# Psychiatric/Mental Health Nursing and Psychotherapy: The position of Horatio: European Psychiatric Nurses

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The provision of psychotherapy in the different countries/states of the EU is a complex issue. In some cases countries legislate for an open policy of qualification and delivery, whilst others are more restrictive. The only general agreement amongst the majority of countries is the necessity to take a masters level course in psychotherapy to be able to practice as a psychotherapist.

This position document outlines Horatio's views on the involvement of psychiatric/mental health nurses (PMHN) in the practice of psychotherapy. It is not intended as a comment on psychotherapy itself nor any other professional discipline wishing to deliver it. The views and/or opinions stated in this document have been informed by consultation with members of Horatio's European Expert Panel of Psychiatric Nursing and colleagues from Australia, the USA and Canada. In addition, it has been guided by information provided by the Nederlandse Associatie voor Psychotherapie (NAP), the United Kingdom Council for Psychotherapy (UKCP), the Malta Association of Psychotherapists (MAP), Deutscher Dachverband für Psychotherapie (DVP) and the European Association of Psychotherapy (EAP). The Strasbourg Declaration on Psychotherapy (1990) has been used throughout in the production of this document.

**Definitions**
The EAP defines psychotherapy as;

*"The exercise of psychotherapy shall be the comprehensive deliberate and planned treatment or therapeutic intervention on the basis of a general and special training of disturbances of behaviour and states of disordered condition, or wider personal developmental need, connected with psycho-social and also psychosomatic factors and causes, by means of scientific psychotherapeutic methods, in an interaction between one or several treated persons, and one or several psychotherapists, with the objective of mitigating or eliminating the established symptoms, to change disturbed*

*patterns of behaviour and attitudes, and to promote a process of maturing, development, sanity and well-being in the treated person"*. (EAP 2009a)

It further identifies 20 different working definitions for psychotherapy, the first three of which are for individuals with either a DSM IV r or ICD-10 diagnosable mental illness or long term mental health problems. Whilst acknowledging that Psychological psychotherapy, *".....is often conducted outwith and very separate from any medical setting"* (EAP 2012) they also state that recipients may be, *"...in hospital or out-patient (psychiatric/mental health team) settings.."* (EAP 2012) and be receiving other forms of treatment, including psycho-pharmacological treatment.

The Strasbourg Declaration on Psychotherapy states that, *"A full psychotherapeutic training covers theory, self-experience, and practice under supervision..."* (item 4) (EAP 2009b). It further states, *"Access to training is through various preliminary qualifications, in particular human and social sciences"* (item 5) (EAP 2009b)

The World Council of Psychotherapy (WCP) identify 16 different recognised forms of psychotherapy, both in group and individuals forms, with a variety of different combinations.

**Horatio Position**

This document considers the above definitions and/or explorations to form the basic premise as to whether or not PMHNs should be allowed to train and practice as psychotherapists. Horatio considers that the issue should be discussed under the following headings:

- Nursing and psychotherapy
- Training and competencies
- Total care package monitoring
- EU Guidance
- Financial implications
- Professional monopolies

**1. Nursing and Psychotherapy**

In the USA the growth of nurse provided therapies dates from the 1950's. One of the earliest papers on the subject comes from Schmahl (1962) who described both the way that psychological technologies and nursing fitted together well but also how nurses could use additional skills to develop better relationships with their patients. By the 1970's there had been a clear development of the types of therapies that could be provided with the educational programmes to support them (Lego 1971, Hardin & Durham 1985). Lappenen Montgomery & Webster (1994) were clear that the growth of nurse therapists was based on the fact that the traditional approach to psychotherapy had failed to meet the needs of accessible, cost effective and accountable mental health services. They identified brief, intermittent and/or possibility-oriented therapy as being consistent with the orientation of PMHN. However, this was not an exclusive list, for example Turner (1992) was using individual psychodynamic psychotherapy with older adults. Perhaps not surprisingly nurse theorists were experimenting with combinations of different forms of psychotherapy and nursing models. Suzanne Lego (1988) was applying Peplau's Interpersonal model to group psychotherapy and DeHowett (1992) was using Imogene King's conceptual model of goal attainment with different individual

approaches. What became clear was that psychiatric nurses providing psychotherapy were associated with being clinical nurse specialists, and more latterly, an advanced nurse practitioner (Wheeler 2008, APNA 2010). Today, any form of psychotherapy by PMHNs is viewed in the USA as being linked to a holistic nursing framework.

