nature of providing such services and said, "… higher accountability will be required from all practitioners, including those in independent practice" (Q1:L10). A different participant also recognised the impact of EBP saying, "The availability of good quality evidence-based psychotherapy services in the public sector will be a significant determining factor in private based services." (Q1:L19). Another participant highlighted the importance of carrying out appropriate research and considered: "Whether there is appropriate and adequate research carried out in psychotherapy as a mental health support and intervention." (Q1:L18)

Overall, there appeared to be some recognition of the importance and relevance of EBP, however, given the relatively low frequency of this theme in the data there would not seem to be widespread recognition of EBP as a contentious issue for PSP. Alternatively, it could be argued that this issue may not impact on PSP.

4.2.10 TRAINING STANDARDS

Coded responses of fifteen were noted for this theme. In discussing this theme one respondent believed:

The lack of recognised standards for Counselling & Psychotherapy qualification makes it very difficult for referrer's to have confidence in that the therapist they refer a patient to is qualified. (Q5:L7)

Agreeing with this position, another respondent summarised the possible impact of regulation on higher training standards:

Statutory regulation will improve training standards for counselling and psychotherapy. Although this may be in the form of more undergraduate degree programmes being offered, or as a minimum requirement for accreditation, this may reduce the number of psychotherapists in private practice due to costs and competing demands of studying at 3rd level. Counsellors and psychotherapists currently accredited may need to up-skill to meet new standards which may result in resistance, a reluctance to move forward (Q3:L24).

Speaking in a broader European context another participant predicted:

European licensure will be important and galvanising and integrating often diverse perspectives, practices, desires and visions between psychotherapists will likely be a huge challenge. It is thus vitally important that training standards are regulated, transparent and internationally recognised. Accreditation plays a significant role and responsibility in the development and maintenance of training standards. (Q3:L16).

One respondent considered the impact of higher training standards or educational requirements saying, "Such forces may also drive the seeking of higher qualifications (a positive from my perspective) in therapy or more specialist areas of expertise." (Q4:L10) Another suggested more care for students in training contexts:

I'd like to see more training courses respect and care for their students rather than put them through gruelling tests of endurance whilst training. The quality of our future practitioners is deeply impacted by the quality of their learning and training experiences. (Q9:L6).

Seeing educational standards as a key issue another respondent maintained the need for:

Increasing educational standards [e.g. current initiative of QQI (formerly HETAC)] to develop standards for counselling and psychotherapy courses consequently there is an increasing requirement for more academic rigour in psychotherapy training including research skills development. (Q1:L10).

While recognising the benefit of appropriate training standards another respondent did not believe they could work: "Training standards are always important because they lend

credibility to the counsellor. I can't see how a universal training standard is going to work." (Q3:L4).

Overlapping the theme of training and costs a respondent contended:

> Firstly, I think it is becoming such an expensive and lengthy endeavour to train as a therapist that it will be very off-putting for a lot of people. Consequently, those who will train will most likely want to recoup their expenses through high fees which in turn will make availability of private therapy more difficult for the ordinary Joe Soap! The private sector may lose the opportunity of some very good therapists because the initial commitment is far too big. (Q3:L6).

In speaking of the impact of training standards on PSP another participant offered:

> As the training standards, though submitted to Dept of Health in 2007? [sic] are still under debate and discussion, it is hard to say at this point, other than to note that attempts are being made to differentiate the in-depth psychotherapies which require intensive 4 yrs + specific training and especially adequate long-term personal psychotherapy, from the counselling approach which especially lacks the length and depth of personal therapeutic input. These attempts are not being welcomed by all and I imagine confusion may result for the public at large. (Q3:L8).

Another respondent supported raising of the standards:

> In terms of the impact on independent practice, I think increased standards will be more reassuring to the public. The public is becoming more informed about standards and qualifications as are referrers (e.g. GPs). (Q3:L10).

However, a dissenting voice did not agree with prevailing training standards:

> A very bad influence because training within the areas of counselling and psychotherapy is dominated by the criterium [sic] of accumulating hours and session and not by reaching a certain point in one's own personal therapy which has no other criterium than one's own subjective position reached in the therapy. (Q3:L20).

Another:

> [Raising standards] has a cost implication for students and, therefore, will have the impact of attracting fewer individuals, and only those who can afford it, rather than necessarily those who are a good 'fit' for the profession. (Q3:L27).

Overall there was broad support for formalising education standards. However, not all agree with the current direction; some voiced concerns about the impact on new trainees.

4.2.11 PROMOTION OF PSP

Within the fifteen coded responses for this theme there were comments related to GP (three responses) and public awareness of psychotherapy (three responses), in addition to the stigma associated with psychotherapy and mental health (three responses). One respondent was optimistic in regard to these subthemes:

> Consumer awareness – with the 'democratisation of expertise', the availability and accessibility of mental health information on the internet (albeit not always reliable). I think consumers have become much more aware of what is available, what standards of care to expect and are litigiously aware." (Q1:L10).

However, another observed that "… the profession is amazingly poorly self-promoted/ marketed." (Q8:L4). Picking up on this theme another respondent questioned "whether there is sufficient education and advertisement of what psychotherapy is and how it can help people." (Q1:L18) Related to this, it was noted:

> I think in this context, while not all therapists are working in the private sector, it is currently very challenging to have a successful and viable practice. I'm not sure how this will transpire in the future, but there may be an increasing need for therapists to develop business competencies, begin to market their practise more visibly and perhaps to consider their independent practice as much a business as a career and/or a vocation as seems to have been traditionally the case. Some therapists may see this as a conflict of values? (Q4:L10).

Overall, the need for making the public aware of PSP and the benefits of psychotherapy is evident.

4.2.12 NEED FOR FUNDING

For this theme, the lack of resources for mental health provision was the general theme, with a frequency of ten responses. One respondent stated, "Existing mental health policy slows down the development of psychotherapy in Ireland as not enough resources are allocated to mental health matters, including psychotherapy." (Q2:L26) Another expressed, "The experience of young children and adolescents having to wait their whole childhood for access to treatment is frightening." (Q6:L8) An assertive participant unequivocally stated, "Public psychiatric services are grossly under resourced." (Q2: L19). One participant believed that:

As it stands there is a lack of resources being put into the public service therefore this is driving the private sector as people in need of these services have little choice. Either they pay for the service or do without treatment." (Q1:L19)

As seen in the earlier theme "Economy and Cost of Therapy" PSP practitioners may be caught between those who need therapy but cannot afford the full cost and the lack of state resources for service provision.

4.2.13 OVERSUPPLY

There were six coded responses recorded for this theme. One respondent referred to, "The over-supply of training programs available throughout the country." (Q1:L25) Another claimed:

I think that there is currently an oversupply of therapists in Ireland (e.g. IACP have over 3,000 members though some of those are associate members etc. – while some therapist have multiple memberships of organisations, adding in members of IAHIP, ICP, PSI etc.). It is a significant number certainly compared to approx. 2,500 GPs in Ireland (Q4:L10).

Though oversupply had a lower frequency of responses than that of other themes, this data suggests that there may be an oversupply of therapists and training places in Ireland.

4.2.14 ROUND 1 SUMMARY

In Round 1 the purpose of gathering information from participants on their thoughts about the issues queried was achieved. Thought the participant sample was not as large as had been envisaged, the number of participants participating (n=26) was in line with the reported range of acceptable participant numbers (Akins et al. 2005). The amount of data (fifteen thousand words) was believed to provide an acceptable basis for the code analysis and progressing to Round 2, using the questionnaire that was developed as part of Round 1.

4.3 ROUND 2 RESULTS

By using a set of items presented in questionnaire form and distributed by email, the objective of Round 2 (Appendix 2) was to generate feedback on the items generated by Round 1 themes. Round 2 was also undertaken in order to establish what level of consensus or dissensus could be achieved for the item statements presented by reference to the selected consensus level (60%). Twenty-three respondents (n=23) participated in Round 2. The following findings were calculated from Round 2.

TABLE 7: DELPHI ROUND 2 ITEM 1

Item 1. Private sector psychotherapy needs to promote its value more effectively

	Number	Percent
Strongly Agree	10	43%
Agree	11	48%
Neutral / Don't Know	2	9%
Disagree	0	0%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Agree	
Standard Deviation	5.46	
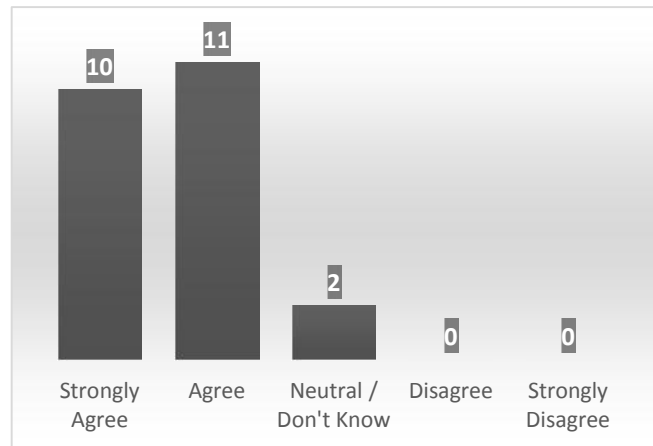
The combined consensus level for Strongly Agree and Agree was 91% which demonstrated clear consensus on the item. There were no Disagree or Strongly Disagree selections. This item showed the highest standard deviation of the instrument results. The outcome for this item was supportive of the themes identified in Round 1.

TABLE 8: DELPHI ROUND 2 ITEM 2

Item 2. Private sector psychotherapy is already, or is in danger of becoming, irrelevant to government policy

	Number	Percent
Strongly Agree	5	22%
Agree	12	52%
Neutral / Don't Know	5	22%
Disagree	1	4%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Agree	
Standard Deviation	4.72	
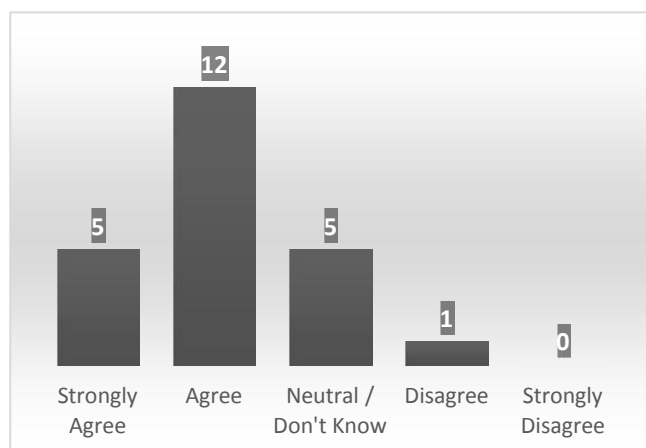
An agreement level of 74% was shown for Strongly Agree combined with Agree. Just one respondent selected Disagree for this statement. Five participants (22%) selected Neutral /

Don't Know for this item. This strong identification of irrelevancy was supportive of Round 1 themes identified in the Regulation and Recognition metatheme.

TABLE 9: DELPHI ROUND 2 ITEM 3

Item 3. The minimum academic requirement for working in private sector psychotherapy should be:

	Number	Percent
Diploma / Certificate	6	26%
Degree	8	35%
Masters	8	35%
Doctorate	0	0%
Other	1	4%
Mode	Degree / Masters	
Standard Deviation	4.04	
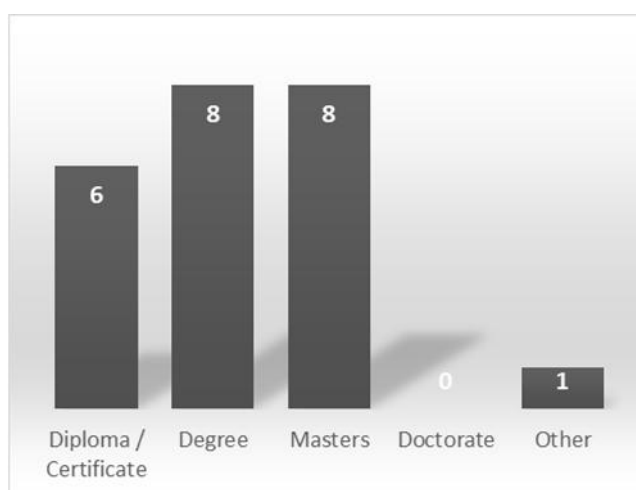
There was some variation in the preferences expressed for this item. Eight respondents selected Degree and Masters options while six respondents (26%) chose Diploma / Certificate. This item was included in Round 3. This item delineated some of the issues contained in the Training Standard theme identified in Round 1.

TABLE 10: DELPHI ROUND 2 ITEM 4

Item 4. Private sector psychotherapy has credibility among referral sources such as GPs and Psychiatrists

|	Number	Percent
Strongly Agree	1	4%
Agree	11	48%
Neutral / Don't Know	3	13%
Disagree	8	35%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Agree	
Standard Deviation	4.72	
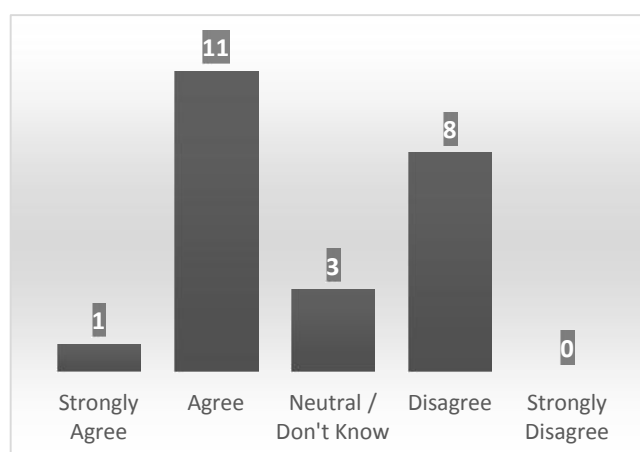
A consensus at the 60% level was not apparent from responses to this question in Round 1. However 53%, a simple majority, chose Agree and Strongly Agree combined, while 35% (eight participants) selected Disagree. This item was included in Round 3. Though not definitive, this result appeared to support the following item related to links with other health professionals. It also enumerated the position of participants in relation to the metatheme of Collaboration and Links discussed in the Round 1 results.

TABLE 11: DELPHI ROUND 2 ITEM 5

5. Private sector psychotherapy has adequate links with other mental health professionals

	Number	Percent
Strongly Agree	1	4%
Agree	2	9%
Neutral / Don't Know	2	9%
Disagree	12	52%
Strongly Disagree	6	26%
Mean	4.6	
Mode	Disagree	
Standard Deviation	4.56	
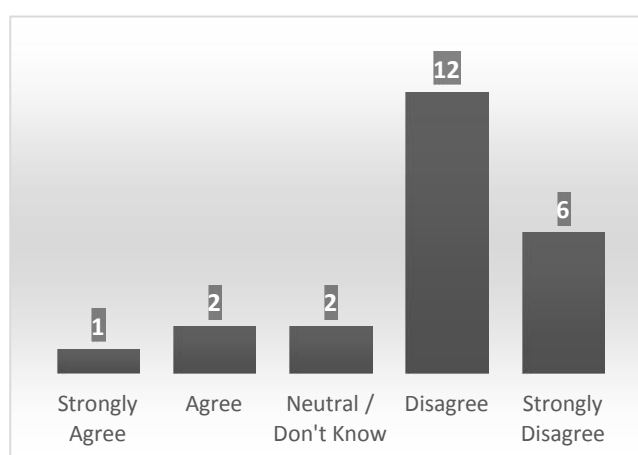
Consensus was found to be reached for this item among combined responses for Disagree and Strongly Disagree (78%). 13% (three respondents) chose Strongly Agree and Agree. This perspective appeared to support the previous item and somewhat relates to the following result, as it appeared to confirm the importance of links both external to the field of PSP and within it. It also confirmed some of the themes identified in the Round 1 metatheme of Collaboration and Links.

TABLE 12: DELPHI ROUND 2 ITEM 6

6. Collaboration between diverse approaches to psychotherapy improves the public standing of psychotherapy

|	Number	Percent
Strongly Agree	7	30%
Agree	8	35%
Neutral / Don't Know	6	26%
Disagree	2	9%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Agree	
Standard Deviation	3.44	
	-	
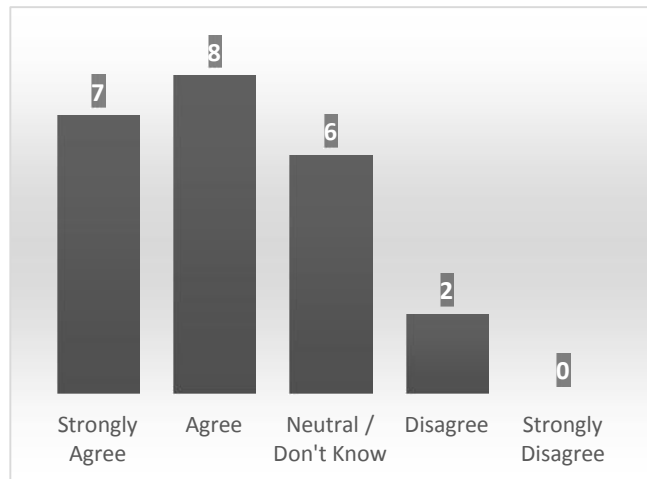
There was 65% consensus among respondents for Strongly Agree and Agree combined. A high proportion of selections were made in the Neutral / Don't Know category, which equated to 26% of the sample. The Standard Deviation is relatively low in comparison with other instrument items. Again, this item supported the theme identified in Round 1 metatheme Collaboration and Links.

