

*Psychotherapy as a treatment option within the Irish health system: General
Practitioners experience with Psychotherapy in Primary Care*

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Abstract

Background Psychotherapy in Ireland remains, by and large, a privatised caring profession with only glimpses of its use in the public health system starting to happen in the last year or so.

Mental health issues affect every social class but are more prevalent among people of lower socio-economic status. This is for a range of reasons including the increased financial and social stressors experienced by that group. People in this group lack the funds to pay for private health care and are therefore at the hands of the public health system.

Ireland in the last twenty years has seen the energetic rise of the Celtic tiger as well as its ugly fall from grace, pushing many individuals and families into the lower socio-economic status bracket. The rise in poverty has seen many people give up their private health insurance. Moreover, this rise in poverty has seen a rise in mental health issues. GPs play a key role in the treatment of these issues as they see the majority of mental health problems in primary care. With more and more research being produced supporting the efficacy of psychotherapy for a wide range of mental health issues, it appears that there is a natural fit for the development of a good relationship between GPs and psychotherapy.

Aim The aim of this research is to examine where psychotherapy fits as a treatment option within the Irish health system focusing on the relationship between psychotherapy and GPs. Gaining information about GPs experience of psychotherapy and the health system as a whole will give clarity on how to strengthen the relationship.

Methods Semi-structured interviews were carried out with five GPs. The interviews were analysed using thematic analysis.

Results There is a division between private patients being able to afford private psychotherapy fees and public patients. There is a similar division between GPs who mainly deal with private patients versus public patients. Furthermore there is a lack of understanding about psychotherapy among GPs but at the same time know that it is beneficial to patients.

Conclusion GPs play a key role in managing mental health patients and therefore referring patients for psychotherapy. Further education is needed for GPs to fully understand the benefits of psychotherapy and the types of patients they can refer for psychotherapy.

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Chapter One – Introduction

1.1 Introduction

In this chapter the current relationship between psychotherapy and primary care will be identified, looking at the types of mental health patients that present to primary care, paying attention to how things are in Ireland with the public-private divide. Government reports will be pinpointed as they identify the need for change in the treatment of mental health patients in Ireland. There will also be a clarification of terms for the research, elaborating on what the medical model means and its enmeshment with psychotherapy's roots. Lastly the aims and objectives will be outlined.

General Practitioners (GPs) in primary care are a significant, relatively untapped potential authority for referring suitable patients for psychotherapy (Davis, 2009). The relationship between primary care and mental health is significant and there is a 'natural affinity' (Davis, 2009 p. 417) between the two since 90% of mental health issues can be dealt with at this level (McDaid, 2013). Patients present to general practice with many different mental health issues such as depression, anxiety, somatic symptoms or psychosocial issues where the use psychotherapy would benefit patients (Davis, 2009). Research has shown that psychotherapy has been effective for treating anxiety and depression (Crit-Christopher, 1992; & Crits-Christopher, 1998 cited in Davis, 2009) as well as vague medical complaints (Mayou, 2007 cited in Davis, 2009) and psycho-social issues such as marriage and work related issues (Davis, 2009).

The field of psychology has much to offer the mental health service user and psychotherapy remains an, 'integral component of evidence-based and guideline-consistent treatment for most mental disorders' (American Psychological Association, 2000 cited in Alexander, Arnkoff, & Glass, 2010 p. 191). However it has been documented that very few patients with anxiety disorders get referred for psychological treatments and this is across

Canada, the United States and Europe (Roberge, Fournier, Menear, & Duhoux, 2014). With one in four patients presenting in general practice with some anxiety disorder, and evidence suggesting they are not being referred appropriately, it begs the question ‘is it the same for other primary care mental health issues?’

These questions are complicated further in Ireland with the two-tier health system that exists, essentially the public and private health care system. Psychotherapy in Ireland is predominantly accessed privately by people who have the means to pay for the costly rates (Boyne, 2009). People who do not have the means to pay for psychotherapy rely on their GP or community mental health team (CMHT), guided by the medical model, otherwise known as the field of psychiatry. The CMHTs are often inconsistent in the services they provide and each patient/client is at the mercy of their catchment area and are often over-stretched.

People with medical cards are an important cohort as over 40% of people in Ireland have medical cards (Citizens Information Board, 2014). By the nature of the medical card scheme, card holders tend to be of lower socio-economic status (LSES). It is widely documented that people with LSES have more stress and are more likely to have mental health problems (Nitzarim, (2012) Levy & O'Hara (2010) Courtland (2007) World Health Organisation, (2001), Thompson, Cole, & Scarinici, Ames, & Brantley, (1999). Therefore medical card patients who are of LSES, because of their risk of mental health problems, need access to treatment options so that they can reach their full potential of health. Consequently it makes sense to have psychotherapy as part of the Irish health system and available to all patients both private and public, and in the primary care setting that is most fitting.

Recommendations in the report ‘*A Vision For Change*’ (AVFC) published by the Department of Health and Children in 2006, as well as the guidelines set out by the National Institute for Health and Care Excellence (NICE), which are considered the gold standard by the medical model, clearly promote psychotherapy and psychological therapies as effective

treatment options for people with mental health problems (NICE National Institute for Care and Excellence, 2015). Despite this clarity there is little movement towards psychotherapy becoming an integral part of the health care system in Ireland. The medical model remains dominant and there is a gap between those in need of psychotherapy and those who actually receive it due to psychotherapy being a highly privatized care service. The aim of this research is to find out if the primary care setting is the most appropriate setting for psychotherapy within the health system.

1.2 Clarification of terms

It is necessary to clarify specific terms and references before moving on. In this research the terms ‘patient’ and ‘client’ will both be used. The term patient will be used specifically in relation to the doctor/patient interactions. The term client will be used in relation to psychotherapist/client interactions. A general practitioner (GP) is a physician who provides routine health care in the community and has not specialized in one specific area of medicine (Health Care Providers, 2015). The terms general practice and primary care will be used interchangeably however the term primary care is also an umbrella term used to describe care provided in the community by GPs, public health nurses, social workers and other health care professionals (McDaid, 2013).

It needs to be clear about what the medical model means since this can be ambiguous, and as Freeth (2007) describes, can be used sweepingly. The medical model is a way of looking at mental health, or any ill health, in terms of a breakdown of a biological process, always looking at an organic cause for the physical or mental problem (Freeth, 2007). The medical model is facilitated by psychiatrists and GPs, and with interventions such as medication, electroconvulsive therapy (ECT), hospital admissions and involuntary admissions. Sigmund Freud, who is considered the father of psychoanalytical psychotherapy, started his career as medical physician and was driven by his medical background in treating

mental health problems as physical matter problems (Gomez, 1997). As Freud's work developed and time passed through the Victorian era he realized that some of his theories had an emotional connection rather than a purely physical/medical reason (Gomez, 1997). Therefore as early as Freud's work there was a change in the strict view of mental health problems being purely medical and there was a move towards recognising the importance of the emotional needs of mental health patients.

Psychotherapy use is increasing in Ireland, as in most other developed countries, however the medical model still has a tight control over the mental health care system in Ireland (Boyne, 2009). If the medical model has a strong hold over the mental health care system, psychotherapy needs to have a good working relationship with the medical model so that it can realise its potential and reach the people that need it. For this to happen the main bodies of psychotherapy need to come together and be united in putting themselves forward and promoting the benefits of psychotherapy not just for private clients but for public clients also.

1.3 Aims and Objectives

The aim of this research is to investigate where psychotherapy fits as a treatment option within the Irish health system for people with mental health problems. The research is focused on the relationship between General Practitioners and psychotherapy because of the large percentage of mental health issues managed at this level. The research seeks to find out if primary care is the appropriate place for psychotherapy to be provided for clients, both public and private.

The rationale for performing research on GPs is to get an insight into those GP's views and opinions, whether they have a clear understanding of what psychotherapy is, and how they view it. Bearing in mind the large amount of patients that present to GPs with mental health issues it is therefore important to understand GPs' views of psychotherapy,

whether they have had positive or negative experiences of it, and to clarify if they see it as an effective treatment option for patients.

A qualitative semi-structured interview was done with five GP to provide a deep understanding of their views. The semi-structured approach provided the space for evaluating experiences both positive and negative. The interviews also looked at the other links that GPs have with specialties such as orthopaedics to examine the relationship between secondary care and primary care in other situations. This approach provided opportunities to understand how to overcome any lack of clarity between psychotherapy and general practice as well as potential opportunities for strengthening the relationship between them.

Chapter Two - Literature review

2.1 Introduction

The literature review began with looking at the history of psychotherapy and psychotherapy in Ireland. The literature highlighted the importance of primary care to mental health as well as identifying the predominance of mental health issues with LSES clients. Further literature demonstrated evidence of the changes taking place within the health service for mental health patients, albeit there are a lot more changes and supports needed. From the literature it became apparent that while medicine and psychotherapy are very different professions, there is common ground which can help promote a better understanding of psychotherapy within the medical profession.

2.2 History of Psychotherapy

Psychotherapy is in its infancy in comparison to psychiatry. However, mental health problems have been around since antiquity. Looking at the history of mental health and who took control of looking after this group of patients begins to give clarity on where psychotherapy is today and where the relationship between the medical model and psychotherapy is less than ideal.

The care provided for people with mental health problems has changed dramatically since the opening of the first asylum in the middle of the 18th century (McLeod, 2010). Back then there were few, if any, therapeutic interventions available to the patients. Furthermore McLeod (2010) highlighted that the 1845 Asylums Act was put in place by public funds due to the increase in asylums being built. This was a reflection of the industrial revolution and a move towards capitalism leaving behind anyone who was not fully able-bodied, of sound mind, and able to earn money.

As history moved on McLeod (2010, p.23) identified how the medical profession began to see some benefit in taking over the care of the asylums, that is the financial gain due to the availability of public funds for the discrete management of the insane members of the upper classes. McLeod (2010) this as a pivotal time in the care for the mentally ill, “the defeat of moral treatment can be seen as a key moment in the history of psychotherapy: science replaced religion as the dominant ideology underlying the treatment of the insane” (p.23).

In 2015 there is a strong sense that psychotherapy is still fighting a battle against the medical model to provide care for people with mental health issues as a whole. The gap between psychotherapy as an effective treatment option and the medical model needs to change to not only benefit the clients receiving psychotherapy but also because of the cost effectiveness for the economy in the long run (APA, 2013)

2.3 Psychotherapy in Ireland

Ireland like most modern countries has seen a steady rise in psychotherapy availability in the last twenty years (Boyne, 2009). Similarly Ireland’s mental health care system and services available are dominated by psychiatry and the medical model (Boyne, 2009) and in Ireland that is delivered by the Health Service Executive (HSE). Boyne (2009) also recognizes that the area of mental health is under-resourced and lacking services in relation to the demand, lacking financial funding in comparison to other areas of health care as well as what he describes as “poverty of ideas” (p.10) in relation to mental health care changes.

Boyne (2009) neatly wraps up psychotherapy’s status in Ireland:

Psychotherapy is currently among the most privatized of all the caring services meaning that it tends to be availed of more by people in the higher socio-economic groups who have sufficient disposable income to pay private fees. By and large it is not available through the medical care system and it not easily accessible to those on lower incomes (p.10)

Currently in Ireland almost half the population receive a medical card (Citizens Information Board, 2014). Therefore almost half the population does not have the means to pay for their own health care needs including high psychotherapy fees. With one in every four patients that presents to a GP presenting with a mental health issue and the stark reality that 44% of all people will encounter mental health problems during their lives (either their own, or within family/friends) (About Mental Health, 2014) this is a significant chunk of the overall health care system services users. Therefore GPs need a wide variety of options available to offer their patients so that they have the best possible chance of recovery from mental health problems.