The growth of nursing-therapists was different within the UK. Their involvement really only began in the 1970's with experimental activities being undertaken at the Maudsely Hospital, London. These early therapists were three-year trained Registered Mental Health Nurses (RMNs) who did not hold undergraduate qualifications and worked primarily with *'selected adult neurotics'* (Marks, Bird & Lindley 1978). Brief therapies (with equally brief training) were also shown to be an area where nurse-therapists performed well (Milne 1984). The last major review of nurse therapy undertaken in the UK was in 2000. Gournay et al (2000) undertook a 25-year follow up of nurses working in behavioural psychotherapy using a sample (n=237) of trained nurse-therapists which showed that that they had made a considerable contribution to mental health service provision, specifically in primary health care, using brief and short term therapies. However, the study concluded that there were too few of them! More recent work in establishing the role/number and types of therapies that nurses have been involved in show marked increases in several areas, but unlike the USA these tend to be condition or modality specific, especially using cognitive behavioural therapy (CBT) and other forms of brief therapies - though not exclusively (Mace et al 2009). According to Mace (2010) whoever is involved in the delivery of psychotherapies in the future will need to take into account the increasing influence of 'risk' in mental health services.

It is clear that some PMHNs have undertaken specific training in different psychotherapeutic modalities, but the majority have not. This is significant because there needs to be a clear differentiation between psychiatric nurse-therapists and psychiatric nurses. Whilst the roles of the therapist will, in most part, be laid down by the therapy itself, the roles of psychiatric nurses who are not therapists but need to act in a supporting role for the patients receiving therapy, are not so clear, i.e. as psychosocial nurses? This will be a challenge for the future, and not just in the USA and UK. In addition, the requirement for nurses to deliver therapies to certain types of patients needs also to be clarified. The General Medical Council in the UK has asked that the term, '*Medical Psychotherapy'* be used to identify the provision of psychotherapy by psychotherapy trained psychiatrists for complex psychiatric cases (Mace & Healy 2011). As the term *Psychiatric-Nurse therapist* is already widely used, perhaps there is a need to introduce '*Psychiatric-Nurse Psychotherapy'* to identify complex care cases where nursing skills and expertise are essential to the patients' potential recovery?

Similar developments to the UK and USA have taken place in other countries around the world and by necessity were nationally and culturally oriented. These include Australia (Hurley, 2009, Monshat et al 2012), Canada (Geertje 2012) and to a certain degree New Zealand (Crowe et al 2010).

The picture in Europe is far more complex with some, though not all, of the developments described above having been replicated. Nurse-therapists (where this is permitted by law or professional codes of practice) appear to perform different types, levels and disease oriented therapies, i.e. in Switzerland with epileptic patients

(Muller et al 2010); Finland with alcohol related disorders (Korkella & Fink-Jenson 2009), Germany with re-hospitalised patients suffering from schizophrenia (Schmidt-Kraepelin et al 2009) and Portugal with patients suffering depressive disorders (Apostolo & Kolcaba 2009). However, the main differentiation between countries that certify nurses to undertake psychotherapy and those that do not appears to be based on two factors.

The first of these is the historical development of mental health services and PMHNs within a country. For example, in Eastern Europe many countries allow modified forms of therapy to be delivered by different professions simply because there are not enough therapists to go around. Countries such as the Czech Rep. allow PMHNs to deliver supportive psychotherapies, whilst so-called professional psychotherapy is only allowed to be offered by psychiatrists and psychologists. There are proposals to allow appropriately trained PMHNs to deliver 180 hours of psychotherapy for people with addictions, but the entry criterion includes a Masters degree in mental health nursing and this is not common in CZ. (Navotna 2012). Thus the development of nurse-therapists is hindered, not by ability or law, but by their academic background.

In Switzerland the situation is even more complicated. The country is a Confederation if 26 cantons. To undertake psychotherapy training most cantons ask for education at university level (Master). However, in eight cantons previous study in psychology is mandatory, a further six cantons strictly define which equivalent qualifications, in combination with psychology, are required, whilst the remaining 12 cantons are more open in their 'equivalent' requirements.

