Psychological services in hospices in the UK and Republic of Ireland

A Price[1] M Hotopf[1] I J Higginson[2] B Monroe[3] M Henderson[1]

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SUMMARY

Objective To evaluate the level of psychological services available to patients and staff in hospices.

Design Questionnaire analysis.

Setting Hospices in the UK and Republic of Ireland.

Participants 224 hospices.

Main outcome measures The availability of professional psychological support for those with advanced disease.

Results Responses were received from 166 hospices (74%). Only 50 hospices (30%) have access to a psychiatrist, whilst 68 (41%) have access to a clinical psychologist and 92 (45%) have neither. Only 21 hospices (12%) have service level agreements with local mental health trusts. Counsellors, complementary therapists and spiritual advisors such as chaplains were more plentiful.

Conclusions Delivery of the NICE guidelines, especially tier four, may be compromised by limited availability of specialist services. This has implications for the psychological assessment of applicants for voluntary euthanasia under an Assisted Dying Act.

INTRODUCTION

Most hospice patients have cancer, 10% of whom may experience a level of psychological distress likely to benefit from specialist psychiatric or psychological intervention.[1] In 1999 a survey of psychological service provision within 97 UK hospices found that access to psychology and psychiatry was 'variable and problematic.' Social work, counselling and chaplaincy services, all able to offer significant psychological support, were more widely available. Many hospices did not refer to psychology or psychiatry even when these services were available.[2] Depression has been identified as being a difficult problem to manage by palliative care physicians in the UK, and access to appropriate psychiatry services described as 'poor and uncoordinated.'[3] Liaison psychiatry services in the UK are expanding but continue to fall well short of the recommendations agreed between various Royal Colleges.[4]

The National Institute of Clinical Excellence (NICE) recently published guidelines on supportive and palliative care for adults with cancer. It recommended that a 'four level model of psychological assessment and intervention' be developed and implemented in each cancer network,[1] admittedly in the absence of supporting evidence. This ranges from level one care, where health and social care are the responsibility of every medical professional coming into contact with the patient, to level four, which comprises assessment and management by mental health specialists. As part of this model, emergency psychiatric services should be available to palliative care services, as should ongoing supervision and training for staff providing psychological support to their patients.

METHOD

To assess the availability of psychological care to hospices, in accordance with the NICE guidelines, we contacted all 224 hospices in the UK and Republic of Ireland with inpatient beds to ask about the level of psychological support available to them. Whilst NICE guidelines only apply to England and Wales we thought it unlikely that hospices in Scotland, Northern Ireland or the Republic of Ireland would advocate a significantly lower level of support. We sent each hospice a questionnaire asking about their current level of support from psychiatry, psychology, counselling, social work, spiritual care and complementary therapy. These were first mailed in March 2005. Non-responders were sent a further questionnaire four weeks later. Those still to respond were telephoned four weeks later.

RESULTS

The total number of questionnaires returned was 166, a response rate of 74%.

The median number of inpatient beds was 12 (interquartile range 6–18). 147 hospices (89.6%) provided a day care service, and 115 (70.1%) provided a home care service.

Table 1 shows which professional services are available to hospice patients. 50 hospices (30.1%) had access to a

[1]Institute of Psychiatry, Department of Psychological Medicine, and [2]Department of Palliative Care, Policy and Rehabilitation, Kings College London, Weston Education Centre, Cutcombe Road, London SE5 9RJ, UK
[3]St Christopher's Hospice, Lawrie Park Road, Sydenham, London SE26 6DZ, UK
Correspondence to: Dr Max Henderson
E-mail: m.henderson@iop.kcl.ac.uk