TABLE 13: DELPHI ROUND 2 ITEM 7

7. There is too much medication being prescribed for mental health issues

|	Number	Percent
Strongly Agree	9	39%
Agree	10	43%
Neutral / Don't Know	3	13%
Disagree	1	4%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Agree	
Standard Deviation	4.62	
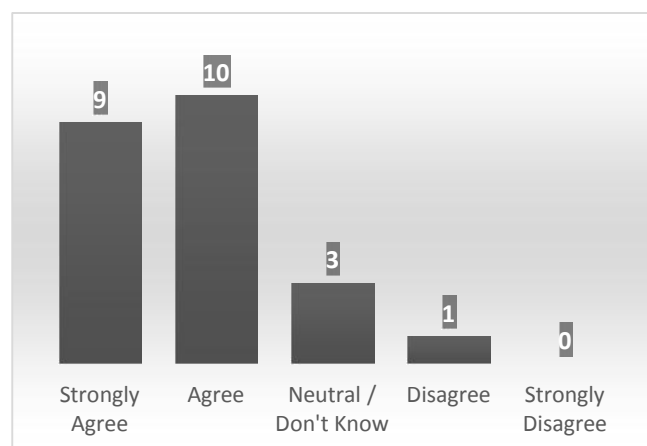
Combining the Strongly Agree and Agree levels, 82% consensus was achieved. Just one respondent disagreed with the item statement, and three participants (13% of the sample) who

selected Neutral / Don't Know. While the issues addressed in this and the following item 8, on utilisation of psychotherapy, were not directly related (those who do not receive a mental health prescription would not necessarily utilise psychotherapy as an alternative) they may overlap. In addition, themes related to items 7, 8 and 9 (related to a quick-fix mentality towards mental health distress) may overlap. This item also referred to the Round 1 metatheme of issues concerning the Medical Model.

TABLE 14: DELPHI ROUND 2 ITEM 8

8. There is adequate utilisation of psychotherapy in response to mental health issues

|	Number	Percent
Strongly Agree	0	0%
Agree	1	4%
Neutral / Don't Know	3	13%
Disagree	7	30%
Strongly Disagree	12	52%
Mean	4.6	
Mode	Strongly Disagree	
Standard Deviation	4.93	
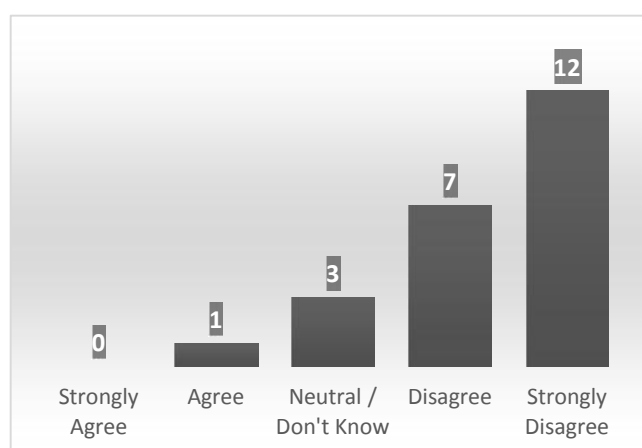
A total of 82% of respondents selected Disagree and Strongly Disagree, with 52% of respondents selecting Strongly Disagree. This result may be connected with the previous result in item 7 (too much medication) and the next item (quick-fix mentality). This item was derived from and supported the Round 1 metatheme Medical Model.

TABLE 15: DELPHI ROUND 2 ITEM 9

9. There is a prevailing quick-fix mentality in public sector responses to mental health distress

|	Number	Percent
Strongly Agree	10	43%
Agree	8	35%
Neutral / Don't Know	4	17%
Disagree	1	4%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Strongly Agree	
Standard Deviation	4.34	

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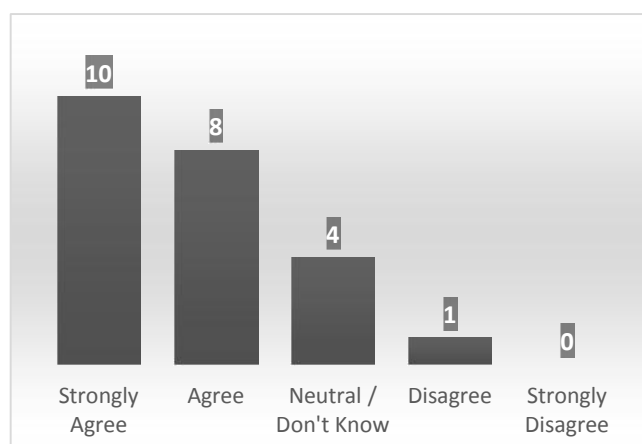
For this item, eighteen participants selected the combined category of Strongly Agree and Agree. This equated to 78% of responses. Just one respondent selected a category in the Disagree side of the scale. This result may be related to the use of medication and utilisation of psychotherapy (items 7 and 8 above) as it appeared to confirm a preference for the use of medication over psychotherapy, which may indicate a preference for treatments representing a quick-fix.

TABLE 16: DELPHI ROUND 2 ITEM 10

10. Thinking about technology, treatment via technology can sometimes be as effective as face to face therapy

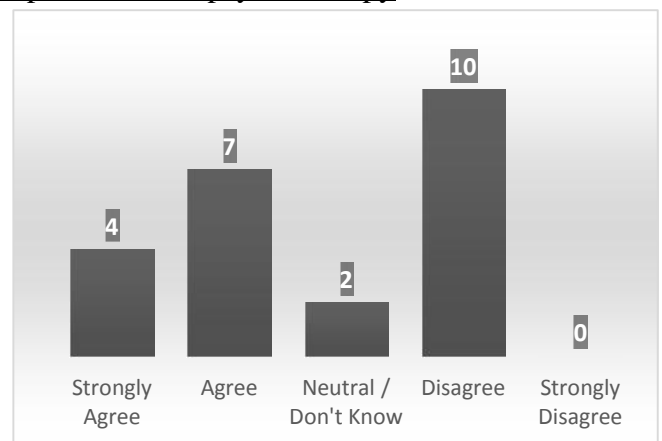|	Number	Percent
Strongly Agree	1	4%
Agree	7	30%
Neutral / Don't Know	4	17%
Disagree	8	35%
Strongly Disagree	3	13%
Mean	4.6	
Mode	Disagree	
Standard Deviation	2.88	
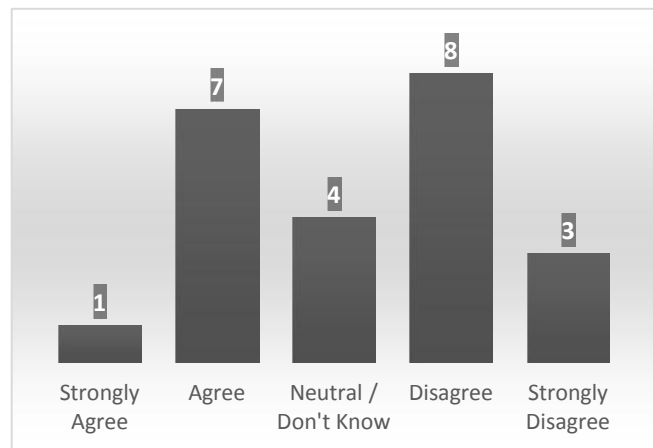
For this item, 34% of respondents (eight participants) selected categories from the Strongly Agree and Agree categories combined. Of respondents, 48% selected at the Disagree and Strongly Disagree level (eleven respondents) while 17% of respondents (four) chose Neutral / Don't Know. This item recorded the lowest Standard Deviation of all the instrument responses. Consensus was not reached at the 60% level. The item was included in the Round 3 questionnaire. The lack of consensus at Round 2 reflected the views contained in the Round 1 Impact of Technology metatheme.

TABLE 17: DELPHI ROUND 2 ITEM 11

11. The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy

|	Number	Percent
Strongly Agree	4	17%
Agree	7	30%
Neutral / Don't Know	2	9%
Disagree	10	43%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Disagree	
Standard Deviation	3.97	

For this item, 47% of respondents selected at the combined Strongly Agree and Agree level, while 52% were at the combined Disagree Strongly / Disagree level. Though a simple majority of respondents was achieved at disagree level, given that a consensus of 60% was not reached this item was included in the Round 3 questionnaire. This was the closest split of the study with eleven selecting Agree combinations and ten respondents selecting Disagree combinations. This lack of consensus reflected the conflict for practitioners demonstrated in the Round 1 responses under the Low-Cost Therapy and Competition metatheme.

TABLE 18: DELPHI ROUND 2 ITEM 12

12. Therapeutic outcome measures should be used in private sector psychotherapy

	Number	Percent
Strongly Agree	5	22%
Agree	10	43%
Neutral / Don't Know	4	17%
Disagree	2	9%
Strongly Disagree	2	9%
Mean	4.6	
Mode	Agree	
Standard Deviation	3.29	
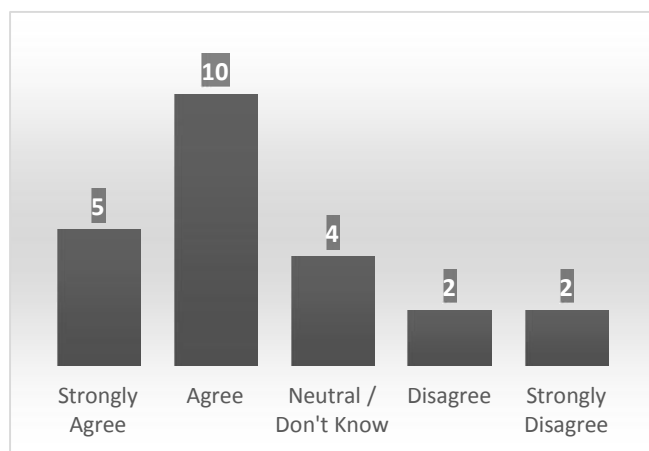
Consensus was achieved above 60% for this item: 65% of respondents selected combined Strongly Agree and Agree for this statement. Four respondents (17%) selected the Neutral / Don't Know category and 18% (rounded figure) selected at the Disagree / Strongly Agree categories combined. This item was in part derived to address the Evidence-Based Practice metatheme identified in Round 1. It was interesting to note that the level of consensus, which was not expected given the variety of comments made by Round 1 respondents.

4.3.1 ROUND 2 RESULTS SUMMARY

The table below shows a summary of the results generated in Round 2. The Round 2 results appeared to be supportive of the issues identified in the Round 1 metatheme results. For those items for which a consensus level of 60% was not attained, these were carried forward into Round 3. These items were: 3,4,10 and 11. They are shown in a separate column on the following table. The items for which consensus was reached in Round 2 were considered closed, and no further questions were issued to participants for Round 3 concerning these consensus items.

TABLE 19: ROUND 2 SUMMARISED RESULTS

A review of Round 2 results gave the following outcomes:

Summary Round 2 Combined Consensus and Mode Results (n=23)	**Round 2 Consensus Achieved (Closed)**		**Round 3 Responses Required**	
	> 60% *	**Mode**	**< 60% ***	**Mode**
1. Private sector psychotherapy needs to promote its value more effectively	91%	Agree		
2. Private sector psychotherapy is already, or is in danger of becoming, irrelevant to government policy	74%	Agree		
3. The minimum academic requirement for working in private sector psychotherapy should be:			-	Degree / Masters
4. Private sector psychotherapy has credibility among referral sources such as GPs and Psychiatrists			52%	Agree
5. Private sector psychotherapy has adequate links with other mental health professionals	78%	Disagree		
6. Collaboration between diverse approaches to psychotherapy improves the public standing of psychotherapy	65%	Agree		
7. There is too much medication being prescribed for mental health issue	82%	Agree		
8. There is adequate utilisation of psychotherapy in response to mental health issues	82%	Strongly Disagree		
9. There is a prevailing quick fix mentality in public sector responses to mental health distress	78%	Strongly Agree		
10. Thinking about technology, treatment via technology can sometimes be as effective as face to face therapy			48%	Disagree
11. The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy			47%**	Disagree**
12. Therapeutic outcome measures should be used in private sector psychotherapy	65%	Agree		

* The consensus % column shows the percentage of respondents who selected either Strongly Agree combined with Agree, or Strongly Disagree combined with Disagree. The mode is the actual mode based on the Likert scale choice selected in each item.

** 47% chose Strongly Agree plus Agree. This was the only item for which the mode was a category (Disagree) not contained in the combined category (Strongly Agree plus Agree equalling 47%).

4.4 ROUND 3 RESULTS

The objective of Round 3 was to establish if consensus could be reached on the items from Round 2 for which consensus had not been reached (items 3, 4, 10 and 11). In Round 3 an email was distributed to participants (Appendix 3) with an information sheet (Appendix 4) providing extracted participant feedback, which had been given in Round 1. For there were nineteen respondents (n=19) in Round 3. Out of these responses, one participant changed his/her selection for one item. The respondent changed his/her choice from Agree to Neutral / Don't Know on item 11 "The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy." This resulted in a split between the results for Agree and Strongly Agree combined and Disagree and Strongly Agree combined, results equal to 43% for each. Two respondents (9%) selected Neutral / Don't Know.

The following is a summary of the final results after Round 3, keeping all sample responses from Round 2 (n = 23) and making an adjustment for the one changed response to item 11:

TABLE 20: ROUND 3 ITEM 11 ADJUSTED

11. The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy

	Number	Percent
Strongly Agree	4	17%
Agree	6	26%
Neutral / Don't Know	3	13%
Disagree	10	43%
Strongly Disagree	0	0%
Mean	4.6	
Mode	Disagree	
Standard Deviation	3.71	

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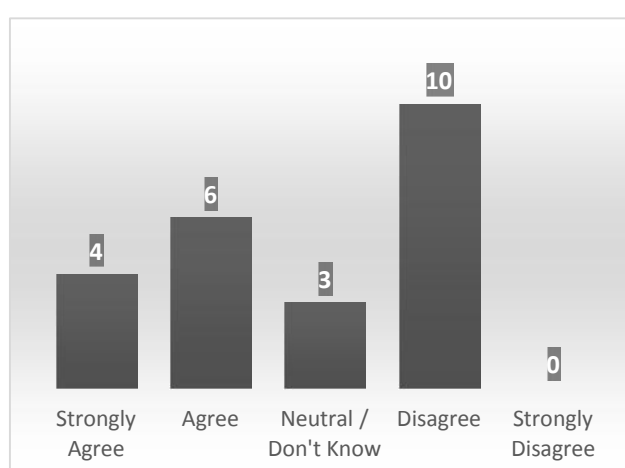
As a result of the amendment incorporated in Round 3, the final table of results is presented below. Responses from participants not completing Round 3 (n=4) were retained as reported in Round 2, giving a final sample size of twenty-three (n=23).

TABLE 21: FINAL OUTCOME AFTER ROUND 3. CONSENSUS AND DISSENSUS.

Round 3 Final Outcome (n=23)

Summary Round 3: Combined Consensus, Dissensus and Mode Results	% Level*	Mode	SD	Finding / Result at 60% Cutoff
1. Private sector psychotherapy needs to promote its value more effectively	91%	Agree	5.46	Consensus
2. Private sector psychotherapy is already, or is in danger of becoming, irrelevant to government policy	74%	Agree	4.72	Consensus
3. The minimum academic requirement for working in private sector psychotherapy should be:	35%	Degree / Masters	4.04	Dissensus
4. Private sector psychotherapy has credibility among referral sources such as GPs and Psychiatrists	52%	Agree	4.72	Dissensus
5. Private sector psychotherapy has adequate links with other mental health professionals	78%	Disagree	4.56	Consensus
6. Collaboration between diverse approaches to psychotherapy improves the public standing of psychotherapy	65%	Agree	3.44	Consensus
7. There is too much medication being prescribed for mental health issues	82%	Agree	4.62	Consensus
8. There is adequate utilisation of psychotherapy in response to mental health issues	82%	Strongly Disagree	4.93	Consensus
9. There is a prevailing quick fix mentality in public sector responses to mental health distress	78%	Strongly Agree	4.34	Consensus
10. Thinking about technology, treatment via technology can sometimes be as effective as face to face therapy	48%	Disagree	2.88	Dissensus
11. The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy**	43%	Disagree	3.71	Dissensus
12. Therapeutic outcome measures should be used in private sector psychotherapy	65%	Agree	3.29	Consensus

The "% Level" column shows the percentage of respondents who selected Strongly Agree combined with Agree or Strongly Disagree combined with Disagree. The mode is the actual mode of the Likert scale categories in each item.

** There was an equal split in this category between the combined modes (Agree plus Strongly Agree versus Disagree plus Strongly Disagree) resulting in a 43% outcome for each.*

4.5   INTERVIEW WITH A SENIOR OFFICIAL OF THE HEALTH SERVICE EXECUTIVE (HSE)

Below is a summary of comments made by the official that were considered most relevant to the focus of the e-Delphi. These comments will be discussed in Chapter 5 in conjunction with the e-Delphi outcomes as informed by the literature review. More extensive extracts of this interview are included in Appendix 6.

4.5.1   SUMMARY OF INTERVIEW ANALYSIS

The official's views appeared to reflect many of the themes that emerged in the e-Delphi study. He appeared somewhat neutral in relation to item 1 of the e-Delphi, which reached a high level of consensus (91%) among participants in relation to the statement that PSP needs to promote its value more effectively. Related to his apparent neutrality on the view expressed in item 1 of the e-Delphi, he appeared essentially to agree with the e-Delphi consensus that PSP is in danger of becoming irrelevant to government policy (a view that reported 74% consensus in item 2). His comments clearly revealed that the future provision of services may not depend on historical professional boundaries but will increasingly depend on cost-benefit evaluations made by the state and by service users. In his comments, he mirrored the e-Delphi theme related to academic requirements, in his critical views on the variation in qualifications of practitioners, (item 3 in the e-Delphi with a dissensus outcome).

He acknowledged the e-Delphi item 4 theme (which reached dissensus), in respect of PSP having credibility among referral sources such as GPs and psychiatrists, that there could be a credibility issue for PSP. His views appeared more certain of this being a difficulty than what emerged in the e-Delphi, in that he recognised the difficulty of finding appropriate referrals for GP patients in need of mental health interventions. His views on collaboration and links (items 5 and 6 of Round 2 of the Delphi) were less explicit, but his overall view of the possibly porous professional boundary of psychotherapy (supported by Van Broeck and Lietaer 2008), suggested that, if PSP practitioners wish to survive as a separate professional entity then links with other professionals may be important for improving credibility and standing.

He acknowledged the difficulties associated with providing medication incorporated in the e-Delphi study (in item 7 of the Delphi, a consensus of 82% reached for too much medication being provided for mental health issues). However, in respect of the consensus reached for items 8 (82% of e-Delphi participants disagreed that there was inadequate utilisation of psychotherapy in response to mental health issue) and 9 (in which 78% agreed that there was

a prevailing quick-fix mentality in public sector responses to mental health issues), he did not appear to have a difficulty with medication or quick-fixes, as long as they were effective treatments and cost-effective from the perspective of the state. He also acknowledged that increasing state provision has limits, a reality that he believed has not been acknowledged publicly. In relation to financial considerations, he discussed the possibility instituting a co-payment for services for mental health issues.