The second factor is the type and modality allowed (for example, everything from basic counselling, through brief therapies and up to psychodynamic approaches) and the preparative training available. In Turkey, for example, there is no psychotherapy law nor traditional institutions or psychotherapists that provide systematic and institutionally-certified psychotherapy training. However, in the last 10-15 years special centres, psychoanalytic psychotherapy organizations/foundations and institutions, plus cognitive-behavioural therapy training centres, have started to appear and psychotherapy education certified by institutes abroad has also been allowed. As the psychiatrist is the professional responsible for regulating patient's treatment, most of these centres restrict training to psychiatrists, whereas a few admit psychologists as well. Even though suitably qualified PMHNs' ability to conduct psychotherapy has not gained full acceptance, some have started to enter training. As psychoanalysis and psychoanalytic psychotherapy is time consuming, expensive and with troublesome training and analysis processes, there is little demand for it amongst nurses who would rather work using cognitive-behavioural therapies and psychodrama. These nurse-therapists are then able to conduct therapies with patients in government organisations (Kutlu 2012). Thus, PMHN is not restricted by academic background (Turkey has a large higher degree trained nursing population) but by a combination of factors, including finances and availability of courses.

These two issues would seem to apply to all European countries, whether they have sophisticated post graduate or direct entry PMHN degree programmes or no programmes at all. The main problem appears to be whether or not national authorities have legislation concerning psychotherapy and if so that it allows, or precludes, PMHNs from undertaking psychotherapy training. There is nothing within

the extant literature which suggests that PMHN are not perfectly capable of undertaking even the most complex of psychotherapeutic activities. Indeed, in many countries around the world they have been doing so for a many years.

## 2. Training and Competencies

This topic has two sections. The first is that of the competencies required to undertake training as a psychotherapist; the second is the code of conduct that stipulates the need for on-going supervision and continuing professional development (CPD) required by professional/registration bodies to ensure safe and competent practice.

As stated above the EAP view inclusiveness, rather than exclusiveness, as the natural way to recruit to the ranks of psychotherapy. They do not differentiate between different professional disciplines and indeed go as far as to state that access to training should be via different professional routes. In this way it is envisaged that there will be a richness of experience that can only enhance the psychotherapeutic options available to clients. Given that there are 16 different forms of psychotherapy it seems almost impossible that one profession would be able to service all of these options and certain professions might be better equipped because of their specific training to be in a position to provide different forms of therapy. The type and style of the therapy will not only be dictated by the form used but also the client groups; thus children may benefit from having a therapist who was trained as a teacher, whilst young adults with long term abuse issues from the support of a psychologist. By default it would seem sensible for people with diagnosable mental illnesses to receive therapy from someone who has been trained in one of the psychiatric disciplines, i.e. a psychiatrist, a clinical psychologist, a psychiatric nurse or a psychiatric social worker. (the rationale for this is discussed at Point 3).

In European states there is no set approach to the recruitment of psychotherapists. Some countries have little or no regulation (e.g. Iceland, Belgium, Finland), whilst others are based on historical attitudes towards education and professional backgrounds (Germany, The Netherlands, Lithuania, Switzerland, Italy, Russia) and require the therapist to have either a psychiatrist or psychologist background. Some countries have yet to develop their psychiatric nurses to a cohort large enough to support further specialism (Slovakia). In other states psychiatric nurses are also added to this list but may require supervision from a psychiatrist to practice with specific patients (Croatia, Czech Rep.). The final group are those countries that have open access and follow the guidance of the EAP (Ireland, UK and to a certain degree, the Netherlands where by law every health professional should, in theory, have access to training as a therapist). Countries also have problems with health insurance companies who dictate who should and should not provide therapy (Switzerland, Germany, The Netherlands).

The critical issue is that of the level of training received by the potential trainee. The WCP recognise the EAP standards as their baseline, i.e. a background in human or social sciences, a total duration of training not be less than 3200 hours, spread over a minimum of seven years, with the first three years being the equivalent of a university degree. The later four years of which must be in a training specific to psychotherapy. Practical Training will include sufficient practice under continuous supervision appropriate to the psychotherapeutic modality and will be at least two years in duration. Placement must be in a mental health setting, or equivalent professional

experience. The placement must provide adequate experience of psycho-social crisis and of collaboration with other specialists in the mental health field (WCP 2012)

For nurses, access to training must be via a university degree in nursing, and specifically psychiatric nursing. Countries that do not have three-year undergraduate programmes to be psychiatric nurse cannot access training via this route. This explains the absence of nurse-psychotherapists in many European counties but should allow for those from countries such as Malta, UK, Ireland and Cyprus. In addition countries with advanced nurse practitioner (ANP) programmes (The Netherlands, Switzerland, Sweden) may also be recruited via this entry portal.