The World Health Organization cited in (Boyne, 2009) has outlined the universality and the impact of mental health:

“Mental and behavioural disorders are found in people of all regions, all countries and all societies. They are present in men and woman at all stages of the life course. They are present among the rich and the poor, and among people living in urban and rural areas” (p.23).

Up until 2014 psychotherapy was not provided by the general medical scheme (GMS). Psychotherapy is not covered by private health insurance (Jones, 2012). However a new scheme was started in 2014 called the ‘*Counselling in Primary Care (CiPC)*’ (HSE. Mental health- our services, 2015). This service is provided by the HSE under the umbrella of the National Counselling Service (NCS) which was set up in 2000 to provide counselling for those who have experienced abuse while in the care of the state (HSE. Mental health- our services, 2015). CiPC is a new branch providing counselling to patients through a primary care team. CiPC provides up to eight sessions for people over 18 and on a medical card (HSE. Mental health- our services, 2015).

While this is a major step forward, this program is very new; it is short-term work and focused on a target subset of the population. Interestingly, while there are over seventy therapists employed by the NCS the therapists that provide counselling through the CiPC

scheme are contracted in and not directly employed by the HSE (HSE. Mental health- our services, 2015). This suggests a lack of commitment on the government's/HSE's behalf in relation to providing other treatment options for mental health patients of Ireland.

2.4 Primary Care, Mental Health and the relationships formed

Primary care is the term that is used to refer to health care provided in communities by GPs, public health nurses, social workers and others in non-specialist settings (McDaid, 2013). It has been estimated that 90% of mental health issues are dealt with by the primary care system in Ireland (McDaid, 2013) and GPs are at the helm of primary care. GPs, unlike hospital doctors, have the advantage of having better knowledge of their patients because of the continuity of care that they provide (Stokes, et al., 2005). Continuity of care has different parts to it but is described by Freeman & Hughes (2010) as the relationship continuity of care and management continuity of care. Continuity of care provide by GPs is advantageous to certain types of patients such as mental health patients (Freeman & Hughes, 2010). It is important to recognize the value of the relationship fostered within the primary care setting between GPs and mental health patients. The importance of continuity of care echoes the importance of the therapeutic relationship. In psychotherapy as Kahn (1997) puts it, 'the relationship is the therapy' (p.1).

There are other similarities between medicine and psychotherapy. In psychotherapy there are over two hundred models of counselling and psychotherapy (McLeod J. , 2010). In medicine, while there are many disciplines, there are also four models of doctor-patient relationship: the paternalistic model, the informative model, the interpretive model and the deliberative model. (Emanuel & Emanuel, 1992). In the paternalistic model the doctor has taken a parental role and the main concern is towards interventions that best promote the health of the patient (Emanuel & Emanuel, 1992). While the informative model, the interpretive model and the deliberative model seek to gain insight into the patient's values

and beliefs (Emanuel & Emanuel, 1992), the paternalistic model is predominantly used (Goodrich & Wang, 1999). As the name suggests the paternalistic model assumes the role of the parent for the doctor while the patient, as the child, is the lesser in the relationship. It is from this disparity in the relationship that difficulties in understanding patient's particularly mental health patients can arise. There is research reporting that some patients do not disclose psychological problems to their GP because of the doctor-patient relationship or because of the doctor's attitude (Bushnell, et al., 2005). The gender of the GP also has a role in the care provided with female GPs more likely to suggest preventive services and to give more time to patients (Schmittiel, Grumbach, Selby, & Queenberry, 2000).

Mental Health Reform (MHR) is an agency advocating for people with mental health problems, looking in detail at issues that come up for them in primary care. Mental Health Reform's 2011 consultation with users of the mental health services raised some of the issues that the services users and their families had in relation to primary care. These issues included:

- Medication is often the only option offered
- The lack of access to counselling
- GPs not explaining the risks and benefits of medication that they are prescribing to their patients
- The need for GPs to be able to access counselling and psychotherapy for someone without having to go through a psychiatrist, and to be able to access Community Mental Health staff directly
- GPs lack of knowledge about mental health and the need for GPs to be more skilled in and knowledgeable about mental health issues (McDaid, 2013).

From the report there was very positive feedback with regard to the treatment people received by their GPs and there was a considerable suggestion that Irish people are more willing to attend with mental health issues (McDaid, 2013).

It is clear from this report that GPs play a vital role for people with mental health issues in Ireland. Furthermore access to counselling and psychotherapy is limited despite a strong desire from services users to have access to counselling and psychotherapy.

The AVFC report clearly outlined the need for the availability of more services such as counselling and psychotherapy (Department of health and Children, 2006). The report, similar to the MHR report, identified that most people present to their GP as the first step in getting formal help for their mental health issue (Department of health and Children, 2006, p.60).

AVFC outlines the importance of primary care for two reasons:

- Most people who present to the primary care setting, that is to the GP, with a mental health issue can be dealt with at the primary care level therefore primary care provides the majority of mental health care.
- GPs have access to community mental health and specialist services that most of the population need (Department of Health and Children, 2006, p. 23).

It was indicated in AVFC that there is a greater need for ‘psychological therapies’ to be available [such as counselling and psychotherapy] at a primary, secondary and tertiary level in recognition of the over reliance on medication (Department of Health and Children, 2006, p. 60).

Therefore GPs are a significant gatekeeper for most people in the community with mental health issues. Similarly GPs are in a great position to advocate psychotherapy as a treatment option for people with mental health issues once they have an understanding of psychotherapy and a reliable source for referral.

Since the AVFC report nine years ago there have been some changes such as the closure of larger institutions and patients being relocated to more community based services as well as the introduction of the CiPC scheme. Also in that time there have been enormous changes in the economy which undoubtedly have been an impediment to any developments. Van Hal (2015) describes how the summer of 2008 saw the beginning of the ‘worst financial economic crisis seen in decades’ (p. 17). Unsurprisingly the financial crisis is having a negative impact on mental health in people in Ireland and other countries affected by the crisis (Van Hal, 2015).

Evidence of decreased disposable income is reflected in the health insurance market which peaked in 2008 when 50.9% of the population had cover. An article at the end of 2013 indicated that the number had dropped to 45% of the population having health cover in 2013 (Bohan, 2013). This figure has probably changed since the introduction of the lifetime community rating for health insurance in May this year. While health insurance does not cover psychotherapy generally this drop certainly indicates a reduction in disposable income for the overall population.

Budget cuts to the health service have been regularly discussed in the media and within politics. Many frontline services and acute care settings have gone on strike and protested the cuts to services. This filters down to the primary care setting cuts. Any budget cuts in relation to mental health warrant review. In the last number of years suicide has increased in Ireland. A report using statistics from the World Health Organization (WHO) identified Ireland as having the highest rates of suicide in females and the second highest in males (Caollai, 2014). Therefore despite budget cuts mental health needs more funding and attention overall. WHO’s (2014) advice in relation to budget cuts:

‘...WHO’s call to all governments in our region: if you have to cut, cut wisely, not broadly, and protect the vulnerable to ensure universal health coverage. This is at the heart of the WHO European policy, Health 2020. Evidence shows that inappropriate cuts in the health sector can worsen the situation. At the same time, the health care

sector should do all it can to minimize wasteful spending and ensure that the resources available are focused on services of proven value' (p. 18)

The needs of mental health service users are complex. While psychotherapy is only one cog in the wheel of mental health in Ireland its voice is relatively unheard and remains fragile in comparison to psychiatry despite research supporting its effectiveness (Carr, 2009) (American Psychological Association, 2013).

With all this in mind, GPs, with the amount of exposure they have to people presenting with mental health issues, are key to giving psychotherapy the voice it needs in the Irish health system. Firstly GPs need to understand psychotherapy and be fully aware of the benefits of psychotherapy so that they feel comfortable and confident in referring for psychotherapy, whether the patient is public or private.

Psychotherapy with lower-socio economic status clients

Stress is a salient feature of being poor. The everyday stress of not having enough material resources invariably leads to more stressful situations (Courtland, 2007). Individuals on low incomes have a higher prevalence of mental health problems than the general population (US department of Health and Human services, 1999; Willaim & Collins, (1995) cited in Grote, Zuckoff, Swartz, Bledsoe, & Geibel, (2007). Therefore, it is important to address the issue of social class and whether people of lower socio-economic status (LSES) or people on the general medical scheme (GMS) receive psychotherapy.

Levy & O'Hara (2010) identified that the rate of mental disorders, particularly depression in women, is much higher in people with low-incomes. The World Health Organization (2001) cited in (Courtland, 2007) identified that “the poor and the deprived have a higher prevalence of mental and behavioural disorders... [and] individuals may be predisposed to mental disorder because of their social situation and those who develop disorders may face further deprivation as a result of being ill” (p.18).

It is widely documented that the low income groups suffer from higher rates of anxiety, depression and alcohol and drug abuse (Adler et al., 1994 cited in Thompson, Cole, & Nitzarim, 2012). Low income clients also have a higher risk of schizophrenia (Holzer et al., 1989 as cited in Scarinici, Ames, & Brantley (1999)

It can be seen that LSES people may be subject to heightened psychological distress, that distress may also impact their earning power, keeping them in an impoverished state (Courtland, 2007). Since psychotherapy remains a highly privatized service LSES clients are less likely to receive psychotherapy.

In the UK, Thompson, Cole, & Nitzarim (2012) noted that there is very little research within psychotherapy in relation to the LSES. Furthermore, Pope and Arthur (2009) cited in (Thompson, Cole, & Nitzarim, 2012) detailed that little is known about the subjective experience of these groups, most likely because so few are in psychotherapy (Kim & Cardemil, 2012). Carter (1991) cited in (Liu, et al., 2004) obtained results that identify social class as a meaningful cultural variable in psychology research that has been associated with effectiveness of psychotherapy.

Gallo and Matthews (2003) cited in Courtland (2007) make an attempt to understand the LSES client, identifying that there is a heightened relationship between negative emotional experiences and negative cognition in LSES clients. ¹ Javier & Herron (2002) describe, “the poor person is one who is need of psychological sustenance based on disruptions to the psyche that are part of deprivation” (p.151).

¹ Courtland (2007) suggests that being from a low-income group can advance negative attitudes and emotions because of continual stressful experiences. Because of the continual stressful experiences, LSES clients use their energy and resources quickly and deplete their financial and emotional reserves (Courtland, 2007). This may lead to a harmful cycle in which more stress results in progressively lower levels of functioning in several areas, and this ultimately leads to physical and mental illness (Courtland, 2007).

On a broader scale, Lott (2002) posits that there needs to be a focus on the poor because their treatment in society has major consequences for society as a whole. Lott (2002) outlines that it is not just the area of psychology and psychotherapy that creates a distancing from the poor; institutions in the fields of education, housing, health care and legal assistance, politics and public policy all also distance themselves from the poor. This reflects what is happening in Ireland with the two tier health care system where people who have the funds are able to access private psychotherapy.