In respect of the technology theme identified in item 10 of the e-Delphi (dissensus reached in relation to the statement that treatment via technology can be sometimes as effective as face-to-face-therapy), the official was clear in stating that there are many technological developments taking place and that these may provide an effective alternative to historical modes of treatment. He believed online or computer-based treatments to be just as effective as more traditional methods.

In relation to item 12 of the e-Delphi, related to consensus among participants that the use of therapeutic outcome measures should be used in PSP, he pointed out that the use of outcome measures was being instituted, but these outcomes were being assessed via manual reporting, rather than computerised, initially.

While the interviewed officials' views appeared to coincide with many of the themes of the e-Delphi, his views also enhanced the findings of the e-Delphi by way contextualising these themes within the realities of state provision. As such his perspectives present a challenge to current PSP provision. It is clear from his comments that many changes were evolving: the perspective of state involvement in mental health treatment, the limits on provision and demands for higher standards by state provision: from 'technological disruption', and the potential proliferation of alternative, cheaper treatments competing with traditional face-to-face PSP treatments. While there may or may not always be a need for PSP, technological changes may result in increased access to and availability of many emerging alternatives for those seeking relief. It remains to be seen whether PSP can evolve and survive as a separately identifiable profession, and in truth whether or not it needs to survive, given the evolving possibilities. These issues will be discussed further in the following chapters.

4.6   CHAPTER SUMMARY

In this chapter, the results of the e-Delphi over three rounds have been presented. In Round 1 participants (n=26) were recruited to establish their views on issues related to the future of

PSP in Ireland. In Round 2 (n=23) the results of Round 1 were analysed and presented to participants by way of a questionnaire using Likert scale items. The Round 2 (n=23) responses were then reviewed to establish the level of consensus reached. Eight of the items presented in Round 2 reached consensus in Round 2. The items which had not reached consensus in Round 2 (items 3, 4, 10 and 11) were redistributed to participants for Round 3 (n=19) via email (Appendix 3) with an information sheet (Appendix 4). Consensus was reached for eight of the twelve items in the e-Delphi questionnaire.

This chapter includes a summary of the thematic analysis of an interview with a senior HSE official. The interview appeared to confirm many of the themes identified in the e-Delphi results. The official gave a viewpoint from a state and resource provision perspectives.

The results appear to provide a consensus among participants that PSP has a need to promote its value more effectively (item 1, 91% consensus). This result relates to the HSE official interview, it seems that the value that state provision assigns to a given profession or treatment may be increasingly based on cost effective solutions rather than the professions' historical standings or perceived value. This view is was confirmed in item 2, in which 74% agreed that PSP is already, or is in danger of becoming irrelevant to government policy.

In exploring academic requirements (item 3), results showed that participants were somewhat split concerning the required standard of educational attainment in Ireland. There was a split between Diploma/Certificate, Degree and Masters (6, 8 and 8 respondents respectively). This may be reflective of the HSE official's view that there was something of a "rattle bag" availability of differing training programmes and significant variability in practitioners' expertise.

The HSE official's perspective may speak to a credibility issue in relation to the future of PSP. In item 4 of the e-Delphi dissensus was reached in relation to the statement that PSP has credibility among referral sources. For this item, there was a simple majority of participants (52% who agreed), which might contradict the official's perspective. However, eight participants or 35% disagreed, while three chose Neutral/Don't Know. This reflects disagreement among e-Delphi participants.

The e-Delphi items 5 and 6 might be somewhat connected to a consideration of credibility. In item 5 there was a strong consensus (of 78%) that PSP had adequate links with other mental health professionals while for item 6, 65% agreed that collaboration between diverse

approaches to psychotherapy improved the public standing of psychotherapy. The participants appeared to have a good opinion of the standing of PSP as it relates to other professions. This may reflect the biases and preferences of panel participants, the majority of whom were practicing psychotherapists. However, panel participants were not as assured concerning how PSP forms part of public policy, as was seen in item 2.

In discussing the use of medication in item 7, 82 % agreed too much medication is being used for mental health issues. From the interview with the HSE official, it is clear that this position cannot be considered in isolation from other factors, which should be considered in the context of the training standards and quality of practitioners, the cost considerations of attending psychotherapy, and its availability. For item 9, 78% agree that there is a prevailing quick-fix mentality in public sector responses to mental health distress. This may be true, as inadequate resources are available for mental health treatments (Faedo and Normand 2013), and there is in addition apparently an increasing imperative for public sector responses to be cost effective (Totton 2000), as confirmed by the discussion with the official. However, the term "quick-fix" was not explicitly defined in this study, so interpreting the response to this item may necessitate care.

The e-Delphi (item 10) results showed dissensus on whether technology and face-to-face were equally effective. There was a lack of agreement between this result and the discussion with the official, who was clear on the efficacy of computerised interventions. From an official perspective, the therapeutic outcomes for face-to-face and computerised therapeutic interventions were similar. Cost and ease of access may inform policy in the future, rather than a preference among many practitioners for face-to-face intervention.

For item 11, concerning whether or not the viability PSP is adversely effected by the availability of low-cost therapy (apart from public provision), there was dissensus among e-Delphi participants. From the official's perspective, it would seem that this question is irrelevant, and that the focus of the state would be on cost-effectiveness and availability.

Finally, for item 12 there was consensus at 65% that outcome measures should be used in PSP, which suggests practitioners recognise the importance of considering the effectiveness of interventions in private sector settings.

The results of the e-Delphi study have been generated from an initial questionnaire developed from the literature review. In the context of the overall aims of this exploration, it is hoped

that by use of an eDelphi study, many of the key issues related to the future of PSP in Ireland have been identified. In respect of the objectives of the study, consensus and dissensus in relation to these issues have been measured for the participant panel. In the context of these objectives, it is hoped that these findings might inform psychotherapists and policy of emerging issues, relevant to the future of PSP. These findings and issues identified will be discussed further below.

CHAPTER 5   <u>DISCUSSION</u>

5.1   <u>INTRODUCTION</u>

This study was designed to explore issues related to the future of PSP in Ireland. First, a literature review related to these issues was completed. In the context of the study, the review identified milestones in the history of psychotherapy and key aspects of research into psychological phenomena have been examined. The history of mental health provision in Ireland was also outlined. Connected with this, some recent developments in mental health policy in Ireland and in the UK were explored. The literature review also discussed issues related to low-cost therapy, the evolving dynamics of the psychiatric domain, GP referral practices and issues related to medication. The review provided a political context for psychotherapy in addition to considering how this context may relate to regulation, professionalization and accreditation. Finally, as part of the literature review, future directions in psychotherapy and related technological developments were explored.

Arising from themes identified in the literature review, an e-Delphi study (n=26) of expert participants in the field of psychotherapy was carried out over three rounds. The previous chapter presented the results of the e-Delphi and a summary of extracts from an interview with an official of the HSE. The e-Delphi was designed to establish if a stable consensus or dissensus level for the instrument created (Appendix 2) could be reached. The twelve items were generated by reference to a thematic analysis (Boyatzis 1998) of a set of open questions asked of participants in the first round. Over the three rounds, consensus was achieved for eight of the items while dissensus was apparent in the remaining four (See Table 21 for the final e-Delphi results).

While the results of the study may not apply to the general population of psychotherapists in private practice, within the sample studied for the e-Delphi there appeared to be clear consensus in relation to many of the items presented. The findings generally related to critical views of our existing mental health structures relevant to PSP: these criticisms also appeared in the literature review and emerged in discussions with the HSE official. The e-Delphi themes in which consensus was reached were related to: the need for psychotherapy to promote its value (91% consensus), the risk for PSP being or becoming irrelevant to government policy in Ireland

(74% consensus), PSP having adequate links with other professionals (78%), the benefits of collaboration within psychotherapy (65%), the overuse of medication in response to mental distress (82% consensus), the under-utilisation of psychotherapy (82% consensus), a prevailing quick-fix mentality in public sector responses to mental distress (78% consensus) and the use of outcome measures in PSP (65%). Dissensus was reached in relation to academic requirements, the credibility of PSP among referral sources, the effectiveness of technology over face-to-face treatment and the impact of low-cost therapy on PSP. These e-Delphi outcomes will be discussed in the context of the literature review.

There are no simple answers to understanding the dynamics and contexts of issues identified in this study. Each element under consideration appears to interact with other, or many other, layers (Fish 1999) and changes over time.

This chapter attempts to contextualise the findings of this study. After providing a brief review for the historical context for PSP in Ireland, it contains an overview and discussion of the e-Delphi results, how these relate to the literature review and what the findings mean. The results of the Delphi study will be discussed in the context of a number of headings or themes derived from the literature review and e-Delphi: 'Regulation and Recognition: Valuing a profession', 'Collaboration and Links', 'Medical Model Versus Psychotherapy?', 'Diversity and Quick-fix', 'Technological Change', 'Low-cost Therapy', 'Evidence-based Practice', 'Training Standards', 'Promotion of PSP', and 'Need for Funding'. A summary of this chapter will then be included.

5.2 REVIEW OF HISTORICAL CONTEXT FOR PSP

Non-governmental provision of mental health services in Ireland has been an element of provision since the establishment of mental asylums, as they were previously known, through philanthropic activity in the 1700s (Walsh and Daly 2007). In the 1800s, the law recognised the provision of such services by non-state institutions (Mauger 2012). From an international perspective, the discovery of the talking cure and development of psychoanalytic treatments in the late 1800s (Lambert 2013) and the impact of the industrial revolution (Batt et al. 2002) provided an impetus in the developed world for the wider availability of psychological treatments for those whose level of mental distress did not merit, or for those who could not afford, access to mental asylum treatments. In the mid-1900s the scientific method was increasingly brought to bear on the issue of human suffering (Lambert 2013). The two World

Wars also provided momentum in developing treatments based on a more scientific approach (Cummings 2006). The prevalence of the psychoanalytic method began to be challenged and increasingly weakened as a result of these factors (Lambert 2013; Freiberg 1978). Arising from these challenges, in the 1950s behaviouralist and person-centred approaches began to take precedence as drivers of change and methods of treatment (Paris 2013). In addition, deinstitutionalisation began and the impact of these changes began to emerge in international policy and practice (Walsh and Daly 2007; Irish Medical Times 2007). At that time, psychopharmacological interventions began to play a more significant part in treatment, partly as a result of the demands of the Federal Drug Administration (FDA) in the USA (Dean 2012). These treatments also facilitated the momentum to close traditional mental institutions in Ireland (Irish Medical Times 2007).

Excessive institutionalisation and the impact of the increasing relevance of human rights perspectives (Mental Health Commission 2001) were particular drivers of change in Ireland in the 1960s. The influence of the Roman Catholic Church in Ireland may have impeded the development of secular services in Ireland at the time (O'Morain et al. 2012). Despite this, the changes taking place in other contexts began to impact on the Irish setting from the 1970s onwards. More services began to be provided outside pastoral Church and state institutional settings, often on a voluntary basis (O'Morain et al. 2012). In the Irish example, the legal framework for state provision of services was developed during the 1980s (Latif and Malik 2012). In this period, accrediting bodies such as the Irish Association for Counselling and Psychotherapy (IACP) and the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) were established to provide accreditation outside existing state regulation (Feldstein 2011). In the early 21st century, the Vision for Change policy document (Department of Health and Children 2006) and the establishment of CORU (Health and Social Care Professionals Act 2005) marked a possibly significant modernisation and regulation in the provision of services. A lengthy period of consultation among regulated and non-regulated providers took place through the Psychological Therapies Forum (2008). This resulted in an agreed, yet still contentious, path for training and recognition of practitioners. Though it has not yet been implemented, it appears that CORU will soon initiate the increased state regulation of psychological therapy services in Ireland (Quality and Qualifications Ireland 2015), which will expand to regulate practitioners currently outside state regulation. This provision will take place within a generally agreed, but not completely resolved, training framework.

5.3 REGULATION AND RECOGNITION: VALUING A PROFESSION?

The Delphi results show a clear consensus in relation to the item 1 statement that "private sector psychotherapy needs to promote its value more effectively" (91% final consensus) especially in light of the growing evidence base for psychotherapy demonstrated in the literature review (Lambert 2013; Nathan and Gorman 2007; Lambert and Forman 2002; Wampold 2001). This theme carried through from the Round 1 responses to the final consensus outcome. One e-Delphi participant commented in Round 1, "As a consequence of this position of 'outsider' in terms of mental health policy the future of private practice is questionable." Taken in conjunction with the areas of the literature review concerning PSP and the impact of political decisions on resources allocated to the field of mental health (Totton 1999) it is evident that PSP in Ireland must evolve if it wishes to acquire significant official standing. It may be that those who work in private practice are not too concerned by the issues raised. However, it seems that PSP is side-lined in the debate about the future of psychotherapy in Ireland. This viewpoint is supported by the second item in the study, which shows that 74% of the panellists agree that "private sector psychotherapy is already, or is in danger of becoming, irrelevant to government policy".

This finding may be of concern as it appears to show how far PSP in Ireland may be from attaining a significant standing in comparison with other stakeholders in the mental health care field. This viewpoint was reflected in the views of the HSE official interviewed, whose main focus appeared to be on questions of cost-effectiveness and efficacy rather than favouring existing professional boundaries. However, in recognising that there may always be a need for PSP, the official acknowledged that the state may not always be able to provide the level of coverage for mental health care that demand might require. The increase in provision, emerging through the National Counselling Service and Counselling in Primary Care initiatives, is directed towards medical card holders. If the state considers it appropriate and cost-effective these services may progressively be expanded to cover low-income earners who do not have medical cards and may eventually be made available to all who need these services, irrespective of income. However, while it may be hoped that such decisions would be based on evidence, it would seem that in an Irish context political and historical considerations, and the lack of funding for mental health, will continue to influence policy development. This may result in a policy development context that is not optimal.

Related to the issue of being valued, is how much practitioners may perceive the future value of PSP. A 2013 IACP survey of its members reported that 29% of the responding sample worked full-time in the field. This suggests that less than three in ten accredited practitioners are full-time. This may be a historical legacy of the voluntary ethos of psychotherapy provision in Ireland, in non-public sector contexts (O'Morain et al. 2012) and may not be of concern. However, for PSP be seen as a profession of comparable standing to other professions (it may not wish to be) it might be expected to have a significant core cohort of full-time professionals, as favoured by Beck (1994), ideally carrying out collaborative research with their clinical colleagues. McGivern et al. (2009) suggested that independent practitioners (those outside the public sector) had less awareness of issues related to regulation than those who worked within the public sector. It may be that many practitioners will not be made aware of the impact of regulation until it may be introduced. The risk is that regulation will be driven by others with opposing interests. As one participant claimed, "Regulation and the way it is taking shape at the moment, through the effect of vested interests, will have a seriously negative influence on the future of psychotherapy in Ireland, as it has done in other countries."

From this study, it appears that Ireland's mental health structures and policies have no explicit recognition for PSP as an important, stand-alone offering or profession. Ultimately, the therapeutic interventions applied may be those considered both effective for individuals and cost-effective for public provision. PSP may not necessarily play a part in these treatments. As the HSE official maintained, "People will vote with their feet." Clients will use whatever is useful for them, and accessible in terms of cost and preference.

5.4   COLLABORATION AND LINKS

For the e-Delphi item 4, asking participants about the credibility of PSP among referral sources such as GPs and psychiatrists, a simple majority (52%) believed that PSP had credibility in relation to its perception among referral sources. However, a significant number (35% or eight e-Delphi respondents) did not agree that PSP had credibility. The simple majority in this item was not reflected in the literature discussion, which demonstrated a low level of referrals from GPs (Copty 2003, for example). Though the GP findings may not speak to an issue of credibility, this may indicate a reluctance to refer to PSP practitioners, given cost issues, stigma associated with mental health distress, and patient preferences. The item 4 dissensus appears to be reflected in diverse comments arising from Round 1 responses. One participant spoke about the need for links saying:

> An issue will be whether private sector psychotherapists are included by other players in the mental provision e.g. doctors, psychiatrists, community psychiatric nurses, social workers. Will psychotherapists in community be included in shared support and care plans?

Perhaps in contradiction to this, 78% agreed that PSP has adequate links with other mental health professionals in the following item 5. This apparent contradiction requires further consideration and research. Connected to issues of credibility and professional links in item 6, 65% agreed that collaboration between diverse approaches to psychotherapy improves the public standing of psychotherapy. Though psychologists are recognised in statute and by Irish health care insurers, many PSP practitioners do not have psychological accreditation, having qualified by different routes. An e-Delphi participant discussed this issue, appealing for:

> More recognition by health insurance and medical card services that this is a valid health option and consequently its cost should be covered rather than borne by the individual.

Most participants believed that collaboration and links are important and that PSP has good standing among other professionals while a sizeable minority believed that PSP does not have sufficient credibility. The levels of GP referrals do not reflect a view that PSP referrals are easily accessible or desirable in Ireland. Complexity is apparent in the rationale behind GP decisions to refer (Ward 2011) but given the apparent contradictions between the e-Delphi finding on Credibility (dissensus for item 4) and the Collaboration/Adequate Links findings (consensus for items 5 and 6) it may be that the 'rattle bag' term used by the HSE official indicates an issue in Ireland; referrers may not be confident in referring clients to PSP (Cocksedge and May 2006).

5.5   MEDICAL MODEL VERSUS PSYCHOTHERAPY?

The Round 1 responses for this theme criticised the extent of the use of medication in mental health responses. This theme might be seen to overlap with the Collaboration and Links theme in terms of referral issues. In Round 3 for the item 7 statement that, "there is too much medication being prescribed for mental health issues" there was 82% agreement or consensus among participants. This was reflected in the finding for item 8 that 82% disagreed with the statement that "there is adequate utilisation of psychotherapy in response to mental health issues" (with a mode of Strongly Disagree). Related to these items was item 9, "there is a prevailing quick-fix mentality in public sector responses to mental health distress" that reached 78% consensus.