Table 1 **Availability of psychological services in hospices in the UK**

Professional Group (n=166)	*Availability of professional [n (%)]*	*If professional available, time allocated as proportion of WTE*		
		Responders (n)	*WTE median*	*IQR*
Spiritual advisor	161 (98.2%)	–	–	–
Complementary Therapist	143 (86.1%)	105	0.75	0.45–1.05
Social Worker	130 (78.3%)	107	1.0	0.35–1.65
Creative Therapist	85 (51.2%)	62	0.49	0.16–0.81
Clinical Psychologist	68 (41.2%)	42	0.2	0.0–0.4
Counsellor	63 (38.0%)	46	0.6	0.25–0.94
Psychiatrist	50 (30.1%)	13	0.1	0.0–0.22
Dual Qualified Professional*	43 (25.9%)	35	1.0	0.82–1.18
RMN	33 (19.9%)	15	1.0	0.8–1.2
Other	31 (18.7%)	24	1.0	0.66–1.31
Psychotherapist	17 (10.2%)	9	0.2	0.02–0.37

*A dual qualified professional is one having two professional trainings, most often social worker and counsellor. IQR, interquartile range; WTE, Whole Time Equivalent

psychiatrist. Those with dedicated professional time (13) had a median of 0.1 Whole Time Equivalent (WTE) psychiatrists. A further 28 said they could request a consultation as required via the local Liaison Psychiatry service or Community Mental Health Team. 21 hospices (12.7%) had service agreements with local Mental Health Trusts for provision of psychological services, and 66 respondents (41.3%) reported difficulties accessing local Mental Health Services. Only 56 respondents (34.4%) reported good access to emergency psychiatric care out of hours.

68 hospices had access to a clinical psychologist; of those, 42 had allocated time, with a median 0.2 WTE. Only 27 of the 68 psychologists work alongside a psychiatrist suggesting hospices may be choosing one or the other. Nevertheless 92 hospices (45%) have access to neither a psychiatrist nor a psychologist.

63 had access to a counsellor, 17 had access to a psychotherapist and 33 had access to a registered mental nurse (RMN). Access to complementary services was greater: 143 (86.1%) had access to a complementary therapist, with a median 0.75 WTE, and 85 (51.2%) had access to a creative therapist. 98.2% of respondents had access to a spiritual advisor and 78.3% access to a social worker (with median 1.0 WTE).

DISCUSSION

As previously reported, access to complementary therapists, social workers and spiritual advisors is high, but these results suggest that hospices have much less access to professionals trained in the management of psychological and psychiatric problems than recommended by the NICE guidelines. Even if professionals are available to the service, they are often only available on an *ad hoc* basis, with little formal service provision. Provision of the NICE model, especially tier four, would appear to be compromised by the limited and inconsistent provision of specialist services.

We believe this is the first survey of its kind. The main strength of this study is the high response rate, which improves the validity of the findings. Although it is cross-sectional in design it is unlikely that major changes in the provision of psychological support to hospices are imminent.

Recent proposals for an Assisted Dying Bill,[5] although temporarily on hold, make this gap in provision all the more important. The House of Lords select committee placed emphasis on the importance of depression and other potentially treatable psychiatric disorders in leading to requests for euthanasia and clouding decision making, a view supported by empirical research.[6] The committee were persuaded of the difficulties of psychological assessment in this patient group and suggested that applicants for voluntary euthanasia have a psychiatric assessment, both for assessment of capacity and to exclude a psychiatric or psychological disorder which might impair judgement.[7] While improving the training available to palliative care physicians on the assessment and management of would go some way to improve the situation, it is not clear that they would be in a position to take on this role.

CONCLUSION

Access to mental health professionals in hospices in the UK and the Republic of Ireland is too limited to fulfil the current NICE guidelines.

Competing interests None declared.

Contributorship M Henderson and M Hotopf developed the idea for the study. A Price, M Hotopf, I Higginson, B Monroe and M Henderson all contributed to the design of the questionnaire. Analysis was performed by M Henderson, M Hotopf and A Price. All authors contributed to the final manuscript.

Guarantor M Henderson.

Ethical approval No ethical approval was required for this survey.

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