Wang and associates (2005) as cited in (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007), “found that people with mental disorders, especially [...] those with low incomes, remained either untreated or did not receive minimally adequate treatment” (p. 296).

In 2002, before the current economic crisis, Walton & Grenyer (2002) highlighted how public money being spent on mental health was decreasing. They suggested that, ‘no modern industrialized society’ (Walton & Grenyer, 2002, p. 418) can meet the healthcare needs of the public without rationing, which inevitably leads to a reduction in individual psychotherapy for LSES clients.²

Smith (2005) identified psychoanalysts as having a history of being very selective in the clients they choose to analyse. The idea that psychotherapy is not for the poor is deeply rooted in psychoanalysis. Freud (1913) stated that, “analytic therapy is almost inaccessible to the poor, both for external and internal reasons”. He further emphasized that, “anyone who tries to deal with the neurosis of a poor person by psychotherapy usually discovers that what

² Smith (2005) identified the political influence in the USA on the availability of psychotherapy for LSES clients. In the 1960s with John F. Kennedy supporting the development of Community Mental Health Centres (CMHC) and with federal funding there was an increase in research in mental health and CMHC were to increase to two thousand nationwide. However in the 1980s the Reagan administration did not advocate Kennedy’s plans and of the two thousand planned CMHCs only seven hundred and fifty were established and all struggle financially (Smith, 2005). Today with the Obama

is required of him is a practical therapy of a very different kind” (p.133). Freud does however recognise that not every poor person can be defined in the same way: “one does... come across deserving people who are helpless from no fault of their own, in whom unpaid treatment does not meet with any of the obstacles that I have mentioned and in whom it leads to excellent results” (p.133).

Altman (1995) as cited in (Smith, 2005), “addressed the classism and racism that are embedded in psychoanalytic theory and practice and described the use of a three-person model for psychoanalytic practice that incorporates the influence of social system” (p. 690).

In Javier & Herron’s (1992) paper they challenged the traditional view that psychoanalysis is not for the poor. They put forward that this assumption can only be made after “careful and objective analysis of the individual’s psychological capacity” (p. 455). This suggests that there is room for a more equality driven approach of psychoanalytical psychotherapy for clients of all income levels, despite psychoanalysis’s deep roots within the middle and upper classes. Javier & Herron (1992) had the following to say, “Writing them [LSES clients] off as untreatable psychoanalytic patients is distorted discrimination rather than either diagnostic or prognostic efficacy” (p.456). This indicates that the psychotherapy profession as a whole needs to move away from its classist roots and be more open to treating people from all backgrounds. This is true now more than ever before given the rise in mental health problems and the knowledge that increased mental health issues have a knock on effect for the economy as a whole.

2.5 Change is in sight

As already mentioned there have been some positive changes made by the government such as the introduction of the CiPC scheme. There is further evidence of change

administration bringing healthcare reform and the Patient Protection and Affordable Care Act passed in 2010, will there be further reductions in funds available for mental health overall.

happening, particularly in the area of psychotherapy and primary care. A seminar in 2012 called ‘*Building bridges between psychotherapy, general practice and primary care*’ was a strong indicator of the possibility of change. One of the key speakers was Professor Bill Shannon. He was the president of the College of General Practitioners and has trained as a psychotherapist. At the seminar Professor Shannon expressed his clear support for psychotherapy as a treatment option within the primary care setting. However he was very clear about the changes that psychotherapy needs to make before this happens. Jones (2012) reviewed the seminar and made recommendations including the following:

“...psychotherapy needs to present its efficacy and profile to the public...requires medical endorsement...associations need to set out a clear and solid set of professional standards...clarity and transparency in relation to professional standards...psychotherapy is currently not sufficiently evidence based or research not adequately utilized in presenting the work of psychotherapy to the public and GPs”
(Irish Association of Humanistic and Integrative Psychotherapy [IAHIP], 2012)

Contrary to the suggestion that psychotherapy is not sufficiently evidence based, there have been some clear reports highlighting the effectiveness of psychotherapy. A report by the American Psychological Association (2013) outlined that psychotherapy is effective across most diagnostic conditions; psychotherapy clients are less likely to require additional treatments; the benefits of psychotherapy continue beyond the treatment time; and most importantly and surprisingly, psychotherapy is cost effective.

Similar extensive research was done by Professor Alan Carr, commissioned by the Irish Council of Psychotherapy (ICP). In summary the review of the research found that psychotherapy is not a placebo but actively aids recovery (Carr, 2009). Carr’s (2009) review of the research found that “38% of the effects of psychotherapy are due to the therapeutic alliance” (p.38) which is at the heart of psychotherapy.

Research carried out in the US looked at the views of fifty-two senior health care system administrators in regard to the changes in the private versus public care for psychiatry (Frueh, et al., 2012). Frueh, et al., (2012) spotted a change in the US with a move towards

more privately funded mental health care impacted public state-owned psychiatric hospitals (p.2). Frueh, et al., (2012) named the reasons for this move as “changing attitudes towards mental illness, deinstitutionalization of the severely mentally ill, growth in the number and types of mental health providers, and expanded insurance coverage options” (p.2).

Adding to this, Foley et al., (2006) cited in Frueh, et al., (2012) recognized that there was a large reduction in public beds since 1970, when 80% were public compared to 27% in 2002 (p.2). Moreover, private psychiatric hospitals are now closing with a move towards outpatient care (Frueh, et al., 2012, p. 2). Frueh, et al., (2012) deduced that the viability of a psychiatric facility [private or public] is a complex system and is dependent on the quantity and quality of community services, including outpatient psychotherapy, linking that if there are sufficient community services [including psychotherapy] acute psychiatric beds should be lower (p.3). This indicates that there is an overall need to move most psychiatric care to the primary care setting.

The research found that hospital stays were longer than needed because of the lack of discharge options as well as acute beds being used inappropriately because of limited resources therefore indicating that community mental health services need to shoulder the weight to help shorten hospital stays (Frueh, et al., 2012, p. 12). Furthermore political and economic reasons were identified as the driving force for bed reduction rather than the demand (Frueh, et al., 2012, p.13). Not surprisingly it was also noted that decisions like this, coupled with the lack of community services, have led to gaps in public mental health care (Frueh, et al., 2012, p13). This problem sounds familiar and echoes what is happening in the Irish health system. In Ireland changes are happening in individual health sectors, not across every health sector (HSE National Vision for Change working group, 2012 p. 15). Therefore if you live in one catchment area you could be offered more services than if you lived in another catchment area.

Another interesting nugget of information from Frueh et al, (2012) was that across the board there was a severe lack of funds to support deinstitutionalization which means more funds are needed for community services (p. 13). Political barriers were also identified with legislators not being aware of the high cost burden of mental health on the economy (Frueh, et al., 2012, p. 14). In Ireland it is estimated that the direct annual cost of poor mental health in Ireland was €3 billion in 2006, or 2% of GNP (About Mental Health, 2014).

Recommendations were made to increase coordination between the outpatient services and the acute psychiatric beds, highlighting again that acute care does not work in isolation (Frueh, et al., 2012). Similar to the Irish health system (Frueh, et al., 2012) identified that “very recent empirical data support the efficacy of a range of psychotherapeutic interventions for adults with severe mental illness yet these interventions have not been widely implemented in public health systems” (p. 17).

2.6 Accepting differences for progress

The main framework of the medical model is assessment, examination, diagnosis and treatment which as Freeth (2007) identifies is at odds with psychotherapy (p.33). Freeth (2007) explains further that using the medical model framework, that is to say applying treatment aimed at eliminating symptoms, is not always aligned with the practices of psychotherapy.

The NICE guidelines are considered the gold standard in health care for the medical model and they outline Cognitive Behavioural Therapy (CBT) and ‘interpersonal therapies’ on the pathways for many mental health disorders (NICE guidelines, 2014). This is a move in the right direction for psychotherapy as a treatment option putting psychotherapy on the radar of the health system. However as Freeth (2007) criticizes there is an over-reliance on diagnosis of mental disorders and therefore disorder-specific treatment by the NICE guidelines (p. 34). More specifically the NICE guidelines based on a biomedical model in

relation to mental health patients in primary care, essentially treating mental health patients the same as patients with physical health problems (Guy, Loewenthal, Thomas, & Stephenson, 2012). This has led to a reduction in choices available for service users and excludes many forms of psychological therapies such as psychodynamic approaches (Guy, Loewenthal, Thomas, & Stephenson, 2012). This medical framework fits poorly with the relationship-centred therapies and lacks the recognition of the individual. Holmes cited in Freeth (2007), states “psychotherapy is concerned with people in a developmental context and cannot be reduced to the technical elimination of disorders” (p. 35).

The medical model favours scientific approaches such as CBT which are easy to measure (Scott, 2010). Therefore to prove effectiveness to the health care system psychotherapy needs to have clear empirical research. Sandell, Andersson, Werbart, & Levin (2013) clarify that the effectiveness of psychotherapy, and how it is practiced in the community, is important not only for the clients receiving it but for politicians, public health-service managers and the psychotherapists themselves (p. 119). Kendall (1998) as cited in (Sandell et al, 2013, p. 119) reiterates the point advising that for psychotherapy to be part of the health care system there needs to be more empirical evaluation of psychotherapy. As well as that, better understanding of how therapy works in practice may help clients get individually tailored treatment interventions and help close the gap between research and practice (Kazdin, 2008; Norcross, 2002 as cited in Sandell et al, 2013, p119). It can also give clearer options for clients (Hoglend, 1999 as cited in Sandell et al, 2013).

The Clinical Outcomes in Routine Evaluation (CORE) have asked important epidemiological questions in the UK and found that in the National Health Service (NHS) different psychotherapies have the same effectiveness (Stiles, Barkham, Mellor-Clark, & Connell, 2008a as cited in Sandell et al, 2013). Similar studies in Ireland could further

support Professor Carr's review of the research in presenting psychotherapy's case to the medical model.

Currently psychotherapy remain unregulated. The Irish Council for Psychotherapy (ICP) is working with the government to create a new registration board to regulate the professional status (Irish Council for Psychotherapy, 2015). ICP is a professional organisation representing five of the main approaches of psychotherapy including psychoanalytical psychotherapy, constructivist psychotherapy, humanistic and integrative psychotherapy, couple and family therapy and cognitive-behavioural therapy. (Irish Council for Psychotherapy, 2015). One of the largest bodies of counselling and psychotherapy professionals, Irish Association for Counselling and psychotherapy (IACP) does not come under the umbrella of the ICP. Perhaps if the two bodies could amalgamate this would give more strength to the profession, more funding for research.

Change is happening, albeit slowly. Recognition of the use of psychotherapy by the medical model is starting to happen though the access to counselling and psychotherapy remains limited. GPs are in a particularly good position to make use of access to and knowledge of other options available to their patients as most mental health issues can be treated in primary care (McDaid, 2013).

2.7 Bringing it all together

To summarise, historically there has been a divide between the medical model and psychotherapy. Similarly there is lack of cohesion between the two main psychotherapy representative bodies. Mental health is a significant part of the health system overall and is costly to the economy. However, most people with mental health issues can be treated cost effectively in the primary care setting with GPs as the custodians of 90% of mental health issues. Despite an increase in empirical research demonstrating psychotherapy's effectiveness, and the recommendations from AVFC, MHR and NICE, there appear to be

very few psychotherapy options for patients in primary care. One exception to this is the new introduction of the CiPC scheme, though it is limited and only available to over 18s with a medical card.