The Vision for Change document (Department of Health and Children 2006) would appear to have many faults, not least of which is a lack of domestic data in grounding its policies (Faedo and Normand 2013). In both in the literature review (for example Carlat 2010) and in the e-Delphi study, problems with overmedication and a lack of focus on treating, rather than reacting to, the specifics of individual mental health presentations (Davies 2013) were identified. The literature review suggests that in Ireland (Fallon 2015) and in other countries we do not have a good history in relation to psychiatry (Dean 2012). The literature also points to the parallel decrease in the use of psychotherapy and increase in the use of medication by psychiatrists (Mojtabai and Olson 2008). The senior official of the HSE contended that decisions around medication and "warehousing" are political and societal decisions. It would appear that many with mental illness are imprisoned (Steinberg, Mills and Romano 2013). The official was aware of the foreshortened lives of many with mental health diagnoses (Nordentoft et al. 2013), saying of the mental health system that it "does a lot of really good work but that it's not all good work."

These findings were reflected in many of the Round 1 e-Delphi comments. While there was some optimism that psychotherapy was gaining in referral considerations, one participant presented a bleak assessment:

> You will [be] stabilized and then discharged to meet up with a psychiatrist who will most likely put you on more meds, if you are public, private is slightly different. Psychotherapy doesn't feature in this scenario for me in my experience. They will also be referred to free counselling or state run service where a waiting list is miles long

This review has shown low referral rates and high variability in treatment responses by GPs (Ward 2011; McCullagh 2010; Sundlov 2008) to dealing with mental distress. We have also seen how issues of concern with the medical model persist (Davies 2013). From the calculations included in the literature review, it appears that a significant number of psychotherapists would be available if resources were properly utilised (Table 1 above). However, more cost-effective alternatives may emerge, in addition to other treatment options currently available, including medication. There may also be a preference among users and GPs for clients to remain in directly managed primary care contexts (Cocksedge and May 2006).

To echo Reeves and Mollon (2009) from the literature review, in an Irish context the progress of mental health policy appears to have little to do with evidence-based approaches to mental

health responses but rather appear to be grounded in historical circumstances which are rarely systematically reviewed. Ireland is in danger of further enshrining the power of the medical model and psychopharmacological approaches to mental distress, rather than focussing on the primacy of individual needs, and on science that supports the efficacy of psychotherapy interventions, and that supports the efficacy of psychotherapy when compared to medication (Davies 2013). The literature review shows that Ireland began the process of Vision for Change in 2006 (Department of Health and Children) with little domestic data; from more recent reviews it appears that this trend is continuing (Mental Health Reform 2015b; Faedo and Normand 2013; Mental Health Commission 2011). In an ostensibly scientific discourse, one would hope that policy could be grounded in a statistical base in a specifically Irish context. However, in the words of the HSE official interviewed "The great advocates for the mental health service have often been advocates for the employment provided by the mental health service, rather than the service provided by the mental health service".

In considering the findings of the literature review and Delphi study in respect to the overuse of medication, the efficacy of medications appears in many instances to be, at best, no better than psychotherapy (Davies 2013). As a contrast to the use of medication to impose social control on those with chronic conditions (Szasz 2010) the Finnish Open Dialogue movement offers alternatives to traditional medication methods, but is reliant on state and community support for long-term care (Mind Freedom n.d.). User groups are clearly demanding change in prescribing practices in favour of psychological interventions (MacGabhann 2014; Evans 2013; Clark 2011).

Given shortages in the supply of trained GPs (IMO 2014), and the costs of employing and maintaining GPs, it may be possible to alleviate this problem by having suitably trained psychotherapists or psychologists, who could act as initial points of contact for mentally distressed patients in Primary Care (McGivern 2012). There is no rationale given in the Vision for Change (Department of Health and Children 2006) report for GP leadership in responding to mental health presentations, though it is assumed in the document, and sustains earlier commitments made that Primary Care is the most important point of entry for clients into mental health services (Department of Health and Children 2001).

Those concerned at the risks of psychotherapists (rather than GPs) acting as entry points to mental health services could recall that there are differing perspectives in other jurisdictions, for example in relation to prescribing rights (McGivern 2012). McGivern argued that support

for maintaining existing prescription rights can be countered, with a reference to potential savings, with proper training, and the potentially reduced use of medication by other professions (though he points out this may bring other problems). Given the proven efficacy of therapy and the cheaper cost of therapy, compared to long-term medication (Layard 2006), a well-trained psychotherapist may be potentially at least as effective as a GP for a given mental health presentation and may provide enhanced continuity of care. This does not equate to PSP being a viable option, as it may be cheaper for the state to directly employ staff rather than to pay hourly rates to PSP practitioners. It may be of interest to compare the typical costs of state provision with PSP provision in Ireland. In the UK example, Callan and Fry (2012) reported the IAPT services were less cost effective than the services they replaced.

This study has confirmed the continued primacy of the medical model in the Irish context, enshrined in existing policy documents, which in a practical context manifests in the excessive use of medication and the underuse of psychotherapy. The continued primacy of the medical model may not be problematic, except for those employed in PSP.

5.6   DIVERSITY AND QUICK-FIX

Item 9 in the Round 2 questionnaire, "There is a prevailing quick-fix mentality in public sector responses to mental health distress" was generated arising from the theme of Diversity and Quick-Fix. This item shows a very high level of consensus at 78%. This outcome overlaps with other outcomes of the study, including those related to the overuse of medication and the lack of utilisation of psychotherapy. It seems that the e-Delphi presents a clear critique of current policy efforts to respond to mental health issues and that, from the perspective of the literature, these efforts are in danger of ignoring the need for an individually focused recovery model, rather than a fixed dosage administration of therapy sessions. The importance of considering individual needs is reflected in the literature, with Stulz et al. (2013) and Kopta et al. (1994) confirming the variation in outcomes related to the number of psychotherapy sessions attended. For some clients, a shorter engagement may be suitable, while for others a significantly longer commitment may be necessary.

While the idea of a quick-fix may have been negatively perceived by participants in the e-Delphi, in reality, a quick-fix may be a preferred option for many clients. Medication may be perceived to be one of these 'quick-fixes' and, despite the misgivings explored in this study, in practical terms, it may be what clients desire. This study does not explicitly answer what

exactly a quick-fix is; more clarity around this term would have been beneficial for the study. One e-Delphi participant did express a clear opinion on the subject:

> Creation of a culture where the widespread quick-fix mentality is applied to those with severe emotional trauma and/or disturbance, resulting in totally unrealistic expectations that an individual who was raised during their developmental years in an emotionally deprived, disturbed or abusive environment should recover adequate mental/emotional functioning in...6, 16 or 20 sessions?

Discussing the future of PSP, though he believed there would always be a place for PSP, the HSE official interviewed for this study envisaged three major providers providing services at three cost levels from cheap to expensive. He believed that face-to-face psychotherapy could become an experience for the elite. He compared the amount of time it takes a GP to meet, greet and treat a patient, with a possible future wherein therapy clients fill out a detailed assessment in advance, and use technological interventions before meeting the therapist. In contrast, he believed there will always be a market for PSP and that people will always need help. He also believed that there is an abundance of providers in Ireland.

It would seem that PSP practitioners need to ensure that the problems of the apparent overuse of medication, and what is problematic with a "quick-fix", must also be articulated more clearly and widely in public contexts. In considering this in conjunction with other findings, it would seem that being able to articulate this position effectively would require greater public standing and recognition for PSP.

5.7   TECHNOLOGICAL CHANGE

In reviewing item 10 ("Treatment via technology can sometimes be as effective as face-to-face therapy") a dissensus was reached. 43% agreed with the item and 43% disagreed (13% selected Neutral / Don't Know). While the item may not have been worded clearly enough for some participants, the item seems to reflect a split in the commitment to, or understanding of, treatment technology by participants.

In their Delphi study, Norcross, Pfund and Prochaska (2013) confirmed many of the issues identified in this study, including the increase in non-traditional interactions with service users, are driven by cost issues. The importance of the technology issue was acknowledged by a senior administrator of the IACP in Feldstein 2011.

The comparison rates of dropout rates between traditional face-to-face delivery and computerised delivery are of relevance in considering the use of technology. While some studies were concerned about dropout rates (Twomey et al. 2013; Waller and Gilbody 2009; Barak et al. 2008), a 1993 study on dropout rates for face-to-face therapies carried out by Wierzbicki and Pekari suggests the dropout rates for face-to-face, and interventions and computerised options, are broadly similar. Gaggioli (2012) was confident that the outcomes for computerised interventions are at least as good as face-to-face therapy.

In the literature review, and as discussed above, it has been seen that dropout rates between face-to-face and computerised interventions are similar. It may also be that current users of these services are naturally resistant to accessing novel treatment delivery routes, but this resistance (Donovan, Spence and March 2013) may decrease over time, as has occurred for many other technological developments.

In the participants' responses there appears to be a belief that a therapeutic alliance combined with a face-to-face experience is essential for effective therapy. One participant predicted in response to the technology item that; "The essence will always be face-to-face therapy with someone the patient trusts and admires." Another acknowledged a difficulty, saying, "I feel somewhat of a dinosaur in this area", which suggested a lack of technological understanding among some participants. The differing views on technology expressed in the Round 1 item 10 dissensus, affirm the literature in that participants appear somewhat divided in their views of technology.

The appropriateness of the assumption of relationality as strongly associated with good outcomes in psychotherapy was questioned in the literature review (Goldfried 2013; Kazdin 2007). In the clinic, however, there is something intuitively inherent to the therapeutic movement that can happen when the relationship is good and appears reparative for the client. Irrespective of whether relationality is key to the success of a particular type of therapy, it may take a client a longer time to reach a psychotherapist in the future, after having been exposed to the spectrum of diverse and lower-cost interventions that are available now and that will be developed.

This study appears to confirm that there is a paradigm shift occurring in the delivery of psychotherapeutic interventions via the use of technology. It is not a given that these new interventions will be delivered via traditional (face-to-face) psychotherapy models of delivery or via PSP. Considering the future impact of technology, the senior HSE official interviewed

discussed possible developments in this area and confirmed the efficacy of computerised CBT compared to face-to-face therapy. He stated that it would be unwise to ignore these developments. From the literature review and e-Delphi responses, it seems that technology is having a greater impact on psychotherapy and PSP. Though there appears to be resistance and uncertainty among study participants, there is clearly some awareness of the potential significance of these developments.

5.8   LOW-COST THERAPY

While there was a recognition of economic challenges and the high cost of PSP in Round 1, comments on this theme reflected a diversity in opinions on whether or not low-cost counselling had a beneficial or detrimental impact on PSP. The final outcome of Round 3 confirms the dissensus among participants in relation to this aspect. Of Round 3 participants 43% agreed, and 43% disagreed, with the statement that "The availability of low-cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy." 13% selected Neutral / Don't Know. This finding may reflect a divergence in therapist views on PSP between those who consider it more of a vocation than a business (Grodski 2000). As Grodski has argued, there is often a difficulty if not a shame for practitioners in reconciling the vocation of psychotherapy with the increasing business demands of PSP. The two considerations may not be mutually exclusive. One Round 1 participants acknowledged the ethical dilemma in respect of providing low-cost services saying:

> I would like counselling to be available to all who wish to pursue it. As a private practitioner, it is difficult if a lot of clients are looking for it as it is difficult to make ends meet if you try to meet the financial costs of being self-employed and yet not take on too many clients (which inevitably will reduce the competence of your work) just to scrape by a living.

The issue of low-cost therapy also speaks to issues of access and equality that were identified in the literature review (Richards and Bower 2011; Glover, Webb and Evison 2010). Chiesa (2008) also discussed the issue of advocacy for those who are not assertive in accessing services. In describing policy options, Bower and Gilbody (2005) differentiated between meeting a need (access) and ensuring fair allocation of a resource according to need (equity). Making resources available is different from ensuring that those who need assistance are empowered to access the services in practice. There appears to be little mention in Irish government mental health policy documents of issues related to equity though these issues are

mentioned in some reports and comments by others in an Irish context (Faedo and Normand 2013; McCarthy 2009 for example). It appears from this study that Irish policy primarily focuses on access, for those with medical cards - while effectively ignoring those who access low-cost services in PSP or voluntary services - rather than equity. From the perspective of PSP, there appears to be a recognition of an ethical need to provide a service for all clients while also considering that this presents a difficulty in making a living.

5.9   EVIDENCE-BASED PRACTICE

For item 12, there was 65% consensus in relation to the statement "Therapeutic outcome measures should be used in private sector psychotherapy". This shows a clear majority in favour of the use of such measures. This is reflective of the findings within the Evidence-Based Practice metatheme of Round 1, which showed study participants generally in favour of EBP. A Round 1 participant expected that in relation to EBP, "… higher accountability will be required from all practitioners, including those in independent practice" which is reflective of the comments made under this theme.

However, in considering the support for measuring outcomes in private sector therapy this risks practice becoming a process of objectifying of clients rather than focusing on their subjective experiences with mental distress (Bowman 2002). This objectifying may be a failing of an over-regulated, prescriptive approach to therapy. At the same time, there is an increasing need for evidence of effectiveness in therapy which can justify the expenditure of public funds. Given concerns about objectification in the literature, an unexpected finding of the e-Delphi study was the consensus in support of outcome measures. From the literature (Lees and Cleminson 2013; Davies 2013; Bowman 2002 as examples), it had been assumed that most therapists in the private sector would be opposed to the use of such measures.

There is no national data about the level of psychological therapy presentations for Ireland (Mental Health Commission 2011). In its 2001 report (Mental Health: New Understanding, New Hope) The World Health Organisation recorded that one in four individuals will experience a mental or neurological disorder at some point in his/her lifetime. While the WHO estimate would not equate to a quarter of the population being in need of independent or other psychotherapeutic interventions each year it should be the ultimate goal of national statistics to understand and quantify as best as possible the treatment gap between known attendances and defined need (Tedstone-Doherty and Moran 2009). If significant, this difference may be accounted for by many reasons including: personal difficulties being solved in the individual's

social context, lack of access, issues of equity, unaffordable service cost, low income, lack of service awareness and other avenues taken to alternative treatments.

The use of outcome measurement instruments in therapy contribute to transparency and the service user experience, as part of a quality control feedback (Evans 2013). The HSE is procuring a system for outcome measurement in its mental health provision services including CIPC and the NCS. This approach will have an impact, not only on psychotherapy, but on the provision of health services in Ireland in general, as it will hopefully provide a more thorough statistical grounding for policy and resource allocation decisions. It remains to be seen how consistently transparent HSE will be in publishing the datasets accumulated; to date the HSE has failed to create a national database. It also remains to be seen how the increasing application of EBP, combined with the use of outcome measures, will inform treatment and drive the kind of interventions used.

From the above, it appears that the future of PSP will be partly dependent on how PSP organisations can achieve recognition among policymakers and referral resource, and how well they compete with other similar health care providers. Bowman (2002) speaks about how the rise of science has challenged authority that had previously retained its power through tradition. The Vision for Change, while presuming to speak on behalf of a contemporary scientific discourse, appears to speak from the position of tradition in delivering service responses focused on medication, a focus that has been critiqued by Davies (2013) among others. The implementation of new policies and resource allocations in the aftermath of the Vision for Change are patchy at best (Mental Health Reform 2015); the process appears to be in crisis and lacks adequate data to facilitate decision making and review (Faedo and Normand 2013). The lack of national data also impacts the development of PSP; there is no apparent use of a national data context for service provision or identification of possible shortfalls in resources. The implementation of mental health policy in Ireland appears to be substantially dependent on the historic dynamics of mental health hierarchies, both official and unofficial, rather than being implemented based on agreed policies driven from a centrally controlled management structure with appropriate evidence-based data considerations to drive change and reform.

5.10 TRAINING STANDARDS

In relation to the minimum academic requirements, a spread of responses was recorded (26%, 35% and 35% for Diploma/Certificate, Degree and Masters respectively) which suggests

diversity in relation to this issue. A recent Irish Association for Counselling and Psychotherapy (IACP 2013a) policy paper in this area reflects a division within the field in relation to academic aspects in that it apparently backtracks on an agreement reached as part of the Psychological Therapies Forum (2008) which had agreed differences between counselling and psychotherapy via the terminology used to describe a Psychological Therapist: Counsellor and a Psychological Therapist: Psychotherapist (requiring bachelor's degree and master's level education respectively). In its 2013 paper on academic standards, the IACP has argued that there is no difference between a counsellor and psychotherapist and that the required education standard for a practicing therapist (counsellor or psychotherapist) should be at bachelor degree level. The IACP position is at odds with what was agreed upon at the Psychological Therapies Forum (2008), the evolving European standards referred to in the literature review (Van Broeck and Lietaer 2008), the historical view of the Irish authorities (Feldstein 2011) and what appears to be the contemporary view of the state as expressed by the HSE official. In this area the comments of the HSE official, who expressed his concern about the variety of training and available approaches can be considered.

Though this is not an issue unique to the Irish context, consistency in training standards appears to be an important issue related to credibility and standing. This view was supported by a number of comments made by participants in the e-Delphi study. In their review of international training standards Van Broeck and Lietaer (2008) recommended master's level training for practitioners. The e-Delphi participants also expressed concerns related to the costs of training for students and the personal challenges experienced by trainees.

Given that the e-Delphi study has found a clear consensus in favour of collaboration between different approaches and is supportive of the perceived credibility of the PSP, it would seem that agreement should again be pursued in this area, as was reached previously via the Psychological Therapies Forum (2008) process, in order to enhance and develop collaboration and credibility.

5.11   PROMOTION OF PSP

It is clear from the literature review, the Round 1 responses and the final consensus levels, that PSP needs to promote its benefits more effectively to the public. Item 1 of the Round 1 questionnaire ("Private sector psychotherapy needs to promote its value more effectively") arrived at a consensus of 91% among participants. This issue overlaps with the statement in item 2 ("Private sector psychotherapy is already, or is in danger of becoming, irrelevant to

government policy") which at a 74% consensus level was supportive of this finding. In considering the dissensus reached in the item 4 statement about credibility among referral sources, PSP may have difficulties in this area and may need to be more assertive in establishing credibility. This issue may overlap with training standards, as referred to in the previous section.

The promotion issue also speaks to the consensus around the excessive use of medication in item 7 and the under-utilisation of psychotherapy in item 8; it may be necessary for PSP to ensure its views on these issues are articulated more clearly in public contexts. In addition, item 9, related to consensus around the prevalence of a quick-fix mentality in public sector responses to mental health issues, would also be of relevance in promoting alternatives to medication and state provision offered by PSP.