These underpinning qualifications are supported through the rules governing the recognition of professional qualifications as laid down in Directive 2005/36/EC concerning the recognition of professional qualifications (European Commission 2011)

The second issue is that of on-going CPD. This is not only the case for registered psychotherapists but supported by the European Council of the Liberal Professions which states,

*"Codes of Conduct should make it clear that professionals have an unequivocal responsibility to develop and maintain competency in their field of practice and to this end must participate in continuous professional development throughout their working lives"* p2 (CEPLIS 2007).

Any individual who has access to supervision through either their own professional or a national psychotherapy body should be in a position to fulfil this obligation. This applies to psychiatric nurses just the same as any other professional group. However, not all states have enough certified psychotherapists to be able to provide the necessary supervision (e.g. Malta, with a population of 400,000 has 51 registered ECP psychotherapists – 38 female, 13 male: Cyprus with a population of 1.2M has only 5 ECP psychotherapists, all female, with neither country having a WCP certified psychotherapist). This issue is not about whether nurses can undertake the required CPD but the national access to the number of certified practitioners able to support and supervise new members into the profession. (This is further addressed at Points 4 and 5).

In conclusion, it is perhaps worth noting that within Europe there is a lack of a uniform legal definition of psychotherapeutic activities in terms of the quality control of training courses or compliance with ethical codes and the national coordination of services. This is highlighted by van Broeck & Lietaer (2008) who examined psychotherapists in 17 European countries. They state:*"Eleven of these have adopted a legal regulation the title and the professional activities of psychologists in health care. Seven have an additional law regulating the title and the professional activities of psychotherapists. In five countries, professionals other than psychologists and medical doctors can obtain a legally protected title and license to practice as a psychotherapist"* (p53).

### 3. Total Care Package Monitoring

This issue relates to the ability of the psychotherapist to be able to monitor the interplay between the impact of psychotherapy with that of psycho-pharmacology and the patient/client's general mental state (including recognisable psychiatric symptomatology). Horatio would argue that a practitioner with background training in this area is more likely to be able to undertake this role. Indeed, medication management is one of the key roles of the PMHN (Horatio 2011) and no other discipline undertakes this role in all clinical environments and on a continuous 24/7 basis. Psychiatrists and *clinical* psychologists will also be able to evaluate mental health status against recognisable psychiatric disorders/illnesses, whilst psychiatric nurses will be accustomed to care management activities, care planning and clinical intervention. PMHN nurses would appear to be better suited to undertaking psychotherapy with those diagnosed with psychiatric conditions rather than other professional groups because of the breath of their previous training, education and practical experience. Issac Marks, a leading psychiatric/psychotherapeutic researcher, demonstrated as early as the 1970's that nurse behaviour therapists were as effective at delivering cognitive behavioural therapy as psychologists and psychiatrists (Marks 1977). At the time psychologists put forward a variety of reasons as to why nurses should not deliver this service, calling them *"cook-book therapists"* Currently, in the UK, 90% of all CBT therapists are from a psychiatric nursing background. In the USA, the provision of psychotherapy by nurses comes via the APN (Masters level and above) route, and in Australia and Canada similar developments are taking place though this depends on the territory and/or state.

There is no evidence to suggest that any one discipline has greater clinical efficacy than any other. What needs to be considered is whether or not a practitioner with a background in psychiatric nursing is better equipped to manage the total care package of a person with a mental illness and if this is more cost effective for employing authorities. The therapist who is able to feedback clinical data to the core psychiatric team does not require a 'third-party' as a go between, and therefore reduces the number of personal involved and the associated costs (plus increasing continuity of care).

### 4. EU Guidance

There is nothing within the EU Guidance, either from the European Commission or the EAP, that precludes suitably qualified practitioners, including psychiatric nurses, from undertaking training for, and practicing as, a certified psychotherapist. Indeed, the EAP have issued a template for national laws governing the training and certification of psychotherapists and this does not support the notion of a discipline monopoly (EAP 2009a). Governments wishing to formulate laws relating to the provision of psychotherapy within their own countries are advised to use this template so as not to violate the guidance approved by 128 psychotherapy organisations within Europe (28 national umbrella associations, 17 European-wide associations for psychotherapy) from 41 European countries.