This indicates that there needs to be a coming together of the different psychotherapy bodies to present themselves collectively to both the medical profession, mainly GPs, and to the political powers that control funding so that psychotherapy can grow from its limited position in the private health care sector and develop its role in primary care where the vast majority of mental health issues are managed.

Qualitative research investigating the relationship between GPs and psychotherapy will give a clearer understanding of where psychotherapy fits within the Irish health system.

Chapter Three - Methodology

3.1 Introduction

In this chapter the methods used to do this research will be outlined. The design of the research enquiry was re-evaluated since its inception and will be noted. The aims and objectives will be briefly re-stated as well as the rationale for adopting a qualitative narrative research approach. The sample of participants will be established and clarified with a table of demographic information. The method of data collection and data analysis will also be outlined. Lastly the ethical considerations for the research will be described.

3.2 Design

Originally the research design proposal was for a mixed methodology approach. This approach would have both qualitative and quantitative parts. The quantitative part would be a survey of GPs to gain a quantitative knowledge of the numbers of patients they see and how many they refer for psychotherapy. For example:

Do you refer patients for psychotherapy?

If yes, how often do you send patients for psychotherapy?

(See appendix 1 for the full list of proposed survey questions). However the database for GPs is protected. Also GP practices that have websites do not have email addresses therefore the process of getting the questionnaire to an appropriate number of GPs for analysis was very difficult. It was more productive to focus on a qualitative research design for this sample. The qualitative part of the research involved semi-structured interviews of five GPs.

A qualitative research approach is most appropriate for this research question as it seeks to gain insight into the knowledge and experiences of GP with regard to how they see and experience psychotherapy.

A narrative research inquiry was used to gather the information. Narrative research can take many forms and is rooted in social science and humanities (Dauite and Lightfoot,

2004 as cited in Creswell, 2006 p.53). Narrative research inquiry in the context of qualitative research, and in relation to this piece of research, is appropriate as it lends itself to focusing on the specific stories told by individuals (Polkingham, 1995 as cited in Creswell, 2006) and in this case GPs.

‘Narrative [inquiry] is understood as a spoken or written text giving an account of an event/action or series of events/actions, chronologically connected’ (Czarniarsk, 2004 p.17 as cited in Creswell, 2006). Furthermore (Creswell, 2006) confirms the appropriateness of narrative inquiry: ‘...researchers may use paradigmatic reasons for a narrative study such as how individuals are enabled and constrained by social resources, socially situated in interactive performances and how narrators develop interpretations’ (p. 56).

For the narrative research inquiry of this research five GPs were interviewed. The interviews were semi-structured, recorded and lasted no longer than an hour. The semi-structured interview is advantageous as it allows space and time for ideas and narratives to unfold.

3.3 Sample group

The sample group of participants were fully qualified and registered GPs or those near the end of their training as a GP in Ireland. There were five participants in total used for the research interviews. The participants were selected randomly from the *Irish College of General Practitioners* (ICGP) website.

The recruitment of the sample was done by letters, which were sent out to the GPs practices. Approximately a week after the letters were sent out a follow-up phone call was made to each practice to see if any of the GPs were interested in taking part in the research interview. One GP was recruited this way. Four of the participants were recruited by word of mouth from the researcher’s place of work and friends who knew GPs. Essentially the sample

became a snowball sample where the existing participants recruit other acquaintances (Explorable.com, 2009).

A gender balance was attempted to be made with the sample as the four recruits gained through word of mouth were male. Forty-two letters were sent out, eighteen of which were sent to male GPs and twenty-two were to female GPs. This is important as research indicates the male and female doctors in primary care have different ways of dealing with patients (Schmittiel, Grumbach, Selby, & Queenberry, 2000).

3.4 Method of Data Collection

The data was collected through semi-structured interviews which is in line with the narrative research inquiry, gaining deep knowledge of the individuals being interviewed. The interviews were held at a time of the interviewee's convenience in their surgery where privacy was maintained for four of them. One of the interviews was carried out in the home of the GP as this was the most convenient place to do the interview. There was no one else present in the home at the time to facilitate privacy for both the interviewer in the questions asked and for the interviewee in his answers. The interviews were recorded with a Dictaphone.

Before the interview started each participant was given an information sheet about the interview and the research question (See appendix 2 for a sample of the of the information sheet). The participants were also given a consent form to fill out and sign (See appendix 3). A short factsheet was also requested to be filled out by the participants with some brief information about themselves and the number of patients they see each week (See appendix 4). See below for the information from the factsheet that was collected from the five participants.

3.5 Demographic information of participants

Pseudonym	Sex	Age Group	Years practicing as a GP	Number of patients seen a week	Number of patients with mental health/psychological problems seen a week
Dr. Stewart	M	65-74	41	160	4-5
Dr. Hennessey	M	55-64	35	100	30
Dr. Murphy	M	45-54	24	100	25
Dr. Kelly	M	45-54	25	200	50
Dr. Flavin	M	35-44	3	150	10

For each interview there were twelve questions with some prompt questions to guide the information (See appendix 5). The interviews lasted between forty-two and sixty minutes. Once the interviews were complete, the recorded interview was uploaded onto a laptop that is password protected that only the researcher has access to. The recorded interviews on the Dictaphone were deleted. As per the data protection guidelines anonymised data was used as per the Data Protection Act 1988 and 2003, safeguarding the individuals with regard to the information and personal data (Hawkes, 2007). The interviews were then transcribed and the analysis began.

3.6 Method of Data Analysis

Thematic analysis was identified as the most appropriate method of data analysis. Thematic analysis seeks to pinpoint and analyse themes that have a pattern in the research data (Braun & Clarke, 2006). One of the benefits of thematic analysis is that it is flexible (Braun & Clarke, 2006). Thematic analysis is fitting for this research since the interviewees bring such diversity to the data as well as a wide scope of different topics from the research question itself. It is through this diversity that such rich data can be provided but at the same time by using thematic analysis processes impart theoretically and methodologically sound approach (Braun & Clarke, 2006).

The interviews were transcribed making the researcher very familiar with the data. This is the first step in the process of thematic analysis (Braun & Clarke, 2006). In the next step of the process each interview was colour coded into themes and subthemes. Braun & Clarke (2006) describe how a theme represents something of significance from the data in relation to the research question. Each theme was selected by the commonality across the five interviews as well as the relevance to the research question (Braun & Clarke, 2006). The themes were also analysed at a latent level which looks at more than just what is being said (Braun & Clarke, 2006). There were approximately twelve themes that demonstrated relevance to the research question as well as a significant pattern in the data set. Each coded theme was revisited and renamed into a smaller subset of themes. The interview was then put into a spreadsheet (See appendix 7 for sample of analysis) where it was clear to see the relevance and appropriateness of the three themes.

3.7 Ethical Consideration

A research proposal was prepared in May 2014 and submitted to the ethics committee of the department of Psychotherapy at Dublin Business School, School of Arts on behalf of the researcher by the research coordinator. Ethical approval was then granted for the research to proceed. Due to time constraints and difficulty in accessing an appropriate number of GPs to conduct a quantitative approach to data collection, the approach was revised and a qualitative approach was adopted. The research proposal included interviews with psychologists and psychiatrists but it became clear that focusing on one profession, namely GPs, would give better clarity and focused the material for the research.

As mentioned above each participant was informed about the research by letter prior to any research being conducted. On the day of each interview an information sheet was given to each participant to read carefully and the interviewer highlighted the main points again verbally. Reassurance was given in relation to anonymity of each interview and it was

highlighted to each participant that a pseudo name would be used and that no personal or identifying information would be used. It was also noted that they had the right to withdraw from the study at any time.

Chapter Four - Results

4.1 Introduction

In this chapter the results and findings of the five semi-structured interviews and the short factsheet information given by the GPs immediately prior to the interviews will be examined. Many themes and subthemes arose from the interviews. Braun & Clarke (2006) describe how a theme is a topic that relates to the research, holds value to the research question, and usually has a pattern within the dataset. In this research, due to the breadth of themes offered by the GPs, three themes were picked and examined in relation to the research question. Due to the openness of some of the questions, and the fact of interviewing GPs who deal with such a wide variety of issues, some interesting but irrelevant topics came up such as nurses pay, the smoking ban, childhood obesity and respite problems for families.

The three themes that will be discussed are:

1. Continuity of care and the relationship with patients in general practice
2. Mental health services in Ireland: treatment, services and perceptions
3. The views and experiences of psychotherapy in general practice

The first theme was a dominant theme present throughout all five interviews. It illustrated each GP's desire to connect with their patients and have face-to-face time with them. The second theme honed in on the specific area of mental health in general practice and highlighted some of the issues facing GPs when referring anyone on for specialist treatment. The third theme focuses on the experience, or lack of thereof, that each GP had in relation to psychotherapy. It seeks to clarify whether GPs understand the process of psychotherapy.

4.2 Fact Sheet information

The fact sheet information proved to hold some interesting and relevant information. See Appendix 5 table 1. Dr. Stewart said he saw 4 or 5 patients per week with psychological or mental health issues. This is approximately 2% of his patients for the week. This figure is

significantly lower than the other GPs who saw between 25 and 50 which equated to 25-30% of their total number of patients they saw. Dr. Stewart very clearly offered the information that he felt he could not be a psychiatrist and finds dealing with patient's depression difficult and monotonous.

Dr. Stewart: I cannot understand how anybody could go into psychiatry. Because it's the same all the time. In general practice you have 15 different things on a morning, you know from, urinary tract infection, hypertension, pregnancy, obesity, arthritis, tonsillitis, otitis media, rosacea, you have them across the board, and that's very interesting. Whereas if you are with somebody who's depressed and you're with them for half an hour and the next patient comes in and they are depressed and you're with them for another half an hour, you'd want to be very very strong mentally to deal with that, in my opinion. Under no circumstances could I ever be a psychiatrist! Couldn't do it! Might be it short term, but I'd just find it too depressing"

Dr. Stewart's significantly lower estimate of the proportion of patients presenting to his practice with mental health problems, in comparison to others, is hard to ignore. The difference suggests that he is avoiding, or not reflecting truthfully, the numbers of mental health issues in his practice. It also suggests discomfort in handling his own negative feelings. Dr. Stewart is displaying signs of cognitive dissonance where he has some conflicting attitudes, beliefs and behaviours (McLeod S. , 2014). These conflicting beliefs are producing feelings of discomfort for Dr. Stewart (McLeod S. , 2014). While clinical supervision is not a routine part of medical practice, this is evidence of the importance of both personal therapy and supervision in the field of psychotherapy.

Dr. Hennessey recognized this need to have some form of mentor/supervisor:

Dr. Hennessey: It is a demanding job and about having access to health for themselves... like psychotherapists are very good at that, like that they have a relationship with a mentor or somebody that they would go to from time to time and to an extent that used to happen to an informal extend in practices.

Dr. Flavin, the youngest GP with just three years training under his belt, also identified a lower number of patients presenting with mental health problems. Of the one

hundred and fifty patients he sees, he believes just ten have mental health problems. Dr. Flavin also expressed that he felt pressured for time when dealing with mental health patients.

4.3 Continuity of care and the relationship with the patients in general practice

A prevailing theme throughout the five interviews with the GPs was the continuity of care that they are able to provide in general practice to their patients. Continuity of care in general practice allows GPs to foster closer relationships with their patients (Stokes, et al., 2005). Continuity of care becomes more important for certain categories of patients including those that are at risk psychologically (Freeman & Hughes, 2010).