Round 1 e-Delphi responses seem to support the need for PSP to make potential clients and referral sources more aware of the benefits of psychotherapy. The literature review (McCullagh 2010; Totton 1990) revealed a stigma associated with using mental health support. McCullagh spoke of normalising access to psychotherapy among users and Todman, Law and MacDougall (2011) discussed a lack of awareness of psychotherapy availability among GPs. In addition to recognising a lack of awareness of the possible benefits of therapy among members of the public and referral sources, Sundlov (2008) recommended more communication between psychologists and GPs. Ward (2011) pointed to the need for the promotion of psychotherapy services in the literature reviewed. The objective of improving awareness of psychotherapy has been adopted by the IACP 2014-2017 Strategic Plan (n.d.) and it is to be hoped that this objective is met.

5.12   NEED FOR FUNDING

It is evident from the Round 1 results and the findings of the literature review that mental health services in Ireland are and have long been underfunded. For its 2016 budget, the Irish government announced an additional allocation of €35 million for primary care and specialist mental health services (Mental Health Reform 2015); it remains to be seen if this funding will be put in place. A significant portion has remained unspent, while €12 million was believed to have been diverted to other spending priorities (Cullen 2016). McDaid of Mental Health Reform claimed that previously announced funding increases were not reflected in an increase in frontline staff. She also pointed out that at 6.5% of overall health spending, mental health allocations are well below what she believes is needed (Mental Health Reform 2015).

In speaking of how funding will be implemented in the future the HSE official interviewed believed that there eventually may be some kind of copayment model, or a credit voucher system. However, he also believed in services being offered free if needed. He recognised that issues of equity and access are societal decisions and he acknowledged that "public health systems are built on self-interest." In discussing this perspective, he believed that, "our community holds harsh views but doesn't articulate them in an honest way" and that providers and politicians are then left to provide a well-meaning narrative. He believes the reality is that, in line with the Layard et al. (2006) argument, there must be some kind of productivity benefit emerging from the investment in health. He would like to think, however, that we, as a culture, have certain values of self, spirituality and relationship that would prevent a dystopian reality emerging.

From the recent reallocation of funding for mental health services to other health areas (Cullen 2016), significant funding issues remain for the provision of mental health services. In the policy context, there is effectively no recognition of the services provided by PSP. Though there has, however, been an expansion of state-managed services via NCS and CIPC resources, an e-Delphi study participant suggests that these may be replacing some PSP services.

5.13 <u>PRACTICAL FUTURE POSSIBLITIES</u>

In 2012 a seminar facilitated by Ed Boyne under the auspices of the Irish Association of Humanistic and Integrative Psychotherapy took place in Dublin. The seminar was titled, "Building Bridges between Psychotherapy, General Practice and Primary Care" (Jones 2013).

The seminar suggested that psychotherapy needed to make prompt improvements in its standing among the public. It recommended that endorsement from the medical world was essential and that the evidence basis for psychotherapy was not being well explained to the public. Among a number of other recommendations, the seminar suggested the importance of collaboration among accrediting bodies, building the Irish research base for psychotherapy and developing relationships with GPs. These recommendations are supported in the literature review and Delphi study carried out for this research. The seminar also suggested the appointment of a champion for psychotherapy who would have some standing in society and who would be able to promote psychotherapy more effectively.

As has been seen above, the HSE official interviewed recommended the possibility of introducing a co-payment or tax credit system for those using private sector therapy. This might help further promote PSP as a possible, alternative resource for addressing mental health

distress among the general population: for those who cannot or do not wish to avail of state services. In the UK, the Centre for Social Justice (Callan and Fry 2012) discussed a "Payment by Outcome" model that was being tested there. In this model, rather than focusing on practice guidelines and prescribing acceptable modalities (inputs), the state focuses on describing required client outcomes (outputs) and pays service providers in proportion to their success in meeting the required standards.

The Callan and Fry report suggested that, based on the available data at the time, the IAPT services were "less cost effective than the primary care counselling services which they largely replaced, and less cost effective than equivalent voluntary sector services." (p.29). The report also observed that much of the spare capacity of private sector practitioners in the UK is not utilised. There may be an opportunity for the Irish state to take advantage of the apparently high number of therapists in Ireland, while potentially saving money through optimising the use of these resources; rather than developing a new, large infrastructure which may be more costly than developing the existing framework.

In addition it may be useful for PSP to seek a defined role in the provision of mental health services (Jones 2013).

5.14 SUMMARY

As is apparent from this overall study the area under exploration is complex and contains many overlapping issues. Historical hierarchies, both formal and informal, are clashing with contemporary political and managed health care demands. In addition, clients are not always aware of the underlying, possibly objectifying, productivity philosophy of public health services and private sector provisions (Bowman 2002). This philosophy seems to encourage a medication focused, quick-fix mentality, yet the medication-focused approach is being increasingly criticised. This critique, however, does not equate to a need for PSP. Encompassing these layers is a large layer of research activity (Fish 1999), which is moving toward more well-defined responses to mental health manifestations. However, battles persist between therapeutic modalities and research approaches seeking primacy, and proof of efficacy (for example Cooper 2011; Shedler 2010). PSP may not of necessity have a future in implementing these outcomes.

It is clear from this study that PSP in Ireland not being adequately promoted. Action is needed for PSP to survive as a significant element of provision resources, but it is not clear that its

survival as a separate offering within the framework is assumed or desirable. In addition, technological changes are further increasing the range of referral resources and client choices, potentially placing further pressure on PSP. It remains to be seen whether or not this is problematic. Arguments in favour of EBP (treatments that may be more likely to be offered in public sector contexts via technological formats in the future) and the cost-effectiveness demands of state provision may be influential in determining how service provision evolves. In addition, this study suggests that EBP considerations in the Irish context have been less important than the historical structures of the field, placing primary care and psychiatry at the helm of treatment. This may continue; there is no indication that policy is moving towards any significant recognition of the relevance of PSP. If PSP is to survive, collectively its adherents must be more vocal in presenting the benefits of PSP, in comparison to the criticised alternatives of "quick-fix" and excessively medication-focused treatments.

CHAPTER 6   CONCLUSION AND IMPLICATIONS

6.1   INTRODUCTION

In this chapter, the contribution of this study to private psychotherapy (PSP) in Ireland will be considered. In presenting the key findings of this study, it will be argued that PSP is in danger of irrelevancy in the context of policy in Ireland. Another key finding is an identified need for PSP practitioners to play a more assertive role in seeking out recognition and enhancing credibility. The final key finding is that technology will have a disruptive impact on PSP in Ireland and elsewhere. The strengths and limitations of the study will be explored. Implications of the study for future research, psychotherapy and PSP will be considered. Implications for policy and training in Ireland will also be discussed. Finally, a perspective from which PSP may be able to differentiate what it offers from other professional boundaries will be offered.

6.2   CONTRIBUTION OF THIS STUDY

For clarity, I will repeat the objectives of the study outlined in the Chapter 1 introduction:

> To explore some of the key issues related to the future of PSP in Ireland arising from the literature review and expert opinion explored in an e-Delphi study.

> To establish what level of consensus or dissensus could be attained related to these issues over the subsequent 2 rounds of an e-Delphi study.

> To inform psychotherapists and psychotherapy policy of emerging issues.

In light of the above aim and objectives, this study may clarify the issues related to the future of Irish PSP. Specifically, this study;-

- Provides an exploration of the weak standing of PSP in Ireland

- Outlines an appreciation of the complexities and issues relevant to the future of PSP

- Affirms many of the issues identified in private sector provision in the UK and USA

- Provides information regarding emerging issues of relevance for PSP practitioners

- Links the historical context for PSP in Ireland with a future-based analysis of the PSP field in Ireland

- Mirrors and explores many of the themes identified in the literature review in an Irish context

- Identifies the importance for PSP of accommodating technological changes that will impact the practice of psychotherapy

6.3   KEY FINDINGS

6.3.1   PSP RELEVANCE IN IRISH MENTAL HEALTH POLICY

While this study has outlined some progress towards the regulation of private sector psychotherapy activity in Ireland, PSP does not appear to have a clearly recognised role in the future planning of service provision, as this has been expressed in policy documents reviewed. Regulation may be about to occur. However, regulation of PSP may not equate to a role in provision, without an explicit recognition in policy.

The apparent gap between evidence in efficacy research and evidence about what is happening on the ground identified in this study, would appear to leave a vacuum in which power and political dynamics interplay. In this space the traditional hierarchies, both informal and informal, appear to prevail in Ireland (such as the dynamics referred to by Totton 2000).

This study has also shown that the excessive use of medication is recognised by participants (item 7) and in the related literature (Davies 2013; Kirsch et al. 2008). The e-Delphi (item 8) has also suggested an inadequate use of psychotherapy, which was reflected in the literature by a reported reduction in the use of psychotherapy among outpatients in the US (Olfson and Marcus 2010). Cost of services (Norcross, Pfund and Prochaska 2013), funding (Mental Health Reform 2015), equity and access issues (Bower and Gilbody 2005) have also been identified as future challenges for policy and practitioners, both in the literature review and in e-Delphi participant comments. It is not clear, from the findings of this study, whether low cost provision is of benefit or a threat to the viability of PSP. However, all of these issues may point to a need for an improved level of collaboration between PSP and other service providers in order to clarify the role, and the practical feasibility of credible alternatives offered through treatments provided by PSP. Again, these issues also speak to the relevance of PSP in policy.

Given all of the above considerations in relation to PSP, this study suggests that if it is not already irrelevant in Irish mental health policy, PSP is in danger of becoming increasingly so.

6.3.2   PSP SEEKING OUT RECOGNITION AND BEING VALUED

The use of outcome measures in PSP was supported by 65% of participants. Evans (2013) discussed the use of outcome measures and transparency as drivers of improved quality and efficacy. He believed that this promotes the political acceptance of treatment. However, the literature on Ireland does not demonstrate the use of outcome measures in private contexts. Perhaps PSP practitioners could enact a clearer commitment in this regard as part of seeking recognition for its value.

Comments in the e-Delphi were supportive of research in a general sense. We see a lack of available data in Ireland on mental health in general and on clinical research specifically. PSP may have an opportunity to occupy this space by encouraging the development of a research aspect in the clinic. Though changes have occurred recently in this area, with recognition of the need for more research focus by the Irish Association for Counselling and Psychotherapy (2013) and the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) (Jones 2013), there has been very little activity apparent in the PSP realm in Ireland to address this need. PSP practitioners would have to organise more effectively, to establish a unique research layer. Such a focus could enhance the credibility and standing of PSP.

Given the low referral levels demonstrated in this study, and the lack of consensus in relation to credibility among these referral sources, it would seem that PSP has some way to go in establishing a credible alternative to existing treatment pathways.

The effort to introduce consistent training standards, among psychological practitioners in Ireland, may represent and attempt to enhance the standing of psychotherapy by an educational route. Though this may be a step towards gaining more policy recognition for PSP, the difficulty remains that the policy architecture does not explicitly recognise PSP. In effect, the CORU training standards (Quality and Qualifications Ireland 2014) may impact PSP by making it increasingly irrelevant: as we already have an existing route to regulation through the Health and Social Care Professionals Act 2005, this may negate the need to recognise (or perhaps employ) non-psychologist PSP practitioners who have taken alternative pathways to becoming psychotherapists. This is an argument that supports the idea of Ed Boyne (Jones 2013) that psychotherapy needs a defined role in the mental health service.

From the medical model perspective, the most powerful perspective in the health services, it would not be logical to weaken this framework, by opening the door to whose qualifications and philosophical stances are at odds with the prevailing discourse. This argument may condense to a preference for objectivity or subjectivity in the praxis of PSP. PSP practitioners may need to decide at which end of this continuum it resides. PSP would have to promote its views in support of its position more effectively, as it has not succeeded in doing so in Ireland.

Overall, it seems that PSP practitioners have not been effective in having their views heard on mental health policy, or through gaining state recognition, in Ireland.

6.3.3 TECHNOLOGICAL DISRUPTION IN IRISH PSP

Among e-Delphi participants this study has found a lack of consensus in relation to the relative efficacy of face-to-face treatment versus technologically based treatments (item 10). Some research literature has suggested that the quality of the relationship, conventionally delivered in face-to-face contexts, is associated with beneficial therapeutic outcomes (Lambert and Barley 2001 for example). However, the association of relationality with outcome is also questioned by other researchers (Goldfried 2013; Kazdin 2007). In contrast to a focus on relationality, efficacy and cost-effectiveness considerations for the use of online interventions have been explicitly recognised in the implementation of the Improved Access to Psychological Therapies (IAPT) policy in England, as part of a stepped-care approach (Richards et al. 2010). This approach uses interventions that are sequentially more costly to provide as the patient progresses through treatment. Lower cost, computer based, interventions are initially offered. This would appear to reflect a cost-effectiveness demand of state provision that may increasingly be a feature of UK, and Irish, policy.

On the basis of the literature review and the dissensus finding of the e-Delphi in relation to the use of technology, we may be at a turning point in relation to the importance and prevalence of technologically based interventions for mental health treatment. It may be that a good therapeutic relationship will continue to be considered an important factor in outcomes for face-to-face treatment. However, this may not be a primary or initial consideration where clients are able to select lower cost, more structured technological interventions that are, or may be in the future, available. Given the rapid increase in the use of online settings for social interactions, we cannot be assured that an assumed cultural value that may be assigned to face-to-face interactions, is something that will continue to be considered as important in the future.

It may be that relationality, or a similar as yet unidentified mechanism that contributes to motivation for change, can be achieved in some manner by online interventions (Emmelkamp et al. 2014). In addition, resistance to newer modes of delivery by therapists and clients may be a factor that will reduce in time, rather than one which will persist (Donovan, Spence and March 2013).

If, as the high level of consensus in e-Delphi item related to diversity may imply, technological interventions continue to emerge, PSP will have to contemplate incorporating and competing with these developments in practice. Already, some research is focusing on carrying out client assessment by online programmes. These programmes provide both diagnostic indications and recommendations for optimum treatment approaches based on the relational preferences of the clients assessed during the initial interactions (Beutler et al. 2012). It may be that one psychotherapist in the future may be able to treat a significantly higher number of clients compared to current norms. These treatments may be delivered in virtual reality environments, perhaps in the longer-term future supported by artificial intelligence (Gaggioli 2012) with significantly diminished interventions by psychotherapists. This will have implications for training and employment of therapists in the future. It remains to be seen in what way these emerging technologies may replace or expand the availability of and access to treatment. These novel treatments may also have relevance to issues of equity that has been identified in the literature (Richards and Bower 2011; Bower and Gilbody 2005) and may be of relevance in an Irish context as these treatments may provide wider access and enhanced equity.

These factors may improve the access to and the availability of effective interventions at a potentially reduced cost compared to conventional face-to-face treatments. Whatever may occur, it is apparent that there is an emerging technological disruption that will impact the future of PSP in Ireland.

6.4   STUDY STRENGTHS

Wulf (1989) discusses the concept of the collaboratory: collaboration plus the laboratory which brings together researchers for asynchronous consensus building and long-term development of knowledge using the internet and other web resources. By bringing together the views of key stakeholders in relation to their views on the future of PSP in Ireland, this study offers a bridge from research to the clinic.

The results of the e-Delphi items appear to affirm and support related elements of the literature review. While the results are not generalizable to psychotherapy as a whole, the themes emerging in the literature review (the value of psychotherapy, academic attainment, issues around medication, underutilisation of psychotherapy and technology are exemplars) were supported in the overall study.

The study brings together the views of experts in the field of PSP and it attempts to synthesise this with evidence in the literature. In doing this, it may offer supportive evidence for the accrediting bodies, and psychotherapists, in seeking recognition and improved standing for PSP.

6.5   STUDY LIMITATIONS

Though it was considered that participants were generous in their responses and time, a more detailed explanation for participants of the Delphi and round processes would have contributed to more data being returned. Some participants appeared to have been surprised at the open nature of the questions. There was a low incidence of changes in opinions by participants from Round 2 to Round 3. This may be as a result of the manner in which the Round was presented via email. Though an information sheet was provided for Round 3, on reflection it may have been useful to confirm electronically that participants read information sheets before each round, before progressing to their responses. Software and resource limitations prevented this. A concern throughout the study, was to avoid overloading participants with excessive demands. Despite this, respondents were thorough and generous in their reactions to requests for information and in their survey participation. In future studies, longer questionnaires might be considered.

It was not possible to recruit all of the panel number that had been planned. The original sample sought was 40 and the study began with 26 participants completing the first round and finished the third round with 19 participants. Inter-group comparisons might have provided a relevant insight into the dynamics of the field. In addition, with 22 participants employed in mental health delivery, this may have resulted the study reporting outcomes favouring views of the dominant participant group. 10 of these were also involved in educational contexts.

In relation to objectivity, it may be possible to incorporate many biases into the Delphi method, particularly at the earlier stages of the process. I had an assumed bias that the Delphi study

would show a strong consensus against the item in favour of outcome measures in PSP. However, 65% believed that outcome measures should be used in PSP.

The Delphi approach has not resolved the issue of what an expert is (Keeney et al. 2011; Avery et al. 2005; Powell 2003). In this study, participation was based on those taking part being "accredited, affiliated or qualified to practise for 3 years or more" and self-selected as "adequately informed to participate in this study" (Appendix 1). The qualifying questions did not establish the nature of participant interest or a confirmed expertise in the issues being studied, though participant interest may be assumed by participation.

The raw data generated in Round 1 did not appear to generate a sizable, clear indication of dissent in relation to regulation. Given the literature (Totton 2000, for example), it had been expected that there would be more questioning of the process and framework of regulation. Issues raised appeared to be more focused on when PSP might be placed in a regulatory framework rather than on the possible difficulties of regulation. It may be of value to explore issues around PSP regulation in Ireland in future research.

Using specialist software, for facilitating anonymous interaction among Delphi participants, might have proved valuable for generating discussion and clarity among participants. In using the Google Forms online software, time out issues were experienced by two participants. This may have had the beneficial effect of focussing the thinking of participants. It was not considered that this adversely impacted on the final outcome.

Though it may be a difficulty in many research studies, some of the language used in the Delphi rounds, such as "quick-fix" may have been unclear.

