

Mental Health and Psychotherapy in the UK Today: Implications For Clergy

Executive Summary

- The Clergy can make a positive and clinically effective contribution to alleviating mental health distress in the population.
- Clergy can operate as part of the wider community mental health care workforce and likely already function in part in this capacity.
- Evidence based psychotherapy skills development through teaching and training courses are now available to enhance existing personal skills of priests.
- Selected teaching and training courses should include a client experience phase of 6-12 months with regular clinical supervision whilst working from their day to day base.

Mental Health and Illness

Currently the World Health Organisation (WHO) estimates that 792 million people or 10.7% of the global population live with a mental health disorder of some kind. The most prevalent currently are anxiety (284 million people, 3.8% of the population) and depression (264 million people, 3.4% of the population). In 2022 the WHO published its World mental health report: transforming mental health for all (1). In the United Kingdom, mental health issues represent one of the largest causes of disability. One in four adults suffers from at least one mental health illness in any given year. Amongst the UK population stigma toward those with mental illness is one of the barriers preventing people from seeking treatment. However, the attitude of people toward mental health has markedly changed in recent years. Mental health is now seen as a key component of wellbeing and living a healthy and productive life. Key facts regarding current mental illness characteristics are shown in table one.

Table One: Key Facts Regarding Current Mental Illness

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- 1 in 4 people experience mental health issues each year.
 - At any given time, 1 in 6 working-age adults have symptoms associated with mental ill health.
 - Mental illness is the second-largest source of burden of disease in England.
 - Mental illnesses are more long-lasting and impactful than other health conditions.
 - The total cost of mental ill health in England is estimated at £105 billion per year.
 - Men aged 40-49 have the highest suicide rates in the UK.
 - 70-75% of people with diagnosable mental illness receive no treatment at all.
 - 75% of mental disorders emerge during adolescence and young adult life.
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The common mental illnesses of anxiety and depression emerge in the second decade of life. Indeed, as noted in table one, some 75% of mental disorders emerge during adolescence and young adult life. Mental illnesses are therefore disorders that occur and begin their impact in young people in most cases. Early intervention in the adolescent years may reduce the recurrent risk rates into adult life and reduce the disability, productivity losses, unemployment, social and personal breakdown and health economic costs associated with chronic and recurrent mental disorders. Key facts regarding child and adolescent mental health are shown in table two.

Table Two: Key Facts Regarding Child and Adolescent Mental Health

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- Half of mental ill health starts by age 15 and 75% develops by age 18.
 - 13% of young people aged 5-19 meet clinical criteria for a mental health disorder.
 - The percentage of young people aged 5-15 with depression or anxiety increased from 3.9% in 2004 to 5.8% in 2017.
 - Between the ages of 16 and 24 anxiety and depression are 3 times more common in females (26%) as males (9%).
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Clergy And Their Current Involvement with Mental Illness

A recent survey in Wales suggests that most clergy regularly recognise individuals with mental illness and will refer to local mental health services. There is however a large minority (around 30%) who are not good at either recognition or referral (2). This, and other, publications, highlight that clergy are currently acting as part of the frontline mental health support and treatment services within their daily lives as priests. Overall surveys of the clergy and their contact with mentally ill individuals have proposed six themes of importance that need further consideration and are shown in table three:

Table Three: Clergy and Their Mental Health Role

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- Recognition of clergy as frontline mental-health workers.
 - Dealing with obstacles to collaboration with others in the mental health system.
 - Revealing and explaining the importance of shared values with other professionals.
 - Improving the knowledge base of the clergy regarding psychotherapy.
 - Explaining the benefits of how mental health professionals work and collaborate.
 - Contributing with other professions to aid prevention of mental health difficulties.
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The Landscape of Psychotherapies