Dr. Stewart was very clear from the outset about the importance of the continuity of care. Dr. Stewart was also the longest practicing GP and had taken over the practice from his father. His wife also practiced in the same surgery.

Dr. Stewart: Medicine I felt, would suit me in terms of general practice, ah, I never had any interest at all in, surgery ah I wasn't really interested in hospital medicine, I suppose and the reason for that was is continuity of care, you know, somebody, if you are in hospital medicine, you see a patient and they're in one week and they're gone, and you wouldn't see them again, no continuity.

Continuity of care has two parts to it, the *relationship continuity* and the *management continuity* both of which can be applied to services provided by a GP. The relationship continuity as described by Freeman & Hughes (2010) is considered to be, 'a continuous therapeutic relationship with a clinician' (p. 4) and the management Freeman & Hughes (2010), 'continuity management including providing and sharing information and care planning and any necessary co-ordination of care required by the patient' (p.4).

Continuity of care in general practice not only gives the GP better knowledge of their patients but has also been linked to increased satisfaction for the care received by the patient and job satisfaction for the GP (Stokes, et al., 2005). Furthermore continuity of care has been documented to have increased positive health outcomes for patients because they are more

likely to take preventive services and to comply with treatments (Stokes, et al., 2005) and therefore reduce costs (Freeman & Hughes, 2010).

Dr. Stewart continues to describe the therapeutic and longevity aspect of the continuity of care.

Dr. Stewart: I suppose the actual friendliness and camaraderie that you have with your patient, the loyalty that the patients have is absolutely amazing and like there are people in this practice that have been with the practice for over 60 years they were here with father and my wife when she was here. but what I think is fantastic about general practice you see kids grow up, you see them born, you see them through childhood, you see them through early adulthood, and then you see them as parents and they're back in again when they have children of their own and there is a cycle you're involved in. and I think that just, that it is a very special relationship and it's something you like or you don't, and I Just love, dealing with people, I find people very interesting.

Similarly

Dr. Hennessey: Well I think the, it's a different type of professional relationship than the one you would experience in the hospital context because you do get to know people very well overall over a very long extended period of time. Like I'm seeing people in this practice that I've seen for 35 years.

However on the other side of things and with the changing nature of general practice due to the need for rapid access to services and larger group practices becoming more common place, continuity of care is not always feasible (Freeman & Hughes, 2010). Freeman & Hughes (2010) have highlighted the importance of continuity of care and how it needs to be addressed by professional leaders and also not taken for granted by the GPs themselves.

These changes in practice were addressed in the interviews and featured as a real concerns for the GPs

Dr. Hennessey: I would be concerned about the future, like the nature of general practice is not going to change. I've often discussed with my friends like people like ourselves we're the last in the line. One of the reasons a lot of people come to us here is because they can't get to see the same doctor. You know they go to a group practice and you don't have a sense of having a relationship with your own personal doctor I think the nature of all that is changing, because the doctors that we train are not staying. You know, there's a whole cohort who went through their postgraduate training in recent years, and they're gone they're not in Dublin or anywhere in Ireland they're gone to Australia they're gone to Canada. And the way practice is developing, the support, well the pressure is really more on larger group practices.

Quality, I think there won't be the same level of continuity of care there. There won't be the same level of individual personal care there.

Another interviewee who shared similar concern but added other difficulties stated:

Dr. Stewart: GPs I think there's going to be a shortage of GP's, because a lot of them are around my age, and in the next 10 years there is going to be a huge number of them retiring. You have females ah, probably the predominant force in medicine now particularly in general practice and, they're am and as they are entitled they like to work part-time they want to marry they want to have families and they want to, to work part-time. And that is a problem when you are trying to cater for big numbers so I don't know how, how, how it will be managed, and this is why we have all these doctor coming in from abroad to fill the gaps, and you only have to look at the paper to see some of them, have an awful lot to be desired, now some of them are pretty clueless and they are desperate to get doctors here. They are employing, and even after interviewing, you'd wonder, you'd wonder how they do it. Some of the things you'd read in the paper, every day, fit to practice before them. I think they ah if they can invest more money in primary care they will get better value for money because it is cheaper to provide care, it's cheaper for a GP to treat a pneumonia in [Name of area where he practices] than it is in the Mater or Beaumont hospital.

Interestingly the popular concern that many doctors are leaving the country was supported by one of the GPs expressing a desire to leave the country.

Dr. Flavin: I got into this game to see patients to try make them better you know and but it just seems to be less and less that and more about the paperwork and following up and less face-to-face time with the patients, which is where we all want to be, we all want to be sitting seeing patients diagnosing treating as opposed to writing forms and letters and ringing making phone calls, you know on the phone all day am so that's the bit, that's the bit annoys me a lot. That's the bit that probably going to force me away for a little while until I see where things are going so it is [sic]. It's a pity, because it is a hugely enjoyable job life and that time in sessions where you are just seeing the patients is very very enjoyable. Am but it just am doesn't balance up at the moment.

It is evident from the findings of the research that continuity of care is important to GPs. Continuity of care is also a salient component of the care needed by mental health patients (Freeman & Hughes, 2010). Continuity of care has health benefits for the patient and job satisfaction for the GPs. Nonetheless changes in general practice are evident and necessary and the interviewees are aware of this but at the same time know not to lose continuity of care as it is such a valuable part of general practice.

4.4 Mental health services in Ireland- Treatment, services and perceptions

The five interviewees had widely varying experiences of mental health services. The difficulty in accessing services was a common theme. There was also a clear split between public and private patients being referred for psychotherapy at primary level. Essentially private patients who had the means to pay for psychotherapy services were referred on for psychotherapy. Public patients were not referred for psychotherapy and were instead referred to a psychiatrist.

Dr. Murphy directly addressed the issue of access to psychiatric services and also identified how access to services for other specialty areas can work whether public or private.

Dr. Murphy: From the mental health point of view, there is a huge lack of a link between primary care and secondary care. I've noticed that... Compared to, say for example orthopaedics where there's a very good link. Like if I had an orthopaedic problem, a minor problem, I know exactly who to contact whether they are public or private I can get things sorted fairly quickly.

Dr. Flavin described his experience of the services being both stretched and restrictive in referring for psychotherapy.

Dr. Flavin: Am so anywhere I've worked so far to refer them for psychotherapy you usually had to go through the psychiatry team first off, [they were] very strict on that. Galway where I've been in up until a few weeks ago was very very restrictive with GPs. Every service is massively stretched down there so generally to get any sort of therapy they went to psychiatry first, [they] were seen then assessed and then referred on if needed... If they were private they organized something privately themselves but outside of that it was very very difficult.

Dr. Stewart had a similar approach to psychotherapy when asked about his experience of referring for psychotherapy.

Dr. Stewart: Basically, we would be referring to psychiatrists initially and then they decide what they need, and they can refer them in that direction. That would be my approach to it. I'd like them seen by a psychiatrist and try and get a diagnosis or a direction and that's what I would tend to do.

Two of the GPs described their practice as being mostly private practices and therefore they were very aware of the privileges that came with that especially in relation to psychotherapy.

Dr. Murphy: You see we're lucky here, we're largely private so we can basically offer whatever they can afford and what is good [is] we have a psychotherapist here part time 3 times a week she[is] a psychoanalyst[sic] psychotherapist and we have a CBT chap who works in Pat's mainly but he comes here once or twice a week mainly.

Time was another key feature for the GPs in relation to mental health patients. There was a strong recognition that more time was needed with mental health patients than most other patients. Dr. Stewart had a very clear view of this.

Dr. Stewart: ...mental health is difficult, because it's time consuming, and if you [...] try and treat someone who has mental health problems in a short space of time you'll fail.

Dr. Flavin also talked about the time needed with mental health patients and was open about the impact that has on him and the practice.

Dr. Flavin: My biggest issue with the consultation [with mental health patients] is that the consultation cannot be done, you need minimum half an hour. So you get something like that into the middle of a busy Monday morning or a busy Friday afternoon and it's quite difficult. I don't enjoy the pressure that comes along with that (laugh) because you are always anxious of the people who are sitting out in the waiting room but you're also very conscious of the person that's in front of you to give them the appropriate consultation and make sure that you've gone through everything with them but I suppose that's just, I do enjoy it but that pressure that added pressure it puts on you it's quite difficult.

The perceptions that the GPs had of mental health patients was mixed. During the interviews the umbrella term of 'mental health patients' was used unless a specific group of patients was brought up by the interviewee. Dr. Kelly had a specific view of personality disorder patients when asked which patients he found the most challenging.

Dr. Kelly: Personality disorders (PD) and there's a lot of them about... You tend to have very few successes in the treatment modalities and depending on the PD they tend to be a very frequent visitor. Some of them never come which is fine but the ones who are very frequent visitors and they are a very difficult people to deal with. Because nothing you do is going to work anyway. They are not really interested in getting better anyway. They have a particular agenda which can be difficult to categorize. They are the most difficult group.

There is also a mixed view of the treatment options available for mental health patients. There was, in spite of this, a general consensus that the drugs today used are better and have less side effects for the patients.

Dr. Murphy: Yeah, yeah... and the SSRIs SNRIs I mean there's, we use them they're very good and certainly since I started medicine, there's a huge revolution in comparison to what we call the dirty drugs of old, they're clean. And yeah, and they do certainly from a biochemical point of view work but they're not the panacea. But unfortunately a lot of doctors have a tendency to prescribe them as an easy option, they work as a lot of people in our clinics they may not have a biochemical basis to their problem, it might psychosocial, it might be that they have no job or whatever, maybe a bad marriage or whatever you know. It may not necessarily be a something that needs medicine.

The experiences the GPs had with community mental health teams were mostly positive but the GPs had very little contact with them. The community mental health teams were closely linked with psychiatrists rather than the GPs.

Dr. Murphy: Generally speaking no, zero is the answer... it's a bit like all domiciliary public services are overstretched.

Dr. Hennessey when asked about his experience with the community mental health teams was very direct.

Dr. Hennessey: I don't really, not now. I would have in the past again in my former practice [had experience with the community mental health teams] ... sometimes I haven't found, the experience has been very mixed... it's been very productive very helpful, and other times it's been less than helpful or the therapy and been entirely focused just on drug treatment with very little other support.

GPs have a lot of exposure to mental health patients, but the services and treatments available are not consistent. Mental health patients also take up more time in general practice which can put GPs under more stress and sometimes influence their perception of certain patients.

4.5 The views and experiences of psychotherapy in general practice

Each GP's experience of psychotherapy varied. The GPs who distinguished their practice as being predominantly private had more experience with referring patients for

psychotherapy. Interestingly there was also a distinct lack of understanding of psychotherapy by all the GPs despite some of the GPs having on-site psychotherapists.

Dr. Murphy: *I think if you get a good therapist who's very practical and not airy-fairy and can help people in a practical way that they can take away [with them] rather than someone who is more intellectual, who is not on their wavelength.*

Dr. Hennessey had the best understanding of psychotherapy and yet had bracketed CBT in with psychotherapy when asked specifically 'what type of patients he referred for psychotherapy?' His answer has a lot of pauses and he repeated words with a mild stammer.