It may be of benefit to spend more time in the planning stages of future studies in gaining access to participants outside one's own field of practice. This might be achieved by seeking higher level support from immediately available supports rather than assuming access will be straightforward. In future, it might be beneficial to adhere to a more rigid timeframe in carrying out a study of this kind.

In revisiting a Delphi, consideration might be given to incorporating a more statistically grounded analysis of responses. This might include using item scales such as semantic differential or rating scales rather than the ordinal Likert scales used. A more statistically grounded approach might also incorporate respondent weighting of their responses and incorporation of these in the analysis of the Round responses. From a review of literature

related to the Delphi method, there is a lack of consensus among Delphi researchers as to what statistical analyses should be used (von der Gracht 2012).

6.6   IMPLICATIONS FOR PSP

There may be an imminent paradigm shift in the application of psychotherapeutic interventions via technology. Ireland is not well prepared for this in PSP, or in psychotherapy in general. The research literature appears to be showing a possibility for the efficacy of online interventions for particular contexts, though there are critiques of this view and contrary findings. Despite this, the stepped care model in the UK is incorporating these electronic interventions and some of these are being piloted in Ireland. Debates about therapeutic models and the value of face-to-face therapy may become redundant, as users encounter options being promoted to them throughout increasingly immersive electronic environments.

Future debates may be focused on techniques that work and market forces will, as they always have, play a huge part in filtering out what works and what is acceptable from what doesn't work or perhaps is not well promoted. There are waves of technological developments yet to come which will significantly evolve our understanding of mental distress treatment. These technological changes will impact on how and where consumers access therapeutic interventions.

There may always be a need for face-to-face therapy, however, I envisage that the market for this may reduce significantly as new technologies come online, as virtual online communities develop and reach out in more and more contexts, and as the use of technology becomes more normalised. This study has also demonstrated the difficulties for PSP, arising from the increasing availability of alternative treatments such as lifestyle modifications (Walsh 2011), and increased provision of services by the state (Cahill 2014). PSP has an increasingly porous boundary in respect of many of its treatments. As the technical aspects of treatment become evidence-based, this may make a given intervention more easily replicable (Van Broeck and Lietaer 2008). As a result of this, I believe that the boundaries of PSP in Ireland may become less defined and increasingly encroached upon. PSP may eventually be crowded out as a separately identifiable activitiy.

From the literature review, while there appear to be instances of overlap of these boundaries with other approaches to mental health care, there has been a history of dissent (Davies 2013) among practitioners who work in private practice and working in public health care settings.

There would appear to be the possibility of a difference between psychotherapy and other professions. However, a clear boundary between psychotherapy and other health care professions is not clear (Totton 2000). PSP may wish to delineate its borders vis a vis other professions more clearly. It is not yet doing this effectively in Ireland, as this boundary relates to a place in policy. PSP, if it is to survive as an identifiably separate treatment option in mental health interventions, may have to define a place for itself in responses to mental health distress. It is not enough to assume that it will survive because of goodwill or its historical contribution. In considering this issue in the Irish context, PSP might need to decide whether it wishes to survive as a separate, professional entity, or persist as a part-time activity with a nebulous boundary between it and other professional groupings.

It may also be useful to consider the importance of having a full-time cohort of professionals in PSP (Beck 1994) rather than 29% of practitioners as reported in the IACP 2013 survey. It is not envisaged that there may be a need to discourage part-time practice. However, there may be a need to encourage a full-time group of practitioners who have the time to develop the profession. Related to this, a possible oversupply of therapists in Ireland was suggested in the literature review and in comments made by e-Delphi participants. The cost and accessibility of PSP, and stigma associated with therapy may be among many other relevant factors. The IACP Strategic Plan for 2014-2017 appears to incorporate reference to the issue of therapist numbers.

Lees and Cleminson (2013) asked if psychotherapy wishes to stand apart from state-controlled productivity driven approaches to psychotherapy. The question of whether there is a need for a strong private psychotherapy sector in Ireland might be addressed by practitioners and accrediting bodies such as IACP and IAHIP. It may be that an interest, in pursuing such a goal, is not sufficiently strong among practitioners to develop PSP and promote its value. In his 2007 study of family therapists in Ireland Carr (abstract) recommends three goals for the profession of family therapists, two of which appear to be relevant to PSP in terms of the possible need to make decisions about these particular issues: the development of a research "infrastructure" for psychotherapy and the introduction of statutory regulation. While these goals are included in the 2014-2017 Strategic Plan of the IACP a higher prioritisation of these issues may be needed. In addition, a greater focus on technological developments may be needed.

6.7   IMPLICATIONS FOR FUTURE RESEARCH

From reviewing the basic data generated in Round 1, there was an acknowledgement of the future implementation of statutory regulation. A significant number of challenges to future

regulation was not apparent in the Round 1 responses. Such challenges could have suggested the inclusion of a separate item in the questionnaire. Given the socio-political context of PSP regulation in Ireland, it might have been of value to generate a more detailed exposition of participant views in relation to statutory regulation and potential alternatives. The question of the framework and mechanics of statutory regulation may merit a separate survey among practitioners.

The Norcross, Pfund and Prochaska (2013) study represents a useful application of the Delphi method in a psychotherapeutic context. A divide between the clinic and research has been identified in the literature review for this study (Norcross, Pfund and Prochaska 2013; Kazdin 2008; Stewart and Chambless 2007). In addressing this divide, a study combining the Norcross, Pfund and Prochaska (2013) Delphi and this e-Delphi study may be a useful basis for initiating a larger study in Ireland.

There is a need for more research, in the area of mental health and in Ireland, with very little domestically-based, published, primary research available. Regular publication of basic data such as the numbers of practitioners per head of population, calculations of hours worked in public and private setting, the type and mix of practitioners, education levels of practitioners, clinical workload of therapists, and types of issues treated, treatment outcome analysis, relative costs of public and private provision, and the size of service user population are needed. The IACP has made some inroads into providing this information about its membership via a 2013 survey of 700 of its members (IACP 2013) as reviewed above. The IACP has also embarked on a commitment to research in its Strategic Plan for 2014-2017 (IACP n.d.). It is hoped that the momentum generated in the IACP's approach in recent years will continue.

There is a difficulty for the HSE in producing regular, consistent, countrywide reviews of performance (Faedo and Normand 2013; Mental Health Commission 2011). While the HSE is in the process of procuring the CORENET outcome measure and reporting system (using manual recording processes initially), it seems that there are issues for the HSE to contend with in establishing a consistent reporting regime in the catchment areas. This system will not address the significant shortcomings in this area, though it may provide the impression that it does. It remains to be seen how transparently the data generated from this system will be shared in the public domain. Transparency is crucial for driving improvement and credibility (Evans 2013).

It may not be of concern to society in general that the therapeutic relationship is important, assuming that it is as important as many practitioners believe. Many practitioners have a preference to work face-to-face with clients. However, I have encountered many clients who were well resourced personally. They have been able to absorb different perspectives, on how they might learn to understand their condition, and make significant gains without a lengthy series of therapy sessions (such as lifestyle changes discussed by Walsh 2011). I have also had clients who have moved from a Skype environment with other therapists, to working with me face-to-face, who have expressed their preference for the face-to-face encounter. There is a need for more systematic gathering of evidence in relation to the pathways that individuals take, and their preferences, in pursuit of feeling better.

In relation to the lack of consensus reached in item 11, regarding the impact of low-cost services on PSP, it may be of benefit to establish a more clear understanding of the issues and effect of these services on PSP and on the practice of psychotherapy in general. In this area of consideration there is again a lack of data in respect of outcomes, presentation types and treatment numbers. It may be of benefit to establish a comparison in dropout rates among private, public and low-cost services.

In treatments utilising technology, it may be of benefit to establish factors in treatment resistance among practitioners and clients (Emmelkamp et al. 2014; Donovan, Spence and March 2013).

It has been difficult to find Irish-based, published, primary research for this study. Training organisations might encourage students to publish articles related to their counselling, psychotherapy or psychology studies. More domestically produced and focused articles would contribute to the body of psychotherapy research and knowledge in Ireland. Bodies such as the IACP might promote this idea through their approved training programmes. Accrediting bodies who publish journals could publish an annual edition devoted to the best student research in the state.

6.8 IMPLICATIONS FOR POLICY

From the review of the literature, the results of the Delphi study, and from discussions with the senior HSE official, it would seem that PSP is ancillary to the current impetus in the HSE and pressure in public spheres to increase service provision. An argument in favour of inclusion of PSP in policy needs to be made if PSP is to be of relevance. Related to whether or not there is

a need or desire for a strong PSP, is its recognition in policy. Recognition in policy may be as important, or more important, than statutory regulation for the survival of a distinct profession.

Policy in Ireland in appears to be driven by traditional power groupings with a nod to the contemporary evidence base. The primacy of Primary Care centres as mental health service points of entry, appears to have been based on historical structures rather than a policy process which considered all the alternatives and made an optimum choice. It may be that PSP can provide a significantly supportive element for mental health policy. However, for that to occur PSP might have to be recognised as a separate professional entity. It has not yet been recognised as such. As has been said above, regulation does not equate to recognition in policy. It would be of value if the HSE was to state what its position might be, if any, in relation to the future of PSP in Ireland and whether it sees that it has role as part of policy development and implementation.

In the interests of equity, and not just access, it may be of benefit for national policy to consider issues of equity in relation to accessing existing services such as the Counselling in Primary Care service and National Counselling Service.

There is a need for a more centrally managed and implemented approach to research, data gathering, monitoring in additional to a more equitable dispersal of funding. Again, this issue is of relevance to considerations related to equity which do not appear to be clearly identified or delineated in Irish policy as these relate to gender, age, culture and disability.

In terms of technology it would be useful for the HSE to publish a position paper on its expectations on the development and future use of technology in delivering mental health treatments in Ireland. This might provide PSP practitioners with a clearer understanding of how these expectations may impact on PSP. It would seem that now is an appropriate time to consider the implications of technological change, as this becomes a more recognised factor in future change in the field (Norcross, Pfund and Prochaska 2013)

6.9   IMPLICATIONS FOR TRAINING

Grodski (2000) reported the difficulties that many practitioners have in establishing a business in the private sector. Training organisations in Ireland might more effectively equip their students with knowledge to establish their therapy businesses, using established marketing tools. This may also have the benefit of promoting PSP in Ireland, and facilitate the development of a cohort of full time practitioners, if that is desirable.

The literature review and the e-Delphi findings suggest a need to train therapists in technology by way of providing an understanding of technologies that are emerging and might enhance, and those that might compete, with PSP offerings in the future.

The use of outcome measures may also be relevant in the context of training. It does not appear that outcomes related to measures are published by training organisations. Use of these measures may be of benefit in assuring that effective interventions are used. In addition, establishing the efficacy or otherwise of interventions carried out by trainees might be beneficial in establishing the credibility of psychotherapy. This might also offer a clearer understanding of the impact of some low-cost services on the viability of PSP in Ireland.

6.10   PERSONAL REFLECTION

In thinking about these results, I have begun to appreciate that I have been moving through the process of working on this thesis in two modes. The first mode has been the seeking professional, looking for professional recognition via completion of a doctorate. The other mode has been as an observing psychotherapist, assessing the world around me and my interactions with the world. These modes strike me as very much opposed and irreconcilable, while I know that we can hold many contradictions in the psyche. During the process, I have been debating internally about the relative merits of statutory regulation, higher academic standards and the impact of issues such as technology and low-cost counselling on me and psychotherapy. This inner debate has been partly between the supposedly objective professional mode and the assessing, subjective modes. Externally the debate between a medicalised, pharmaceutically grounded, measuring, goal-oriented approach to mental distress and an approach to psychotherapy based on the personal, experiential and practice of craft has mirrored my inner debate.

As I progressed through the study, it has been difficult to separate my evolving views of the studied phenomenon from my developing understanding of the literature and data. Initially, I may have had a strong bias arising from a personal interest in PSP, working as a practitioner in independent practice. However, as I realised over the duration of the study, at the beginning these views were not as well-informed or as grounded in fact as I had assumed. I believe that I went from occupying a gadfly position to a more reasoned and supported view of PSP. My belief and support for PSP has been enhanced and consolidated as a result of this study, but with a deeper appreciation of the complexities involved. In addition, I have a greater awareness

of the part that PSP practitioners are playing, or are perhaps not playing, in facilitating the possible eroding of PSP as a separate field or profession.

From the work and reading carried out for this thesis, it would seem that the craft-based, experiential, skill transfer concept of psychotherapy training offers a more clearly defined alternative to training offered in formalised academic contexts than I had appreciated or understood. I had entered the work with a vague sense of the differences between how psychotherapy is practised in medical and non-medical hierarchies. It is clearer to me now, both how obvious and how subtle the differences between the two positions are, and yet how intertwined they are and how practitioners often cross the divide between them. I am not certain that these differences can be reconciled. In saying that, I have arrived at a deeper understanding of the dynamics that prevail in the PSP context. I hope that I have explored some issues of relevance. I have a more clear vision of PSP as the best place to engage in the kind of practice that suits my preferences.

It seems that the difference between practice in medical and non-medical contexts is enshrined in the real differences between the medical model approach to the treatment of mental distress, and that offered by psychotherapists trained in experientially-orientated settings. My preference, and the reason I became a psychotherapist, remains for an approach that is grounded in the subjective experience of the individual. This study had deepened my appreciation of that position. That is not to say that I have dismissed the scientific method. However, I now conceptualise science as it relates to psychotherapy in a similar way to how I might apply a given therapy modality; as something useful, that should be used with care when sitting with the complexity of human suffering. I believe the benefits of a greater appreciation of both the science and subjectivity, or art, of psychotherapy have enhanced my practice.

As part of my response to this study, I have set up an online Linkedin group called Psychotherapy in Private Practice in Ireland (PIPPI). This grouping has 94 members most of whom are private sector practitioners based in Ireland. I intend to develop this group as a support and lobbying group on behalf of private sector psychotherapy practitioners who are members of accredited bodies or designated professions.

6.11   WHAT PSP IN IRELAND CAN OFFER

In making a case for the relevance of PSP as a result of this study, the following characteristics of PSP are proposed. Individually, they may not represent a unique boundary for PSP as many

of these characteristics may be observed among practitioners irrespective of context. Together, however, these characteristics may present a unique offering that PSP can provide. They assume a desire and impetus to organise in order for PSP to survive as a separate entity in the Irish mental health domain. Based on the literature review, and in considering the results of the e-Delphi study, in relation to PSP the following is a descriptive list of the unique context within which PSP practitioners can support clients. This perspective, or stance, may also offer a defining boundary for contemporary PSP in Ireland:

1. A counterpoint to prevailing therapeutic certainties that can focus on client individuality (Lambert 2013).

2. A challenge to power groupings overseeing the mental health discourse (Totton 2000).

3. A space for the long-term exploration of client issues (Davies 2013; Priebe 2006).

4. A sphere in which psychotherapy can be practiced away from increasingly prescriptive guidelines emerging in the public health sphere (Heidi, Neimeyer and Williams 2005).

5. A space for those who do not wish to engage in state-administered mental health interventions, for both therapists and clients (Lees and Cleminson 2013).

6. A confidential space away from the gaze of the state and the pressure of inherently normative demands generated by productivity-oriented therapy (Davies 2013).

7. A focus on the subjective experience of the individual rather than on the reporting requirements of the state (Bowman 2002).

In conclusion, I will include feedback from an anonymous e-Delphi participant that may offer a summation of the potentially different position of PSP compared to direct state provision in facilitating treatment:

> Its role is to exercise the critical conscience of the profession as a whole. Independent psychotherapy has a vital role in a modern secular society. Its task is to be the guardian and liberator of the individual conscience. No other sector of society has specifically this responsibility.
>
> Psychotherapy in the public sector does not have this task, because the therapist in the public sector is an employee of (or under contract to) a government agency (or some other third party), and his or her responsibilities are therefore of necessity diffused. The therapist in the public

sector always has the task of attempting to reconcile the needs of his patient with the expectations of his employer. And the expectations of the therapist's employer, if the employer is not the patient, will always diverge in some measure from the needs of the patient.

The independent practitioner, on the other hand, one who is being paid directly by his or her patient, has not just the duty but also the incentive to work with the patient to discover what health means for him or her, irrespective of what any third party may judge. The independent therapist has the task of discovering what health means for each of his patients in a way that the therapist working in the public sector does not. His responsibilities are to the private conscience of the patient only.

The crunch point is this: as a society we must decide whether we trust adult individuals to exercise personal conscience in the decisions of their private lives, or we do not.

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APPENDIX 1: E-DELPHI ROUND 1 EMAIL, PLAIN LANGUAGE STATEMENT AND QUESTIONNAIRE

Dear XXXX

Thank you for agreeing to participate in my research study.

Below is an explanation (plain language statement) of the approach I am using. It involves two or three rounds: in round one you answer questions broadly. I then take your responses and extract themes which are then collated with other responses. These are then used to create questionnaires for use in subsequent rounds of the study. It's called a Delphi study.

A LINK TO THE QUESTIONNAIRE IS AT THE END OF THIS EMAIL AFTER THE PLAIN LANGUAGE STATEMENT. PLEASE CLICK THE LINK TO PARTICIPATE IN THE STUDY.

Ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Thanks and regards,

Finian Fallon

Doctoral Candidate

Doctorate in Psychotherapy

Dublin City University

Mobile: XXXXXXXXX

_____

PLAIN LANGUAGE STATEMENT

Title: The future of private sector (independent) psychotherapy services in Ireland

Introduction:

This research study is designed to explore the future of private sector (independent) psychotherapy in Ireland. The word independent is used and refers to psychotherapy that is practiced by accredited practitioners working outside of the HSE in private practice.

The Principal Investigator is Finian Fallon (mobile number 0876666425). The research is undertaken under the supervision of Professor Anthony Staines and Doctor Evelyn Gordon with the ethical approval of Dublin City University.

What is asked from you:

You are asked to discuss questions in relation to issues about how experts view issues that may impact on the future of private sector psychotherapy. The discussion is designed to contribute to a greater understanding of the future of private sector psychotherapy. The format for participation is known as a Delphi study. It is designed to ensure that participants feel free and open in their contributions and are not too influenced by their professional standing or the excessive influence of other professionals.