Psychotherapies are now subject to the highest standards of clinical scientific evaluation. This ensures that only interventions that have an evidence base confirming their clinical effectiveness will be considered by the National Institute of Health and Care Excellence (NICE) for use in the NHS. This is important as there are many psychotherapies proposed and indeed marketed as treatments with their own training courses but lack an acceptable evidence base. The reality is that few of the hundreds of named therapies have been approved by NICE. Clinical scientific evaluation is essential if a psychotherapy is to be considered as clinically effective and safe for use by mental health professionals. Principles of establishing an evidence base for a psychotherapy are shown in figure one:

Figure One: The Four Principles Of Evidence Based Psychotherapy Practice

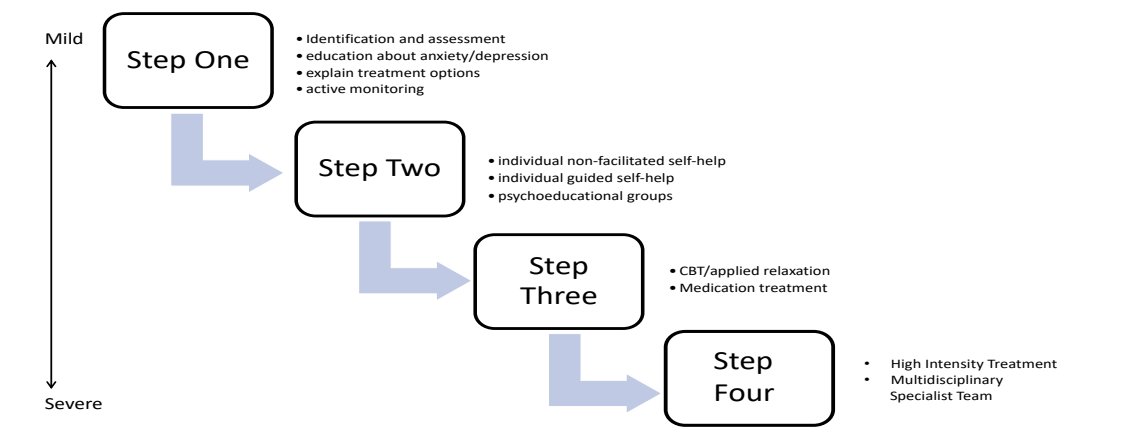


The figure shows that the evidence base is achieved through an additive summary of information from four components. Ideally a psychotherapy has been tested in a randomised controlled trial to assess its effectiveness against a current reference intervention in current use. Qualitative information from the experience of receiving the psychotherapy under investigation is invaluable in understanding its acceptance and value to those receiving the therapy. For a psychotherapy to be useful it should be deliverable within the context and environment where

it will be implemented. Finally, the intervention must be acceptable to the practitioners who are the intended deliverers of the therapy.

Current recommendations from NICE for both anxiety and depression are framed as a stepped care model. This means applying interventions of increasing intensity according to the level of severity of the individual. A summary of this model is shown in figure two:

Figure Two: Summary of The Stepped Care Model For Anxiety Or Depression



The above figure is a selected representation of stepped care models proposed by NICE. For precise details please visit <https://www.nice.org.uk/guidance>

For those in the front line of mental health care in the community the key components from this model are shown in table four.

Table Four: Some Key Principles Of Mental Health Practise In The Community

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- Making a simple assessment of problems, concerns, and level of personal impairment.
 - Being empathic and offering advice and support.
 - Giving information about local community organisations and support for anxiety/depression.
 - Offering a brief psychosocial intervention for distressed individuals whose lives are impaired.
 - Being aware of how to refer to mental health professionals.
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The mental health workforce is of very low volume compared to the increasing proportion of the public seeking help for their mental health difficulties. Providing knowledge and skills in psychotherapy intervention for the public requires growing the workforce and the evidence-based methods in this field is a public mental health priority. The clergy have a unique place in meeting the needs of their parishioners and communities from a spiritual perspective. To what extent however are the clergy equipped to offer mental health care to these communities? Do the available resources for clergy provide the knowledge, skills and techniques required to ensure that can deliver safe and effective mental health support and intervention? Finally, what are the psychotherapy components that are distinct from those outlined in table four above which may be of value for the clergy to learn.