### 5. Financial Implications

As mentioned at Points 1 and 2 above, there are cost implications for restricting the provision of psychiatric services to either one discipline or a discipline that does not have the background training in psychiatric care (not therapy alone). For example, a psychology undergraduate degree alone does not equip a person as how to be able to recognise the impact of medication and/or side effects on a patient's mental state nor

to recognise the increase or flow in subtle psychiatric symptoms. Specific training as a *Clinical* psychologist would be needed to be able to achieve this. Similarly, it would not be necessary for a psychiatrist to require additional training to recognise mental health status or psychopharmacological changes in a patient receiving psychotherapy.

Individuals who are not able to meet all the three criteria, i.e. psychotherapy certification, medication and care management experience and a practical understanding of psychiatric illness, will require additional training in the deficit area to be able to fully contribute to the total care package. This will require additional funding.

Also, in the absence of one of these three criteria an individual will need to be supported by additional staff to be able to complete the care continuum, especially within in-patient services. This has cost implications for both employing authorities (in the case of national health services) and medical insurance companies (in the case of private health care).

Even as early as the 1970's it was recognised that nurse-therapists could work with certain clinical groups in a more cost effective way than others. Ginsberg and Marks (1977) found that nurse-therapists were more cost effective than other disciplines in treating selected neurotic problems with significant and lasting reduction in patient distress plus economic benefits for employers.

### 6. Professional monopolies

As already stated, there is no evidence to suggest that any one discipline is better at providing psychological therapies than any other (Roth & Fonagy (2006). Results of the efficacy of psychological therapies must be investigated in a country-bound fashion to establish whether or not the therapies provided really do meet the needs of the population. Different countries will have their own successes and failures. However, to suggest that only one discipline can provide these therapies seems to suggest hidden motives on the part of that discipline. The EAP challenged Italian Law for professions other than psychologists to provide psychotherapy, and won the case.

For a country to place the responsibility of providing its psychotherapy in the hands of one discipline only, against all the evidence to the contrary and the guidance of both the EAP (2009b) and WCP (2012), does not make either clinical or financial sense. Questions such as the following need to be addressed: how many members of that one discipline are there available per head of population to be able to deliver a national service; is one discipline able to provide the full range of 16 different types of psychotherapy, what happens if this one discipline starts to dictate selection of psychotherapeutic forms thus potentially reducing the options available to both the client and/or the country as a whole and where is the local evidence to substantiate the monopolisation of a country's total package of psychotherapeutic care?

The American Psychiatric Nursing Association, in conjunction with the International Society of Psychiatric and Mental Health Nurses, saw the provision of psychotherapy by PMHNs as the "fourth P" of advanced nurse practitioners (the others being Psychopharmacology, Physical assessment and Pathophysiology) (APNA 2010). This position statement was not challenged by any other discipline within the broader health community of the United States of America, with its vast array of health

resources and the influence of health insurance companies. Why smaller nations within the EU should consider that they have the resources they need, through the use of one specific discipline, to provide for all its psychotherapeutic needs challenges the wisdom of the USA decision and the guidance of the EAP and WCP.

**Summary and Recommendations**

The situation concerning who should, and should not, deliver psychotherapies in Europe is both complex and complicated. However, the literature is quiet clear that PMHNs with the appropriate academic professional education can (and do) enter into psychotherapy training programmes and, when qualified, may be certified as psychotherapists.

Given the information contained within this document, Horatio recommends the following:

1. Entry to psychotherapy training should be open to all the Liberal Disciplines, including psychiatric nursing, for a country to be able to provide a full range of therapies.
2. Entry should be set at a basic undergraduate level (BSc PMHN)
3. Courses for psychotherapy certification should meet the criteria set by the EAP and WCP
4. Countries should not limit the provision of psychotherapy to one discipline for both clinical effectiveness and cost benefit reasons
5. Appropriately trained psychiatric nurse-therapists should be incorporated into mental health services especially where there are significant and complex mental health illnesses that require combined psychotherapeutic and psychopharmacological support.
6. Nurses who are not delivering psychotherapies but are supporting patients who are receiving them, should be trained as to how to compliment the work of the therapist.

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