The Delphi study works as follows:

If you wish to participate I will give you access to an electronically based questionnaire that I will ask you to complete. This should take 20-30 minutes. When I receive your data I will code it so that it is kept confidential. I will then analyse your responses along with the responses of other participants to see if themes can be extracted from the data.

I will then create a questionnaire around these themes and issue this questionnaire to you for another round of the study. This second round should only take 10-15 minutes. There may be a third round of the study to clarify issues.

Finally if you wish I will share the results of my study with you and the other participants.

Potential risk to you:

I don't envisage any risk to you from participation. The content of your participation is anonymous and confidential. In the final study no one will be able to identify what you have said. If you have any difficulties or questions about the research that you feel I cannot adequately answer, please contact The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-700 8000.

Any data received by me is treated as confidential and will be stored so as to ensure your anonymity and confidentiality. Any data generated by our discussions will be stored in a locked cabinet only accessible by me.

In some extremely rare circumstances I may be legally required to disclose information however this would only take place on the basis of a legal instruction to do so. Such occurrences are very rare.

All data will be destroyed after a period of 7 years from completion of the study.

Possible Benefits:

By participating in this research you may assist in providing a better understanding and clarity around what issues may influence the future of independent (private sector) psychotherapy in Ireland.

Participation:

Involvement in the Research Study is voluntary and you may decide not to participate or decline to have their data used at any time during the period in which this research is being carried out (between now and April 2014) without any adverse consequences. You may withdraw at any time from participation.

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-700 8000.

Thank you for taking the time to participate.

Finian Fallon.

[NOTE THIS QUESTIONNAIRE WAS PRESENTED ELECTRONICALLY AND DID NOT APPEAR EXACTLY AS PRESENTED HERE]

Thank you for participating in this study. In relation to confidentiality no one apart from the researcher will be able to identify the individual responsible for responses to this questionnaire. Your participation in the study is anonymous.

If at any time you do not wish to continue participating in the research please feel free to do so. If you wish to have your participation in the study withdrawn please notify the researcher who contacted you about your participation.

Please select yes or no for the following statemeents:

I have read the Plain Language Statement (or had it read to me) Y/N

I understand the information provided Y/N

I have had an opportunity to ask questions and discuss this study Y/N

I have received satisfactory answers to all my questions Y/N

I consider that I am adequately informed to participate in this study Y/N

CURRENT POSITION

NAME: _____

JOB TITLE(S): _____

PLEASE PROVIDE YOUR RELEVANT PROFESSIONAL AFFILIATIONS / ACCREDITATIONS / ORGANISATION:

_____

HAVE YOU BEEN ACCREDITED / AFFILIATED / QUALIFIED TO PRACTISE FOR 3 YEARS OR MORE? (Y/N) __

IF YOU HAVE NOT BEEN ACCREDITED / AFFILIATED FOR 3 YEARS OR MORE YOUR FURTHER PARTICIPATION IN THIS RESEARCH IS NOT REQUIRED. THANK YOU FOR TAKING PART.

DEMOGRAPHIC DETAILS

MALE/FEMALE: _____   AGE: _____

PLEASE INDICATE WHICH PROFESSION YOU WORK IN (SELECT MULTIPLE IF APPLICABLE):

PSYCHOTHERAPIST, COUNSELLOR OR PSYCHOLOGIST _____

PSYCHIATRIST   _____

GENERAL PRACTITIONER / MEDICAL DOCTOR   _____

EDUCATOR IN PSYCHOLOGY/PSYCHOTHERAPY   _____

POLICY PROFESSIONAL   _____

POLITICIAN   _____

ISSUES RELEVANT TO THE FUTURE OF PSYCHOTHERAPY IN IRELAND

Delphi Round 1

Please provide your answers to the following questions. You can provide as much content as you wish.

QUESTION 1

PLEASE OUTLINE THE KEY ISSUES THAT YOU BELIEVE MAY INFLUENCE THE FUTURE OF INDEPENDENT (PRIVATE SECTOR) PSYCHOTHERAPY IN IRELAND?

QUESTION 2

WHAT IMPACT DO YOU THINK CURRENT MENTAL HEALTH POLICY MAY HAVE ON THE FUTURE OF INDEPENDENT (PRIVATE SECTOR) PSYCHOTHERAPY IN IRELAND?

QUESTION 3

WHAT IMPACT DO YOU THINK THE TRAINING STANDARDS FOR COUNSELLING AND PSYCHOTHERAPY ACCREDITATION MAY HAVE ON THE FUTURE OF INDEPENDENT (PRIVATE SECTOR) PSYCHOTHERAPY IN IRELAND?

QUESTION 4

WHAT COMPETITIVE FORCES DO YOU THINK MAY AFFECT THE FUTURE OF INDEPENDENT (PRIVATE *SECTOR) PSYCOTHERAPY IN IRELAND?

QUESTION 5

WHAT IMPACT DO YOU BELIEVE THE MEDICAL MODEL APPROACH TO MENTAL DISTRESS MAY HAVE ON THE FUTURE OF INDEPENDENT PSYCHOTHERAPY (PRIVATE SECTOR) IN IRELAND?

QUESTION 6

WHAT IMPACT DO YOU BELIEVE EXISTING RESPONSES TO MENTAL DISTRESS NOW HAVE ON INDEPENDENT PSYCOTHERAPY (PRIVATE SECTOR) IN IRELAND?

QUESTION 7

WHAT IMPACT DO YOU BELIEVE THE PROVISION OF LOW COST COUNSELLING WILL HAVE ON THE FUTURE OF INDEPENDENT (PRIVATE SECTOR) PSYCHOTHERAPY IN IRELAND?

QUESTION 8

WHAT IMPACT DO YOU BELIEVE TECHNOLOGY MAY HAVE ON THE FUTURE OF INDEPENDENT (PRIVATE SECTOR) PSYCHOTHERAPY IN IRELAND?

QUESTION 9

WHAT CHANGES WOULD YOU LIKE TO SEE THAT WOULD HAVE AN IMPACT ON THE FUTURE OF INDEPENDENT (PRIVATE SECTOR) PSYCHOTHERAPY IN IRELAND?

DO YOU WISH TO RECEIVE THE RESULTS OF THIS STUDY (Y/N)? _____

APPENDIX 2: E-DELPHI ROUND 2 EMAIL AND QUESTIONNAIRE

Dear Colleague

You may remember some time ago you kindly participated in the above by completing a questionnaire for the above study.

The data you provided has been aggregated and analysed to create a brief questionnaire for the second round. The second round questionnaire is now online for your completion (link at the bottom of this email).

This information will be aggregated, analysed and returned to you for one final round (Round 3) in order to see if consensus can be reached on the responses given.

My apologies for the length of time taken to send the questionnaire to you, this was due to a number of reasons which I won't detail here.

I would be grateful for your prompt response. Completion should take no longer than 5 minutes.

The link is at the bottom of the page. Please click on it to complete the questionnaire. Participation is of course confidential and voluntary.

Thanks and regards,

Finian

Doctoral Candidate
Doctorate in Psychotherapy
Dublin City University
Dublin 9.
P: XXXXX
M: XXXX

Below are the questions used in Round 2 which were included in an online form:

1	Private sector psychotherapy needs to promote its value more effectively
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
2	Private sector psychotherapy is already, or is in danger of becoming, irrelevant to government policy
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
3	The minimum academic requirement for working in private sector psychotherapy should be:
	(a) Diploma / Certificate (b) Degree (c) Masters (d) Doctorate (e) other
4	Private sector psychotherapy has credibility among referral sources such as GPs and Psychiatrists
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
5	Private sector psychotherapy has adequate links with other mental health professionals
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
6	Collaboration between diverse approaches to psychotherapy improves the public standing of psychotherapy
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
7	There is too much medication being prescribed for mental health issues
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
8	There is adequate utilisation of psychotherapy in response to mental health issues
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
9	There is a prevailing quick fix mentality in public sector responses to mental health distress
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
10	Thinking about technology, treatment via technology can sometimes be as effective as face to face therapy
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree
11	The availability of low cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy
	Strongly Agree　　　Agree　　　Neutral / Don't Know　　　Disagree　　　Strongly Disagree

12	Therapeutic outcome measures are needed in private sector psychotherapy				
	Strongly Agree	Agree	Neutral / Don't Know	Disagree	Strongly Disagree
13	Please add any brief comments you may have in relation to this questionnaire				

APPENDIX 3. E-DELPHI ROUND 3 EMAIL AND QUESTIONNAIRE.

Dear Colleague

Thank you for your continued participation in this study. This is the final round of the research.

The purpose of a Delphi study is to see if consensus can be reached, or to see if disagreement among participants is stable. The nature of the study is somewhat speculative and asks for your "best guess", but informed, awareness of the subject matter. There is no right or wrong answer, rather your considered opinion is sought.

Round 2 questions were based on a thematic analysis of the Round 1 responses provided by participants including you.

In Round 2 there were four questions where consensus was not reached. In this final round you are asked to review the responses given by other participants to these questions and consider whether or not you might change your previous response, which is also included below.

Please reply to this email and place your responses in the area indicated below.

If you have any difficulty please call me on XXXX and if necessary we can go through the data together. A brief statistical analysis of the Round 2 responses to the questions included here are included beneath this email.

_____

For clarity, in this study private sector psychotherapy refers to counselling and psychotherapy that is provided in private clinic settings, outside HSE provision, to clients who pay for their therapy personally (including low cost services).

The question numbers are the same as used in Round 2. There are just 4 questions to consider. The accompanying Word document provides some excerpts for your consideration from Round 1 responses relevant to the 4 questions below.
In Round 2 the following responses were given by participants:

_____

Question 3. The minimum academic requirement for working in private sector psychotherapy should be:

	Number of Participants	Percent
Diploma / Certificate	6	26%
Degree	8	35%
Masters	8	35%
Doctorate	0	0%
Other	1	4%

Your response was: <u>XXXX.</u>   Please consider your previous response and note here your new selection, if desired. _____

_____

Question 4. Private sector psychotherapy has credibility among referral sources such as GPs and psychiatrists.

	Number of Participants	Percent
Strongly Agree	1	4%
Agree	11	48%
Neutral / Don't Know	3	13%
Disagree	8	35%
Strongly Disagree	0	0%

Your Round 2 response was: <u>XXXX</u>   Please consider your previous response and note here your new selection, if desired. _____

_____

Question 10. Thinking about technology, treatment via technology can sometimes be as effective as face to face therapy.

	Number of Participants	Percent
Strongly Agree	1	4%
Agree	7	30%
Neutral / Don't Know	4	17%
Disagree	8	35%
Strongly Disagree	3	13%

Your Round 2 response was: <u>XXXX</u>. Please consider your previous response and note here your new selection, if desired. _____

_____

Question 11. The availability of low cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sectore psychotherapy.

	Number of Participants	Percent
Strongly Agree	4	17%
Agree	7	30%
Neutral / Don't Know	2	9%
Disagree	10	43%
Strongly Disagree	0	0%

Your Round 2 response was: <u>XXXX</u>. Please consider your previous response and note here your new selection, if desired. _____

Statistical Analysis of Round 2 Questions included in Round 3. For information purposes only.

QUESTION	Mean	Mode	Standard Deviation
3. The minimum academic requirement for working in private sector psychotherapy should be.	n/a	Degree / Masters	n/a
4. Private sector psychotherapy has credibility among referral sources such as GPs and Psychiatrists	4.6	Agree	4.72
10. Thinking about technology, treatment via technology can sometimes be as effective as face to face therapy	4.6	Disagree	2.88
11. The availability of low cost therapy services (not including provision of therapy for medical card holders) is damaging the viability of private sector psychotherapy	4.6	Disagree	3.97

APPENDIX 4: E-DELPHI ROUND 3 INFORMATION SHEET

(ATTACHED TO ROUND 3 EMAIL)

WHAT ARE ISSUES RELEVANT TO THE Future of Private Sector Psychotherapy in Ireland?

An e-Delphi Study

ROUND 3 INFORMATION SHEET

On the following pages are edited selections from Round 1 responses for your information in relation to themes addressed in Round 3.

Question 3. Academic Standards.

Therapists should engage in their own process and this should be mandatory however that doesn't mean they are doing so in the moment of therapy, I know people who have engaged in courses that require this but still have a lot of work to do on themselves so I would ask what were their therapists like? Where were they trained? Have they engaged in their own process and when?

I think like any other body people should have strong educational and ethical standards achieved in order to be working in a profession.

Standards will need to match equivalent professions, if psychotherapists are to be taken seriously

Firstly, I think it is becoming such an expensive and lengthy endeavour to train as a therapist that it will be very off-putting for a lot of people. Consequently, those who will train will most likely want to recoup their expenses through high fees which in turn will make availability of private therapy more difficult for the ordinary joe soap! The private sector may lose the opportunity of some very good therapists because the initial commitment is far too big.

If the academic standards rise, many good counsellors might be lost.

However raising the academic standard is not a bad idea as the industry will then be perceived as more professional. Lack of professionalism is often leveled at counsellors and psychotherapists e.g. anybody can put a plaque on their wall saying they are a counsellor.

I think training standards are always positive and result in best trained psychotherapists allowing patients best possible treatment.

Accreditation, strong informed leadership will be essential in harnessing the profession of psychotherapy, which is; let's face it highly unregulated in Ireland to date. European licensure will be important and galvanising and integrating often diverse perspectives, practices, desires and visions between psychotherapists will likely be a huge challenge. It is thus vitally important that training standards are regulated, transparent and internationally recognised. Accreditation plays a significant role and responsibility in the development and maintenance of training standards.

A very bad influence because training within the areas of counselling and psychotherapy is dominated by the criteria of accumulating hours and session and not by reaching a certain point in one's own personal therapy which has no other criteria than one's own subjective position reached in the therapy.

In my view this is an area which needs to be 'tidied up' and for me it goes hand in hand with statutory regulation and the establishment of a register similar to the HPC in the UK. This will increase training standards and ensure consistency for private clients also.

At the moment there are too many unregulated trainings which it could be argued are more focused on monetary gain or 'bums on seats' mentality rather than high quality graduates with appropriate placement skills, theory and research practitioners also.

Perhaps it demotivates future therapists as standards and duration of accreditation process increases considerably, so in that regard it could impact negatively; alternatively if one has the drive, ability and interest in the area the sector could only benefit from such professionalism/enthusiasm

Question 4. Credibility.

Whether there is sufficient education and advertisement of what psychotherapy is and how it can help people.

Whether there is appropriate and adequate research carried out in psychotherapy as a mental health support and intervention.

An issue will be whether private sector psychotherapists are included by other players in the mental provision - e.g doctors, psychiatrists, community psychiatric nurses, social workers. Will psychotherapists in community be included in shared support and care plans?

Whether psychotherapy becomes a regulated profession will be a significant factor

If people are being better informed by providing information and education on mental health if this policy goes forward, it may in turn encourage people to attend counselling/psychotherapy.

At present it is incumbent of GPs and other health professionals to source high quality therapists and then recommend them to our patients. Quality is not uniform throughout.

The current public emphasis on expressing emotional difficulty may result in more persons seeking psychotherapy privately, as would informed GP referrals. Primary care is a key area.

But I think that the public at large rely on the authorized services sanctioned by the HSE which relies too much, with individual exceptions, on the medical model and a wish for quick-fix, The experience of young children and adolescents having to wait their whole childhood for access to treatment is frightening; however our economic situation hardly enables many to seek private help, though some do. I know colleagues are finding it hard to fill their spaces these last years.

In future it could go either way, depending on our economy,, educating GPs as well as other factors

Question 10. Technology.

I think that online therapy will increase in scale but I fear it will need to be regulated. Already chat room forums are becoming popular and their use in group support situations can be excellent. Definitely 'self-help' questionnaires and CBT type exercises will become more widely used and how they are delivered too (eg use of Apps).

On a basic level I can see counsellors simply producing funky web-sites for themselves, the profession is amazingly poorly self-promoted/marketed.

Reduce it to a computer like science based practice in some cases which will further erode the personal relational nature of the psychotherapeutic relationship, and promote the quick-fix mentality for some persons who would be totally unsuited and thus might dismiss psychotherapy as useless and even dangerous.

Education again!

I believe it may have a great impact.
It will lower cost for both the therapist and the user.
New technology will make the service available to more users.
Therapists will be able to source clients in different countries and different parts of Ireland, not just locally.
There will always be a place for f2f counselling but using new technology to deliver the service will become normal.

I think since the invention of the telephone and perhaps even prior to that, technology has been a part of therapy! However, the advent of the internet has brought new opportunities and challenges to the practice of therapy and will bring potentially significant changes to how therapists will work in the future, whether in independent practice or otherwise. I think this may well be a key area of change. While I don't see myself becoming an avatar therapist, for example, I do find the concept of integrating new technologies into therapy intriguing and see how such innovations may be useful for clients who present with perhaps social anxiety, phobia etc.

E-therapy is growing in popularity, though I believe it to be a specialist area that requires specialist competencies and not without its ethical challenges. Clients are demanding in a sense more accessible, immediate, convenient and more cost effective forms of psychological therapy.

Some forms of therapy or therapeutic support may be more technologically appropriate - (for example CBT, Psycho-education) or some particular symptoms/presenting issues.

Internet based therapy certainly challenges the notice of what constitutes therapeutic space as does the ubiquitous nature of social media. In addition, clients are expecting therapist to engage in ever increasing forms of out of office communication (texting appointments/emails etc.).

Social networking is increasingly being recommended as a means to promote their practice (e.g. an increasing number of online marketing services provide this service) and independent therapists are encouraged to develop an online presence. It presents an opportunity to reach a large audience while on the other hand potentially raises interesting ethical challenges for therapists (e.g. professional boundaries/self-disclosure, confidentiality, privacy, e-professionalism and so forth).

The availability of the WWW extends the scope of practice beyond one's geographical local, hence practice may extend globally. This raises interesting legal questions for professional bodies who accredit therapist to practice in a particular jurisdiction. In the US, in California for example, licensed therapists are prohibited to practising beyond state lines. How it is monitored is perhaps another question.

There is growing evidence of the benefits of online services, boards and email services along with complete electronic therapy services as being very beneficial and akin to how young people generally communicate all the time. They have their place however I feel meeting a person face to face in a meaningful way will never be obsolete

We are already providing the option for students to receive synchronous/asynchronous therapy online. I believe this sector will grow but again depending on how well a particular website is marketed, they may develop a monopoly, especially since service users can access one practitioner from anywhere in the world.