Dr. Hennessey: *I'd send a lot. Well pretty much anyone who is depressed... people with phobias or people with anxiety or people with panic attacks, actually sleep disorder as well CBT can be very useful in that regard am.*

Dr. Hennessey: *... one of the main benefits from psychotherapy and CBT [is] you're equipping the person with the skills that makes them self-reliant.*

Dr. Kelly was unsure of the role of the in-house 'counsellor' when asked about his experience of sending patients for psychotherapy he responded with:

Dr. Kelly: *Well we have an in-house counsellor but whether they get psychotherapy, psychoanalysis, I don't know, I'm not 100% sure. They get something I don't even know what that is, but they get something. I don't know if there is a formal structure put there.*

Earlier in the interview he added to the confusion of this person's role by speaking about psychology.

Dr. Kelly: *... I have an in house counsellor and two in house trainee psychologists as well...who are training under her.*

Despite this lack of understanding there was an overarching positive view of psychotherapy and the benefits it has for patients as well as more long term potential cost saving for the HSE.

Dr. Murphy: *There's a huge roll for psychotherapy, full stop you know. It's a question of how it's funded really. Here...we fund it ourselves because patients pay for it, the service it works [well] that way on a private model.*

Dr. Hennessey: *The main services we would use we find them extremely useful because they are a group practice. So they have different people with different skills sets within one practice. We would use them a lot, because when we'd refer the person on they would meet one of the partners who would be a very experienced psychotherapist ... So that's the main service we'd use in the private context we'd have a very positive experience, and we've [been] using them for a number of years.*

Dr. Stewart, who did not refer patients for psychotherapy, did refer patients for CBT. He would be happy to learn more about it to improve the GP patient relationship.

Dr. Stewart: *You can get it [CBT] both, private and public and like the public hospitals... usually they'd have patients usually on both medication and CBT. CBT does a lot of good in 80-90% and 10% say it's a waste of time and you'd expect that.*

Dr. Stewart in response to being asked if he would like to know more about psychotherapy:

Dr. Stewart: *Yes, yes I would, I certainly would, there's room for improvement everywhere, there's room for improvement between the patient, the consultant, the GP and consultant, the GP and the patient.*

Dr. Murphy was very direct in seeing a link between having more talk therapies and how that could overall reduce the costs to the HSE.

Dr. Murphy: *We had no counselling service available unless they went through the psychiatric services medical route and left primary care and some HSE driven ... that they could cut back on the drug bills if they employed a few counsellors and psychotherapy and other area modalities*

There was also reference to how education in relation to psychotherapy and the types of referrals accepted could help strengthen the relationship between both professions.

Dr. Flavin: *I suppose, firstly, education. Letting GPs know kind of who should be referred... what the benefits are, what exactly is involved... 'cos I think the better the understanding that we have of it, the more, not that you need to sell these things but I suppose you do at times but you know you can pick up the patients that it's going to be of benefit to, the kind of cohort that may respond to that sort of treatment, so education [of GPs].*

Dr. Flavin also emphasized that having psychotherapy in primary care can benefit the patient and support the GPs in their decision making.

Dr. Flavin: *I suppose for us again... a liaison person that could be down the corridor and that you'll be able to say or to pick up the phone to and say 'lookit I'm thinking*

this, what do you feel?' And if it's a counsellor, you know, look I think he needs to be seen by psychiatry or whatever it would be.

Dr. Flavin: I would have had that...when I worked there in one the primary care centres where you have the community mental health team there, you know, you would meet them in the corridor and say you know 'lookit what do you think'

4.6 Summary

The results from the interviews highlighted that across the participants, the relationship or the continuity of care that a GP is able to provide at primary level, in comparison to hospital doctors is important to each GP. Continuity of care gives the GPs better knowledge of their patients.

For GPs dealing with mental health patients the time needed to give to these patients was a concern. The GPs expressed frustration in relation to limited access to treatment options besides drug therapy. It was also noted that for public patients options are limited to referral to the public psychiatrist.

The experience the GPs had with community mental health teams was limited and services they provided were inconsistent and closely linked with the psychiatry rather than the general practice. These services were also thought to be over-stretched.

The experiences the GPs had with psychotherapy was diverse and delineated between public and private practice. There was a clear lack of understanding in relation to psychotherapy and confusion in relation to different approaches and professional roles. With that said there was a generally positive opinion about psychotherapy and a willingness to know more and to be more closely linked with general practice.

Chapter Five - Discussion and Conclusion

5.1 Introduction

The aim of this research is to examine where psychotherapy fits as a treatment option within the Irish public health system focusing on the relationship between psychotherapy and GPs. As GPs deal with a large proportion of mental health issues at primary level (McDaid, 2013) gaining information about GPs experiences with psychotherapy and the health system as a whole will give clarity on how, if possible, to strengthen the relationship with both professions and to identify if primary care is where psychotherapy fits.

In this section the results from the interviews will be interpreted. Firstly, the experience of doing the interviews with GPs will be described and discussed. Following on from there the three themes extrapolated from the data set using thematic analysis and presented in the results section will be discussed in relation to the literature, theory and the research question. The prominent themes are:

- Continuity of care and the relationship with the patients in general practice, this is a key element of the role of the GP, knowing their patients better than hospital doctors and also creating a positive bidirectional relationship.
- Mental health services in Ireland- Treatment, services and perceptions was a theme that highlighted the divide between public and private patients, and the difficulty in accessing services from primary level.
- The views and experiences of psychotherapy in general practice was again reflected in the delineation between public and private. There was an overall lack of clear understanding of psychotherapy however the GPs had some awareness of the benefits of psychotherapy and its appropriateness for primary level.

5.2 The experience of the interviews

The experience of doing the five interviews left the interviewer with many different feelings. For three of the participants, the interviewer was left with an overall positive feeling and enthusiasm for the research. However two of the participants left the interviewer with the feeling of being a burden. During the interview when there was any brief space both participants wanted to rush to the next question: 'So go on there' pointing to the clip board in the interviewer's hand with the questions. This also influenced the interviewer and how some of the questions were asked. This level of discomfort left little space for elaboration on some of the answers being given. Both of these interviews were approximately forty minutes in length in comparison to the other that were almost an hour in length.

This feeling of being rushed is likely to be a mirroring of the busyness that the GPs experience every day in general practice and the pressures of having to get through many patients in a short period of time.

5.3 Continuity of care and the relationship with the patients in general practice

Continuity of care is at the heart of general practice and primary care (Stokes, et al., 2005). For a GP there are different parts to the umbrella term including personal continuity, information continuity and management continuity (Stokes, et al., 2005). The collaboration of these elements creates a relationship with patients that not only benefits both doctor and patient but also contributes to cost effective health outcomes (Stokes, et al., 2005).

Continuity of care and the relationship with patients in general practice is comparable to the therapeutic relationship co-created in psychotherapy dyad. The therapeutic alliance has been well-documented for its importance across many approaches to psychotherapy (McLeod J. , 2010). Akin to the different parts of the continuity of care provided by GPs, the therapeutic relationship is described as having many layers: the working alliance, the

transference, the real relationship, the reparative relationship, the transpersonal and the contextual relationship (Lapworth, Sills, & Fish, 2001).

Bordin's (1979) model of the therapeutic relationship elaborates further on the relationship. Bordin (1979) was influenced by psychoanalysis and took some of the basic elements of the psychoanalytic relationship, but made the language more user friendly (McLeod, 2010). Goals are the 'shared articulation of the desired outcome' and to define the direction the therapy is taking. Tasks are the 'specific activities that the partnership will engage in to facilitate change'. The goals are mutually agreed by the therapist and client. Bonds are 'a sense of common commitment and a shared understanding in the activity'. This is the containment for the therapy (Lapworth, Sills, & Fish, 2001). Bordin was able to identify the importance of the therapeutic alliance as it provided a theoretical justification for the value of the real human part of the relationship (McLeod, 2010). McLeod (2010) suggests that Bordin was trying to develop a theory that would transcend any specific therapeutic approach.

There were concerns about the future of general practice among the GPs because of the move towards larger group practices and the reduction of the continuity of care which is a crucial element for each GP. Therefore from the findings it can be extrapolated that the kinship between the therapeutic alliance, for psychotherapy, and the continuity of care, for the GP, means that environment of primary levels is fitting for psychotherapy.

On further interpretation of the role of continuity of care for the GPs, many of the participants expressed a dislike for hospital medicine and enjoying more the autonomy of working by themselves as well as the loyalty given to them by their patients. It is worth evaluating the role that each GP gives themselves. In an ideal world the doctor-patient relationship would be one of equality where a person needing medical treatment would seek

assistance from a medical expert. In reality that relationship historically lacked equality and is ripe for many unconscious processes.

The researcher was aware of the difference in how doctors approach patients and how psychotherapists approach clients. From the outset of training psychotherapists are advised to be aware of the power imbalance in the work (Zur, 2014) and have the guidance of supervision to help prevent any abuse of the position. Supervision is not a mandatory part of medical practice. However both profession, however they approach the patient/client, want the same thing: for the person to feel better and live their lives to their full potential. The position that each profession takes up is indicative of this difference, and of how individuals and society sees psychotherapy in comparison to the medical profession. It also highlights the fragility of psychotherapy as a profession.

The paternalistic model of the doctor-patient relationship, which according to Goodrich & Wang (1999) is still used among doctors, sees virtually all the patient's power handed over to the doctor. Compliance is a central theme in this model and the word compliance itself suggests an imbalance of power between doctor and patients (Goodrich & Wang, 1999). Compliance strips the patient down to behaviour that needs to be controlled by the doctor (Goodrich & Wang, 1999).

Moreover from a psychoanalytical viewpoint the relationship between doctor and patient is evidence of Lacan's theory of the four discourses, particularly the Master discourse. Lacan's theory is based on fundamental relationships which create certain social bonds (Verhaeghe, 1995). The agent, the person speaking, is the master-signifier, in this case the doctor. Lacan posits that the master-signifier is presenting as master of myself and is pretending to be undivided, the whole self, and tries join the second signifier at the place of the other which in this case is the patient (Verhaeghe, 1995). This causes a division between the two and the hidden truth for the master, the doctor, is that he is divided (Verhaeghe,

1995). The master-signifier, the doctor, has knowledge and the second signifier needs to sustain this master (Verhaeghe, 1995). Commonly the master reduces the patient to an object of his knowledge (Verhaeghe, 1995). In the doctor-patient relationship the doctor has the medical knowledge unlike the patient maintaining the master discourse.

There are some contradictions to the idea of the continuity of care being akin to the psychotherapeutic relationship and that is evident in the disparity that exists in the doctor-patient relationship (Goodrich & Wang, 1999). There is a new model, the Candib model, which acknowledges the inequality and also looks at similarities between student-teacher relationships (Goodrich & Wang, 1999). This model draws from the idea that the teacher strives to give the student autonomy and attempts to enhance the power of the patients (Goodrich & Wang, 1999). This model also lends itself to understanding the patient and creating empowerment through the interactions of the doctor and patient (Goodrich & Wang, 1999).

5.4 Mental health services in Ireland- Treatment, services and perceptions

From the findings the GPs had different views and experiences of what percentage of their overall patients presented with mental health issues. This is identified in the fact sheet information (See Appendix 5). Nationally it has been documented that a third of GPs said that 10% of their patients had mental health issues and a third stated that 10-20% of their presenting patients presented with mental health issues (Coptly, 2004 as cited in McDaid (2013)). A study just a few years later by Doherty, et al. (2007) as cited in (McDaid, 2013) stated that 30% of patients presenting had some degree of psychological distress. Given this data and the change in the economic crisis since 2007 it is more likely that the number of people presenting with mental health issues is more in line with the 30% than the lower values given by two of the GPs.