Psychotherapy training in early career and community based mental health professionals

In 2008 NHS England introduced the Increasing Access to Psychological Treatments (IAPT) with the objective of providing professionally trained therapists in primary care (3). The community reach of this program by 2018 was estimated at around 16%-20% of those with a mental health illness. This means that despite the excellence of IAPT services in delivering treatment to many in the community (over 500,000 treated cases per year) there is much room for other skilled providers including the clergy. Interestingly the evidence suggests that IAPT interventions, which are relatively brief being delivered generally in weeks or a few months, are most effective

in mild cases of anxiety and depression and may produce better results for those who are over 65 (3). Although IAPT has been trialled with children and adolescents results have been unremarkable. This may be due to a set of co-occurring implementation difficulties facing NHS providers including lack of funds to employ trained staff, prioritising waiting list reduction over treatment and not building funds to support and supervise therapy practitioners. Low provision of supervision is particularly counterproductive as it leads to a loss of skills in those who have been funded to undertake training in mental health care and provide the IAPT service for young people. Clergy are already engaged in mental health support and are a strong candidate group for enhancing their skills to deliver a modern brief evidence based mental health support and intervention perhaps with a particular emphasis on the younger populations such as working age adults, apprentices, students, and adolescents.

What mental health training may be best for Clergy in the UK

Over the past twenty years mental health researchers have reported that brief psychotherapies for anxiety and depression are as effective as longer treatments and therefore offer greater clinical and cost effectiveness. This is the experience in the IAPT program. As well as having overall beneficial outcomes for less cost brief methods do not appear to carry any greater adverse effects. On average a brief approach will deliver 4 to 8 sessions of therapy over 12 to 20 weeks. For many milder cases however, there are reports of such psychotherapies being perhaps 1 or 2 sessions only with beneficial effects within 4 to 6 weeks. The results have virtually all been achieved with therapists delivering a treatment they have been trained in and continue to receive a degree of supervision during the treatment they are delivering. Practitioners can obtain face to face teaching, but increasingly online training is the preferred educative medium through which to learn and brief psychotherapy. There are many online training opportunities, but the majority do not appear to offer the degree of comprehensive teaching and ongoing supervision during the first year of practise as is used in the published research studies.

To date there is no clear-cut preferred type of brief psychotherapy for anxiety or depression. Recent findings from studies on adolescents with depression associated with anxiety have shown that 2 active components in brief therapy for reducing symptoms and improving well-being are the provision of active information about current mental state and prescribing social and personal activities that enhance adaptive behaviour. Importantly brief therapies are less reliant on techniques that require an in-depth knowledge of cognitive processing or emotional regulation. This means that training and supervision, like treatment itself, can be quicker and cheaper to achieve whilst delivering the same clinical effect as more in-depth psychological therapies.

Not all mental health difficulties will benefit from a brief intervention. Many individuals suffer with long-term difficulties and disabilities of mind and mental health practitioners will need to consider support and advice over months and perhaps years to assist them to cope and function to the best of their abilities. The clergy already contribute to this body of work using prayer and spiritual advice for those with conditions such as dementia. There may however be added value for clergy in learning a mental health framework to align with existing spiritual approaches used with such individuals.