Question 11. Low Cost Counselling.

I think low cost therapy is good in one sense because if people need help at least there is somewhere they can find it. However what you have is people who want to pay low cost because they don't think therapy is important enough to be paid for, that in my opinion is different to being able to afford it. I know people who have counselled clients in these centres who are giving up their time to discover that clients work shift work, are taxi drivers etc who just don't want to go private, but who go on their annual holiday and drink every night of the weekend. I know therapists who can't do this because they can't afford it. So what I'm saying is that low cost should require a note from social welfare or some official marker to state that you don't have the means.

I think the impact on private work will be steady erosion over time.

I think it will encourage a great number of people to at least try counselling as a valid means of achieving good mental health.

It's a dilemma! As an empathetic human being, I would like counselling to be available to all who wish to pursue it. As a private practitioner, it is difficult if a lot of clients are looking for it as it is difficult to make ends meet if you try to meet the financial costs of being self-employed and yet not take on too many clients (which inevitably will reduce the competence of your work) just to scrape by a living.

I don't believe it has any great affect because the users of low cost counselling do not have the financial reserves to fund private counselling.

If more people have the experience of therapy, when they are in a position to pay for it they will. So low cost counselling can only help the industry.

Whereas it is easy to see that it is helpful to people on low incomes, it may serve to de-value the service. Some people do not value services which are 'cheap'.

Naturally, it will be a significant threat however there will always be private clients who are happy to pay more for a quality service. This however becomes quite elitist work and maybe not so satisfying as having a high through-put of clients and the satisfaction of witnessing and connecting with them in their journey to enhanced psychological wellbeing. I suggest practitioners to offer a range of services for diversity; low, mid and high cost work even pro bono for a good cause.

APPENDIX 5: ETHICAL PERMISSION FROM DCU

DCU RESEARCH ETHICS COMMITTEE LETTER:

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

DCU

Prof. Anthony Staines
School of Nursing & Human Sciences

19th June 2013

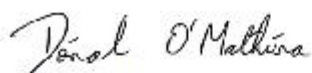**REC Reference:**   DCUREC/2013/165

Proposal Title: The Future of Independent Psychotherapy Services in Ireland

Applicants: Prof. Anthony Staines, Dr. Evelyn Gordon, Mr. Finian Fallon

Dear Anthony,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal. Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. Should substantial modifications to the research protocol be required at a later stage, a further submission should be made to the REC.

Yours sincerely,

DCU
Research & Innovation

Dr. Donal O'Mathuna
Chairperson
DCU Research Ethics Committee

APPENDIX 6: EXTRACTS FROM INTERVIEW WITH HSE OFFICIAL

STATUTORY REGULATION

Below are extended extracts from an interview with an official of the Health Service Executive (HSE) in June 2014. In discussing possible future regulations on PSP the official stated that "If psychotherapy is to be taken seriously it will have to be regulated, the question is by whom." This comment appeared to refer to the question of whether the state would become more directly involved in the regulation of PSP or would choose to regulate PSP at a distance via legislation which may leave accreditation responsibilities to the existing representative bodies, as it does with the Psychological Society of Ireland (PSI) as recognised by Irish law.

POLITICS AND PSYCHOTHERAPY

In discussing a recent report concerning the treatment of children who died in state care the official was critical, saying:

> Suddenly we are all surprised about something we all knew about, find someone to blame some other to plant this on. But in 1950 Ireland held the world record for hospitalising… no one came anywhere close to level of hospitalising we did. Magdalene laundries and child homes and everything else are dwarfed by the machine that was the mental health system… [which] encompassed vulnerable people, people with unwelcome sexual orientations, people who were unwelcome in their families, people with the occasional mental illness, people with epilepsy, people with neurological disorders, the elderly, this was the… solution.

This appeared to confirm a poor history of state provision for vulnerable populations in Ireland and refers to an ability in our culture to ignore these problems for a considerable time. Continuing with this theme the official implied a need for a realistic acknowledgement of the cost is involved in providing these services:

> We can do a load of different things we can do warehousing; we can do recovery… Tell us what you are willing to pay for and we will migrate to that but if you take no interest and if you build a large wall around us if you ignore it even when we took down the large wall and if you prefer not to have this conversation... don't be surprised if it's going to be disappointing or if it's going to fall short.

He also acknowledged the complexity of the issues discussed saying they are:

> Hugely complex and unsolved problems. And in the meantime do we wait for a better solution and say I'm really sorry your generation [is] going to have to condemn to lifelong disability, very poor productivity, very poor quality of life, alienation and a foreshortened life. We know that people with mental illness, with significant mental health needs, their life is discounted by about 25 [years]. In our reality there is a large machine called the mental health system which does a lot of really good work but it's not all good work.

This comment recognised the poor health outcomes for those with chronic mental health problems. The official discussed the impossibility of providing comprehensive coverage for mental health issues and suggested that the state may be beginning to move away from this aspiration:

> We have a model in Ireland where if someone is stretched on their couch watching daytime television all day and they clutch their chest we will come in we will mobilise [,we will] lift them off that couch and do anything it takes to save their life, put in a stent, or anything else that is required to place them back on the couch. Now I don't know how much more our community, and you can see the messaging is about this, look at our healthy Ireland. It's about saying "Well we told you how to look after yourself you chose not to do that and now you are coming to me about it, you know, read the instructions, and if and if you have left it [until] late in your life to do that well it's not too late but best of luck with it". So the state is moving further back from this assumed responsibility… [America doesn't] need to have a public health system because there is another…[person] climbing over the railing or another Irish guy flying in or whatever it is who will man the trenches or the convenience store so there is no great imperative on them to keep their population healthy 'cause they have a disposable population. Public health systems are built on self-interest…

In continuing to discuss this theme, the official mentioned a lack of honesty in communicating the shift away from wider provision and his concerns on issue:

> Our community holds harsh views but doesn't articulate them in an honest way. And then it falls to providers and politicians to provide a narrative to that. That makes it all seem well meaning. The solution for mental health and indeed for psychotherapies, and this is what Lord Layard was able to stack up… we can recover people, this person will come back to work and has a contribution to make. Now that contribution is it that they're going to be suitable for doing pharmacological tests on, for providing employment for brighter members of their community who are more agile. What is their function? That's a very dystopian view I would like to think we are not going down that route. I would like to think we have spiritual values, we've connectivity values we have a sense of self we have a sense of others. They're nice ideas we can't afford them.

This view appears to contain both a hope for a more connected society and an acknowledgment that reality may not support this view. The official continued, saying:

> We are now passing the point where we have one hundred thousand staff working in the health system which is actuarily about the number of staff you need the run a health service for 4.6 million people. If you are well arranged (we are not well arranged, but if you are it would work well). Our population is going to continue to grow: our workforce is compelled to drop….

This comment suggests that the level of resource provision may be reaching the point at which reorganisation, rather than more resources, may be required.

ACCREDITATION AND PROFESSIONALISATION

When asked if the existing accreditation system would be viewed as adequate for requirements of the state, the official said, "Simply being out there trading as a therapist is no guarantee of anything." He continued, "If people would restrict themselves to a brass plaque I would be much more comfortable with that … but they're putting up a chalkboard. Today it's kinesiology, and the next day it's Jungian work… and [working with] vulnerable people…" This suggests that there are risks inherent in the current framework. He also expressed a concern about, "such a smorgasbord of not just therapies and therapists but accreditation bodies, but we have just gone to the next generation of being inconsistent." He clarified that this is an issue of safety: "there's no safety in anyone telling you that they are a therapist of a certain level." He maintained in relation to this issue that:

> I have worked with some very finely skilled, hugely educated people who have extraordinary competencies but they're all in the same rattle bag with someone who did an evening course and an encounter weekend… in terms of safety, it's as safe as its weakest link.

EVIDENCE-BASED THERAPY

In discussing the use of EBT and outcome measures the official observed:

> Individuals get to see [their] own results and [these are aggregated and] anonymised for the whole service… it's actually working its way through our procurement at the moment… using a paper-based version initially but want to use the online version…

This appeared to confirm that outcome measures are an intended part of the state's provision of services though as yet the progression of this is limited to a manual collation of the data.

The official discussed the importance of focusing on the needs of service provision rather than professional status or standing:

> Vision for mental health nursing… brought together all the stakeholders… [This took] a long time to explain to people… [I'm] not here trying to preserve the profession; that's not the object of the exercise. If it's had its day, it's had its day, as long as it has utility we will keep talking about it. If we're talking about nursing the noun or nursing the verb is really immaterial. [The question should be:] how can I get this done safely?

Speaking on the Vision for Change document (Department of Health and Children 2006), and whether or not it was based on evidence the official stated:

> [In] mental health legislation psychiatrist appears over sixty times in the legislation I don't think the term psychotherapist appears at all…The word alcohol appears twice… There are certain dishonesties in the document as well.

From this, it may be gathered that the safety of the individual is increasingly the focus of development of provision rather than maintaining or supporting professional boundaries. However, it would also seem that the official acknowledged a lack of evidence in the policy. In addition, he clarified that his concern is to make cost-effective provision rather than to protect existing professions.

MENTAL HEALTH SERVICE PROVISION IN IRELAND

The official discussed the relative cost of providing outcome-focused service, which is cost effective in comparison to the historical provision of services in higher cost structures:

> I met with a group of registrars and we talked about recovery and they were kind of cautious and sceptical and they were using the bunny ears when they used the word recover and I had to explain to them, "Lads I can get someone minded for €8.65 an hour". At that point they were charging a quarter of a million a year; that's a lot of minding I can get done. If we look at our relationship with the prison system [costs] seventy thousand a year to keep someone in prison. They're fed, they're watered, they have healthcare, they're not bugging other people… If I am to offer them a psychiatric service that's two hundred to three hundred thousand a year. Will they be any better? Are the outcomes good? Will we get all the convenience of not having to watch the spectacle of someone descending into psychosis… These are political and sociological debates and we are using a very crude instrument that was invented back in 1815 called the psychiatric system to try and answer these.

Related to this consideration the official spoke of the need for providing cost-effective interventions, especially given funding realities, "You have to be dynamic because we are in a totally new space, as our traditional funding models can't keep up." The official offered a warning in relation to the funding situation prevailing at the time of the interview:

> But that [the disintegration of services] is probably facing us, given the level of investment we are making. We're still enjoying the flywheel effect but we're slowing. Until the middle of 2012 we were extracting more effectiveness and more throughput out of our mental health services and all our services... but somewhere around the middle of 2012 the flywheel started to slow down and the rate of slowing down is becoming more obvious and evident… [The] graphic slide I was using was KerPlunk where you pull out a cocktail stick and then you pull out another one and you get away with it so you pull out two at a time… and the games ends very dramatically when you lose your marbles and the whole thing collapses.

Here the official seemed to be suggesting that a point had been reached where provision was seriously lacking and the previous momentum of the system was beginning to deteriorate. In respect of this issue the official referred to the relative decline in mental health spending:

> [We are] struggling now with 5.3% of the health budget… We have had to retreat back from this all-encompassing concept of mental health to what is struggling to be called psychiatry soon to be called psychosis only. That's all fascinating but the taxpayer… tends not to find themselves in that narrow band… and disinvest from public health systems and the extra-welfarist approach that goes with that. As a provider… [you] can provide anything you can pay for if you can't pay for it let's stop fantasising. You may not welcome my honesty saying, "You cannot afford it you're not paying it and I can't magic it."

In this statement, the official outlined the limited levels of possible provision, which are not perhaps recognised in policy. He also confirmed the move from a focus in resources on psychiatric service provision to more widely available services.

COLLABORATION AND LINKS

In the context of collaboration and links the official stating a shift in focus to what service is being provided rather than who is providing it or how it is delivered, saying:

> [The] next Vision for Change or [the] one after will stray away from using this language of professions and assuming that these professions come with certain competencies… Which stable they come out of will become less relevant…When we apply that to psychotherapies, I don't really care what your beliefs are: can you do the following?

FUTURE OF PSP

As part of the interview the official was asked to predict what PSP in Ireland might look like in ten years:

> You would probably be talking about a conglomerate no more than probably three major providers, probably not distinguishing themselves terribly except in marketing offering some sort of different type experience. One would be cheap and cheerless another will be a premium brand and then there will be a middle ground which travels between the two, the people who began premium and couldn't afford it and fell down or the people who decide that the cheap and cheerless service wasn't the one for them. Cheap isn't cheerful... if the technologies improve we could be left with a completely redundant, nice experience and it might go the hot rock business, it might be found on the fringes of spa treatments, in exclusive hotels, it will only be for an elite if you really want to work for that group and talk about first world problems... but for the more widespread group they will find their psychotherapeutic needs met in their own community.

Again, the official confirmed a necessarily cost effective perspective on provision, with a possibility that PSP could find itself offering services to wealthy service users. The official confirmed this view in consideration of a possible future in which technological and other options would be available:

> Psychotherapists are going to have to become more available whether they become drive through telephonic… web based face time augmented by technology. … If you look at primary care, GPs see people in seven minutes. Two minutes meet and seat and greet… two minutes diagnosis… two minutes to give a script or make that phone call to (?) and a minute to get you out the door… [It] has to be psychotherapy to-go, and whether that's going to be instructions based on some algorithmic self-referral, a lot of detail that you fill out before you ever meet the therapist, who decides you're scenario forty-seven: again you get solution forty-seven to go with that, and there is some tailoring going on and probably a bit of blood chemistry thrown in there… Ultimately it comes back to the consumer experience, and it has to be experienced to be rated… Whether psychotherapy is on the top shelf…when you've clambered all your way through the materials, when you've watched all the YouTube clips… [tested] the galvanic skin response, and used the VR technologies, and all of that and you're still

not happy… [we] might find there's a surgical solution to this, a photo-optic solution, a kinetic approach: we don't know [how] that [will look in the future].

Notwithstanding the possible future availability of many alternatives to face-to-face PSP, the official believed, "[There] always will be a private sector market. People who don't have mental illnesses but need help rather than medications…may seek out PSP (or other cost effective solutions)."

LOW-COST THERAPY

The official discussed the availability of services and how those in need might fund the interventions, saying that while services should be available based on need, funding of them is a decision that has to be made collectively:

> Services should be available for those who need them… how that gets funded… is a different debate… If someone gets run over we don't go over to check in their pocket if they have cover[age] we deal with that… Eligibility and equity, and whether [people] have access are societal decisions.

However, he also suggested that there should be some direct contribution to provision by those applyin for services:

> Social and community, and sometimes in private service, [should be] offered on sliding scale, people should make a contribution, investment in self, part of therapeutic process… should be a cash payment, that's how we value things in our society. [It] will come with some form of co-payment…

EVOLVING PSYCHIATRIC PRACTICES

In relation to the position of psychiatry in mental health provision the official was asked if psychiatry has too much power, to which he responded he, " 'Can't disagree." In discussing the phenomenon of warehousing the mentally ill in prisons, discussed by Steinberg, Mills and Romano (2013) for example, the official contended:

> [In] 1970 [there were] 749 prisoners in Irish prisons and fifteen thousand psychiatric beds. Today we have twelve hundred acute psych beds and there's five thousand prison places. 7% of prison population have psychosis. [This] is about twice the international norm… if you look at UK and US [there are] ten times as many people in the US prisons with mental illness than in the mental health system… so [where lies] our obligation[? There's a rule of thumb] known as Penrose Law where you lose one and gain the other. Society, and politicians on our behalf, make decisions as to whether they want to invest in prisons or [a mental health] service… Is it a question of investing in psychiatry or in something else?

It would seem that this statement confirmed the warehousing phenomenon in Ireland while reflecting on choices related to this approach.

GP REFERRAL PRACTICES

When asked about the low level of referrals from GPs to psychotherapists, the official pointed out the ethical difficulty for doctors in providing treatment where preferred referrals are potentially not available:

> …There are many collateral routes… 35% [of primary care presentations are] in relation to mental health in primary care [according to] 2006 research… If you go to the GP with an alcohol problem and the GP doesn't have an alcohol solution… Why would I pursue that line of questioning… ethically opening up all sorts of dilemmas? 95% of issues remain, of MH issues remain in primary care… [Of the] 10% referred to CMHS… 40% will be no-show. [The] adults wait time [is] 6 weeks [for] psychiatric disorders… [There is a] significant schism between those two worlds, hence CIPC.

The official appeared to recognise the lack of availability of these services in addition to talking about waiting time difficulties and the non-attendance of those needing the services.

CRITIQUES OF EXCESSIVE MEDICATION

In discussing the use of medication the official inferred that there was an over-reliance on medication and observed "[The] medical model is saying, "Here's the problem, here's the solution, here's the script prize" [The response] goes to medication even though people have made huge changes in their lives."

TECHNOLOGY IN PSYCHOTHERAPY

As part of the discussion, the official was asked about the Norcross Pfund and Prochaska (2013) Delphi study that found a change of the view in participants, indicating a recognition that technology would play a significant part in the evolution of psychotherapy provision. In response to this he reasoned:

> People vote with their feet… Computerised CBT is having the same benefits as face time… Wicklow software reading [the] emotional content of face[s]… [We are] seeing location sensitive technologies… where you were before you had a crisis… [There is the] Ginsberg project in Scotland [researching] levels of tweeting, and texting, and [social media comments on] self-harm… Technology [is] diverting [users] away from old haunts… [It would be] very unwise to ignore it.

From this, it seemed clear that the official agreed with the discussed study and: he implied the possibility of a move away from face-to-face therapies. He went on to confirm this view, maintaining:

> Anyone who thinks that the technology is going to go away or [is] not going to bother me. This is highly labour intensive all technology goes after the labour intensive. That's where savings can be made, that's where fortunes are made and they're made by displacing someone who is occupying the space. When the ship industry collapsed, the ecosystem, the environment that supported whole generations… it all imploded.

ECONOMY AND COSTS OF THERAPY

Connected with the issue of technology, in discussing the costs of therapy, the official believed that those seeking services were thoughtful in their choices. He claimed that, "The customer will go with the best cost best-fit solution… If you're producing solutions that cost a thousand times more, then it had better be a thousand times more effective…The consumer is very canny and will switch allegiance…" With this, he again presented a view that the market may decide the future of treatment based on the availability of cost-effective solutions rather than on following historical pathways to treatment, such as face-to-face PSP.