While all of the GPs were aware of the variety of issues that may present there was also an explicit expression that most mental health issues can be treated at primary level. This is reflective of the literature and reports including the AVFC report and the MHR report which identified that 90% of mental health issues are addressed at primary level (McDaid, 2013). Coptly (2004) as cited in McDaid (2013) listed the common mental health issues in primary care, anxiety disorders 49%, depression 24%, and emotional difficulties 20%.

Another finding from the interviews was that time pressure was a principal factor when dealing with mental health patients. This added pressure influenced the GP's perceptions of mental health patients who might need more than the usual allotted time for each consultation. This is reflective of the literature where GPs have expressed that they could treat mental health patients better if they had more time and increased support (Coptly & Whitford, 2005).

When this issue of time came up during the interviews there was a feeling of pressure and weight felt in the room. While there was never a mention of mental health patients being 'heart sink' patients, in actual fact two of the GPs expressed an aversion to the phrase:

Dr. Murphy: You see I would see challenging patients as a challenge. So I don't, I don't believe in this 'heart sink' sort of acceptance that some GPs have.

There was a heaviness present during that part of the interview. On a cognitive level the GPs were being politically correct in the face of the nature of the interview however on interpreting the transactional exchange during the interview there is a less favourable view of mental health patients.

Dr. Stewart's view was that patients deal better with cancer than they do with depression. His view was a very medical view of the patients. Dr. Stewart also spoke highly of the drugs used for mental health patients today and referred patients for CBT and not for any other form of psychotherapy. This suggests that Dr. Stewart himself is more suited to dealing with things that are more tangible or solid, and perhaps relies on diagnostics such as

scan results and treatment pathways. Which is very different from the psychotherapeutic relationship where the therapist goes solely on what the client brings to them.

Accessing services was another essential component of the findings with a division between public and private patients. The language used by the GPs confirmed the disparity between services with Dr. Murphy expressing pity for the public patients because the public patient has limited options.

Dr. Murphy: So from a private point of view, there's plenty of good people out there. The poor public fella with a medical card, struggles a bit.

Dr. Hennessey also had a parapraxis adding the word 'avoid' into the sentence when talking about public mental health teams. Freud (2001) described parapraxis as a, 'slip of the tongue' (p. 25) that can happen to anyone, it can also be something written or something read, and for that instance the person believes that thought or wants to see something that is not written. It is thought to reveal unconscious wishes or attitudes (Freud, 2001).

Dr. Hennessey: So we wouldn't have much involvement and in my experience people who have money who can avoid afford private care usually don't go to public mental health teams.

Dr. Hennessey in using the word avoid he is saying 'stay away' from something that he unconsciously wishes for his patients, that they keep away from, in this case, the public mental health system.

Putting aside the public-private divide, all the GPs expressed frustration at the difficulty in accessing psychiatric services as well as a lack of respect in relation to the referrals from the hospital psychiatric services. These findings correlate with the MHR report in 2011 compiled by services users and their families. It was highlighted in that report that service users were concerned that GPs could only access counselling and psychotherapy through the psychiatric services (McDaid, 2013). It was also noted that GPs did not have any direct links with the community mental health teams (McDaid, 2013). Moreover the services

users also felt that GPs lacked enough knowledge about mental health issues (McDaid, 2013). This was not evident in the interviews with most of the participants expressing their own feelings of comfort and competence in dealing with most mental health issues at primary level.

Dr. Hennessey: A lot of the time in mental health, is that we work quite competently to deal with them... the vast bulk of mental health issues can actually [be] dealt with in general practice.

Dr. Murphy: Ah yeah, the rest of them [mental health patients] are easy enough. You're serious enough psychotics once they are stabilized or even when they are not stabilized they are relatively easy and straightforward to deal with.

Dr. Flavin: I think most GPs, a lot of us are quite comfortable to a point.

The difference between the GP's own opinions in comparison to the report from the MHR is highly suggestive that GPs find it hard to accept that they might not have the knowledge to deal with the various types of mental health patients that might present in general practice. It has also been documented that GPs lack enough psychiatric training (Coptly & Whitford, 2005).

5.5 The views and experiences of psychotherapy in general practice

Dr. Stewart did not have experience of referring patients for psychotherapy except for CBT. He referred patients to psychiatry if he felt that they needed specialist treatment. It is not surprising that Dr. Stewart's estimated number of mental health patients was lower than the other GPs and the national average of 10-20% (Coptly, 2004 as cited in McDaid (2013)). He also experienced all depressions as the same, was an advocate of the drugs used for mental health patients and believed that people handle cancer better than depression. While Dr. Stewart was positive in his response when asked if he would like to learn more about psychotherapy, he moved quickly on to a different subject that suited him better.

Dr. Stewart: Yes, yes I would, I certainly would, there's room for improvement everywhere, there's room for improvement between the patient, the consultant, the GP and consultant, the GP and the patient, you know people are different, and ah some people, am and some people might have an interest in psychiatry, say ah, I'm very interested in old folk, I really really enjoy for what it's called geriatrics

It is clear from the data that Dr. Stewart has a very medical view of patients and is focused on getting a diagnosis.

Dr. Stewart: what I try to do [with mental health patients] is get inside their heads and see what way are they thinking and you try and get a diagnosis.

There is strong evidence that Dr. Stewart is in denial and avoiding the real number of mental health patients. If Dr. Stewart had more education about psychotherapy then he would be able to refer patients for psychotherapy without going through the psychiatric services which is what the services users want. It has been documented in the literature that GPs overall have insufficient training in the area of psychiatry (Coptly & Whitford, 2005) which correlates with the findings of this research. According to the ICGP website, GPs in training do a four month rotation in psychiatry during the four year training (North Dublin city GP Training Scheme, 2015).

It is worth noting that Dr. Stewart was recruited by word of mouth and therefore did not specifically have an interest in the research question, rather he was doing a favour for someone.

Dr. Hennessey also demonstrated some ambivalence in relation to referring patients. In the first part of the interview he vocalized that he would refer a wide variety of patients for psychotherapy but in the latter part of the interview he expressed a low referral rate either for psychotherapy or psychiatry and also a desire to hold onto patients and to use drug therapy.

Dr. Hennessey: I suppose the more simple less dramatic presentations you might deal with exclusively yourself and not need referral. You know somebody who has a reactive depression to some event in life you don't need to send them anywhere. Seeing them yourself and giving them some advice and some pointers and maybe using medication as well might be appropriate and you might not need to refer on.

Since time pressures are a significant issue for GPs (Stokes, et al., 2005) one would think that referring on patients for psychotherapy, even for short term work, would support GPs with regard to this growing concern as was the result of a study of GPs in Ireland in

2005 (Coptly & Whitford, 2005). Therefore there is evidence of it being difficult for GPs to let go of their patients. This is suggestive of a master discourse playing out in the doctor-patient relationship. In holding onto their patients the GPs are maintaining their own power.

5.6 Summary

The research asks ‘Where does psychotherapy fit within the Irish health care system?’ examining if primary care is an appropriate place to provide psychotherapy. Continuity of care is at the heart of general practice and benefits both doctor and patient. This is paralleled in psychotherapy by the therapeutic alliance which is the foundation of psychotherapy particularly Humanistic and Integrative psychotherapy (Lapworth, Sills, & Fish, 2001). The vast majority of mental health is provide by primary care and there in a national move to provide as much care as possible for mental health patients in the community (McDaid, 2013). GPs are under tremendous time pressure to see patients as quickly as possible and mental health patients can often take up a lot of their time, tainting their view of this cohort of patients. While GPs are aware that psychotherapy benefits patients they do not understand psychotherapy and are confused by different roles and professions. This mounting evidence sees that psychotherapy does fit in primary care, albeit for this amalgamation to happen GPs need further education and training on the use of psychotherapy, the benefits it has, and the types of patient they care refer for psychotherapy.

5.7 Conclusion

The primary aim of this research took slightly a different approach to a psychotherapy research question. Rather than explore psychotherapeutic experiences the aim of this research was to take a broader look at psychotherapy’s place, if at all, within the Irish health care system. It was essential to focus on one area of the health system so as to produce clear and focused data. It was also important to consider where the most appropriate place is for psychotherapy within the health system. That focus was primary care. There is extensive

literature stating that the majority of mental health issues are managed at primary level. With a deeper understanding of the relationship GPs have with psychotherapy and mental health as a whole it was possible to establish that primary level is one good place to provide psychotherapy. Therefore psychotherapy does have a place in the primary care level of the Irish health care system. However the conditions need to be right for psychotherapy to be provided at this level.

While GPs are the driving force behind primary care they are under extreme time pressures when dealing with mental health patients who have been shown to take up more time than other patients in primary care. This can sometimes skew the GPs their views of this cohort of patients. GPs overall lack clear understanding about psychotherapy, about how it works and what's involved. Therefore for psychotherapy to be married into primary care, which appears to be the most appropriate place for it, doctors need more education and training on its use and benefits for patients.

5.8 Strengths and Limitations

The researcher was aware of the limitations of the study. The sample size of five participants was small therefore the results and finding of this research cannot be generalized. As this research was a qualitative study, the small set of participants allowed for in-depth information to be gathered which can be seen as a strength.

It should also be noted that there was some 'snowballing' in the recruitment of the interviewees, and a lack of organic interest in the research question itself by some the participants – this may have reduced the opportunity for richer findings.

The bias of the researcher must also be acknowledged. The researcher, as a trainee psychotherapist, has a desire to have this research question answered.

From the letters sent out, one male GP responded positively to take part in the research interview. Many GPs cited that they were too busy or that they did not have an

interest in the subject. However of the GPs who declined five responded personally by phone to express that they could not take part and one sent a letter back to say that this was not an area of interest for her.

5.9 Recommendations

Recommendations for further research are to do the original quantitative part of the study, which is a survey of GPs to find out the how many GPs refer patients to psychotherapy. Also, to facilitate the broader question of ‘where psychotherapy fits as a treatment option in Ireland’, gaining understanding of the experiences of psychiatrists would give a clearer view of how or if psychotherapy fits within the Irish mental health care system at secondary level. Finally research with psychotherapists who currently work in primary care or with GPs, examining their experiences, would help answer the broader question from the therapist’s point of view.

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Appendices

Appendix 1 - Questions for survey

1. What is your age?
2. How long have you been practicing as a GP?
3. Where did you do your GP training?
4. How many patients do you see a week?
5. How many patients do see a week with mental health or psychological problems?
6. Do you refer patients for psychotherapy?
7. If yes, how often do you send patients for psychotherapy?
8. Do you have a psychotherapist you would regularly refer patients to?
9. Do you think psychotherapy is effective?
10. How often do you refer patients to the community mental health team?
11. Are the same services available in each community mental health team?
12. Would you like to see more psychotherapy available to patients?
13. Does a patient's level of insurance/GSM status influence the referral type?

Appendix 2 - Information sheet



INFORMATION FORM

My name is Michelle MacSweeney and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with the relationship between GPs and psychotherapy. I will be exploring the views of people like yourself who work in Primary Care as GPs in Ireland.