What is learned and delivered in Brief Psychotherapy Methods

Firstly, all brief psychotherapies teach core interpersonal skills that have been common to most psychotherapies. These include developing a particular professional relationship with the client termed a collaborative working alliance. This is an active information giving and receiving process which establishes professional trust between the therapist and the client. This relationship can be established in the first session. Clients are sensitive to being heard and feeling that they are understood which appears to be best generated through an active conversational and person focused approach. Secondly, the therapist must learn to evaluate the risks and protective factors and determine what type of interventions maybe beneficial. These may range from simple advice, explaining about mental difficulties and prescribing a different way to perceive the recent difficulties through to giving a more comprehensive prescribing of social and/or personal behaviours to be carried out. Some brief psychotherapies focus their approaches on specific problem-solving techniques, others emphasise the delineating solutions rapidly rather than undertaking in depth problem analysis. Positive effects have also been reported for the simple delivery of alternative explanations for current distress that offer a more adaptive perception of any social difficulties or personal downturns in life. Whilst there is good evidence that brief active interventions have quite rapid beneficial effects in adults and adolescents precisely which elements (adaptive explanations, active collaborating, offering behavioural strategies or prescribing engaging in social and interpersonal environments) are more effective for what type of problems remains unclear. Brief therapies are in general more rapidly focused on positive outward looking methods emphasising strengths and the value of social relationships. Recent work with mildly anxious and depressed adolescents post the COVID pandemic has shown that a single session of delivering either an active educative information about the mind or suggesting using behaviours that can reduce mental distress are effective in reducing symptoms and can be delivered via digital media as well as face to face (4).

One brief method developed in Cambridge is termed Brief Psychosocial Intervention (BPI). This evolved from many years of clinical experience with depressed and anxious adolescents being treated in NHS in Manchester and Cambridge in the UK (5). The evidence base for BPI is one of the strongest established to date for young people with depression. BPI is now adopted by NICE and recommended as one of the psychological treatments for depressed youth. This method offers teaching and training to early career individuals in mental health practise as well as to more experienced practitioners. Training in BPI is delivered through CambridgeBPI (formerly GKMH)* and trainees rapidly learn and deliver the methods without having to undertake a lengthy course in specialist interventions such as CBT. The key element from a practitioner perspective is that teaching and training courses in brief psychotherapy should have built into its curriculum a clinical phase where clients are seen, assessed and receive intervention from trainees under ongoing supervision. BPI is pragmatic and incorporates three elements associated with effective outcomes shown in table five:

Table Five: Principles of Brief Psychosocial Intervention

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- Pedagogic methods: active collaboration and giving information about mental states and what mental distress can do to disrupt personal and social. behaviour.
 - Prosocial and personal prescribing: providing alternative strategies in the social. and personal environment to. enhance adaptive and reduce maladaptive behaviours.
 - Habilitation: Supporting and reinforcing the gains made through the above techniques over time.
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Clergy with their existing abilities in listening and advising are in a very good position to enhance these skills with training and supervision in a brief psychotherapy method such as BPI.

How to train in BPI and other Brief Psychotherapies

Here is our Cambridge based example of a brief psychotherapy training program that is built on a comprehensive evidence base for an intervention that is approved by NICE. BPI has a training program and pathway that is suitable for those with minimal to extensive experience in mental health care of young people and families. A BPI training involves 16 hours of video teaching and training plus 6 subsequent months of ongoing monthly supervision on clients being seen in their local setting. In addition, there are 3 video group sessions for the trainees meeting with the trainers and their local supervisors at 3, 6 and 12 months after the teaching course. Feedback from trainees in the NHS at all levels of experience has been >95% positive. The ongoing clinical case training and supervision with BPI experts has been seen as invaluable to the trainee's skills development and confidence in practising BPI. There are many other brief psychotherapy trainings offered, some with extensive didactic and seminar style and the chance to have ongoing contact and refresher courses with ongoing learning with the course providers (e.g. <https://www.brief.org.uk>). There are also many higher education organisations in the UK offering courses, training, accreditations, and seminars in brief psychotherapy methods. Finally, many higher education institutions offer the NHS approved low Intensity psychological therapy PGCert. Low Intensity Psychological Therapies PGCert provides the skills to be an IAPT practitioner discussed above. Trainees learn how to use brief, evidence-based psychological approaches for the treatment of mental health problems and are employed in primary care and other NHS settings.

There is every likelihood that Clergy are fully able to undertake a training in a brief psychotherapy. This would give added value to their existing skills and contribute much needed expertise to front line mental health care.

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