What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a GP. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions but this is unlikely to happen.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in

scientific publications.

Name of Participant (in block letters) _____

Signature_____

Date / /

Appendix 3 - Consent form



CONSENT FORM

Protocol Title:

An Investigation into where Psychotherapy fits within the Irish health system with a focus on the relationship between General Practitioners and psychotherapy

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes **No**

*I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.*

Yes **No**

I understand that my identity will remain anonymous at all times.

Yes **No**

I am aware of the potential risks of this research study.

Yes **No**

I am aware that audio recordings will be made of sessions

Yes **No**

I have been given a copy of the Information Leaflet and this Consent form for my records.

Yes **No**

Participant _____

Signature and dated

Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them.

Signature

Name in Block Capitals

Date

Appendix 4 - Factsheet

1. What is your age? Please tick

25-34

35-44

45-54

55-64

65-74

74+

2. How long have you been practicing as a GP?

3. Where did you do your GP training?

4. Approximately how many patients do you see a week?

5. Approximately how many patients do you see a week with mental health
or psychological problems?

Appendix 5 - Demographic information about GPs

Pseudonym	Sex	Age Group	Years practicing as a GP	Number of patients seen per week	Number of patients with mental health/psychological problems seen per week
Dr. Stewart	M	65-74	41	160	4-5
Dr. Hennessey	M	55-64	35	100	30
Dr. Murphy	M	45-54	24	100	25
Dr. Kelly	M	45-54	25	200	50
Dr. Flavin	M	35-44	3	150	10

Appendix 6 - Semi-structured interview questions

Questions for interviews

1. Can you tell me what attracted you to the field of medicine and particularly to being a GP?
(Prompt question: was there any particular element of being a GP? How important do you think the relationship is for treating patients)
2. Is there an area of medical practice that you feel is ever lacking in primary care support i.e. Obstetrics, paediatrics, oncology, psychiatry etc.
3. How would you like to see this amended?
4. From your experience what patients do you find the most challenging in your practice?
5. Can you tell me about your experience of treating patients with mental health problems at primary level?
(Prompt question: have you seen a change in how treatment is provided for patients with mental health over the years?)
6. What in your experience has shown to have positive outcomes for patients with mental health problems
7. What treatment options do you offer to your patients with mental health issues?
8. Can you tell me about the community mental health teams and your experience with them?
9. Is there any changes that you would like to see in the area or mental health in primary care?
10. Do you have any experience of referring patients for psychotherapy? And if so how did you find the experience for you and for your patient?
(prompt questions: did you have any feedback via your patient positive or negative? What type of patients do you refer you for psychotherapy?)
11. Can you tell me anything that you believe would be useful to strengthening the links between psychotherapy and primary care?
12. Is there anything else you would like to add, or anything you would like to speak about?

Appendix 7 - Sample of analysis of transcript

Speaker	Line no.	Transcript	Analysis	Interpretation	Theme
Interviewer	35	And Can you tell me about your experience of treating patients with mental health problems at primary level?			
Dr. Flavin	36	Dr: Flavin: Am so yeah i mean you would do. Am you see its something that we are seeing more and more coming through am and that's from you know from young adolescents all the way up.	MHP can be anyone		Mental health
Interviewer	37	Am so a hell of a lot more depression anxiety am so it's certainly i have noticed that kind of maybe once a upon a time you were seeing kind of 2-3 cases whereas now you see up at around 10- 15. am so and then, there's the problems that go along with that.			Mental health
Dr. Flavin	38	Am my biggest issue with the consultation is that the consultation cannot be done anything in that first presentation. you need minimum half an hour. So you get something like that into the middle of a busy monday morning or a busy friday afternoon and it's it's quite difficult.	The time it takes with MHP	He seems to have an 'issue'	Mental health
Dr. Flavin	39	I don't enjoy the pressure that comes along with that (laugh) because you are alway anxious of the people who are sitting out in the waiting room but you're also very conscious of the person that's in front of you to give them the appropriate consultation and make sure that you've gone through everything with them but i suppose that's just, i do enjoy it but that pressure that added pressure it puts on you it's quite difficult.	Maybe because he is new at it	If he doesn't enjoy the pressure maybe hs dose not want to see how many pts have some mental health element to their problems	Mental health

Interviewer	40	have you seen a change in how treatment is provided for patients with mental health over the years?			
Dr. Flavin	41	Am medicine wise... not a huge amount i'd have to say am. Still coming out of a lot of the same things am it kinda of just depends on the consultant who's using what but in general no not a huge amount difference in therapies.	A sense of letting the consultants lead the way		Drugs
Dr. Flavin	42	Again the biggest issue is getting access to talking therapies is quite difficult and that's not only, you know a lot of that's down to the patients the patients are slower to buy into that side of things i think than am, you know they go 3/4 times and they feel it's not doing them any good so they stop going am or else they have waited so long for it, they've kind of become fed up with it and things have moved along on a different path for them am but you know.	Access to services	The GP can only do so much, the person needs to want to get better or at least buy into the talk therapy	Experience with psychotherapy
Dr. Flavin	43	Certainly medicine wise i haven't seen any changes am so i haven't, i suppose there's just so much more coming through the system now that waiting times and getting access to the other treatments can be difficult.	Access to services		Mental health
Interviewer	44	What in your experience has shown to have positive outcomes for patients with mental health problems from either drug therapy or talk therapy?			
Dr. Flavin	45	am I suppose the biggest benefit i've always noticed and that's dual therapy. am so you know medicine has a point to play too, to a point. It's always going to be a bit of a war, (laugh) i always say this to the patients like, the medicines there and it work on the background but it, it's not going	pts have to want to get better	Not letting go the medical part of treatment	Experience with psychotherapy

		to be the reason you get better am so the main best responses i've seen from patients are the patients who buy into their, whatever their counselling or their therapy or CBT or whatever the helping prescribed, people who buy into that get a good relationship with their therapist am and are willing and want to you know find a reason to why they feel the way they are am you find i mean, i think that they just take off and it's its fantastic to see am. whereas people who don't who are medicine medicine medicine they get worked up they get more medicines up to 3 medicines.			
Interviewer	46	Do you have any experience of referring patients for psychotherapy?			
Dr. Flavin	47	Am yeah, for us in general practice it's it's quite a difficult one to you know, besides counselling am unless people want to go off and arrange privately their own treatment it can be quite difficult, so we do end up using, going through the psychiatry team so that they have access to the facilities required.	Difficult when the pt is not private	Psychiatry in control of the public pts	Experience with psychotherapy
Dr. Flavin	48	I mean there are good counselling services out there am and ones that aren't overly expensive it's nice they way they have moved towards a self referral service.	Awareness of the cost	Suggesting that there some bad ones also	Experience with psychotherapy
Dr. Flavin	49	Am because you know i think no matter what you know you get patients coming into you and you will have a cohort of those that want you to make them better but with any illness like this they need want to get themselves better, they really want to buy into that side of things am so we've moved	Pts need to want to get better	leaving the onus out to the pt, would they do the same if it was a cardiac problem?	Experience with psychotherapy

		towards kind of putting the ball in their court and all we can to do it give them all the information and then they go from there if they feel that that's something that they want to do am so like the services are there it's just getting at them, and getting access to them it's difficult i suppose i've worked in you know large private practices where money isn't an issue and kind of they can go off and organise it themselves and that's not an issue.			
Dr. Flavin	50	where i work now it's heavily GMS and you know to try and get them into the system its its quite difficult and plus as well i suppose there's an educational issue as well, they don't see how this is going to benefit them they don't see the larger picture so am so that's often a barrier as well.	Multiple factors	How it can be hard for pts to see how it will benefit them	Mental health
Interviewer	51	Can you tell me about the community mental health teams and your experience with them?			
Dr. Flavin	52	Am, not a huge amount, i have to say am. i mean we don't really, you know they might come to us if if there's an issue or they want medication changed but to actually sit down and to have a detailed discussion about a patient we don't really am a lot of that tends to go through the, i mean if there's an issue it tends to go through the, they're probably linked in with psychiatry at that stage so they through the psychiatrist and really the only time we see them is when a script comes back that needs to be changed to GMS. But no we don't have a huge contact with them.		A disconnect with the CMH teams	Mental health
Interviewer	53	From the different practices that you have worked in would you say that that the teams are			

		consistent, the community mental health teams? Or have you seen differences in the services?			
Dr. Flavin	54	No i think they are generally quite consistent am in there approach to people am so they are.			Mental health
	55	It's a great service to have, i mean i suppose unless there's a crisis am we rarely have any interaction with them. It generally tends to go through the team post us as i says if there's a crisis we're usually brought in or something happens am we're only really bought into the loop if there's a change if there's something of that nature am but you know we don't tend to get a huge amount back from them.	Ambivalence	Psychiatry in control of the CMH teams	Mental health
Interviewer	56	Ok, ok.			
Interviewer	57	Is there any changes that you would like to see in the area or mental health in primary care?			
Dr. Flavin	58	am i suppose, access would be one. Am I think most GPs a lot of us a quite comfortable to a point very resistent on taking out the scripts and writing you know whatever am for the patient.	Access to services		Mental health
Dr. Flavin	59	We're all more anxious in getting the patient linked into whatever service we feel they need am so having more direct access would be nicer am maybe having you maybe a liaison person that rather than having to refer a patient in for an outpatients, that if there was someone that we could pick up the phone to and say that lookit i have XY and a Z and he's presenting or she's presenting with this I'm thinking they may need, you know they may need admission, they may need counselling 'what do you think?' am just			Mental health

		somebody that would be on the phone to be able to kind of assist you or say yeah no, lookit it think really need to be seen in OPD or or whatever just to have that liaison.			
Dr. Flavin	60	As i says most of us are quite comfortable in dealing with it at the start but it's when things start getting wound up and we're not sure just to have somebody at the end of the phone that you can say lookit 'i'm thinking this i don't know, will you feel that need to bring them in to you know to an outpatients what do you think, somebody to sound it off that has good experience and can give us a little bit of feedback that would be nice. am i suppose more integration of services we're a little bit all over the place am with regards to what we know.		Fear of admitting that they can't deal with some issues	Mental health
Dr. Flavin	61	Like addiction counselling it's in one place CAHMS is in another place. you know you have counselling in 5 or 6 different places and so something that was streamlined for us that you that we knew cos we're alway kind of following the same protocol am as opposed to, what do we do here. It's something you hear quite frequently from radid access, where have you used lately for counselling where's good, where can they be seen in a short period of time am so we're kind of going all over the place am so something that you know we could maybe say that this is for one thing and bringing it all together in one centre and we're having to bounce people around to different places.		Bringing services together	Mental health
Interviewer	62	Do you think that it would be good to have			

		psychotherapy available to patients in the primary care centres?			
Dr. Flavin	63	Absolutely, yeah yeah, am and not only, I suppose for us again, not that that would be but a liaison person that could be down the corridor and that you'll be able to say or to pick up the phone to and say lookit I'm thinking this what do you feel, and if it's a counsellor, you know look i think he needs to be seen a psychiatry or whatever it would just be handier then am you know.	Solutions to the problems		Mental health
Dr. Flavin	64	I would have had that in ballina, when i worked there in one the primary care centres am where you have the community mental health team there, you know you would meet them in the corridor and say you know lookit what do you think? or that so am certainly one place where they go to that streamlines.		Places where it works	Comparison of other services

--END--