

**The Development of an Integrated Multi-disciplinary Psychological Therapies Service
in Selby & York**

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Abstract

The Adult Psychological Therapies Department of Selby and York is a service that has been evolving into its present form over the last few years. Previously, most service providers for adults in the area operated separately, but in 2000 the senior clinicians started meeting to consider closer working relations. Seven years later the services have become an integrated, multi-disciplinary department with around 40 clinical staff offering a single-point of entry for a wide range of therapeutic approaches in individual, couple, and group settings. The hub of the department is the Referral Allocation Team, which is basically an extension and continuation of the group of clinicians who met to consider the merging of the service in the first place. The Team consists of the senior clinicians from each of the seven clinical teams that now make up the service. As well as ensuring that patients are efficiently allocated to the most suitable therapy, it continues the task of integrating and developing the service to adapt to the various new challenges the NHS and its patients present. The latest challenge has been to integrate and adapt the Stepped Care Model into its referral allocation system as one of the pilot sites for the Government's Improving Access to Psychological Therapies Programme (IAPT).

Keywords: Psychological Therapies, integrated, single-point of entry, Referral Allocation Team, Stepped Care Model, Improving Access to Psychological Therapies Programme (IAPT)

Introduction

From Layard to the Stepped Care Model...

There has been an explosion in interest in psychological therapies over the last three years. The fuse for this was lit by Lord Layard's now-famous paper 'Mental Health – Britain's biggest social problem,' prepared for the Government's Strategy Unit in December 2004. Presenting the scale of the problem, the economist said that mental illness accounted for as much unhappiness in the Nation as did poverty. Also, and most significantly, he pointed out that the economic cost of mental illness was £25 billion, or 2 per cent of GDP. Included in these costs was that of incapacity benefit – 'there are now more mentally ill people drawing incapacity benefits than there are people on Job Seekers' Allowance (Layard 2004: 2). The implication of all this was that it makes economic sense for the Government to invest in improving psychological therapy services – especially in terms of getting people off incapacity benefit and back into work.

The government's main response to Layard has been its Improving Access to Psychological Therapies Programme (IAPT) which has set up pilot sites around the country to trial new systems of service delivery based mainly on the Stepped

Care Model (NICE 2004; National Institute for Mental Health England.). This model proposes five “steps” of intervention from GP care with “watchful waiting” (step 1) for sub-clinical levels of distress; guided self-help and psycho-education (step 2) for mild distress; through short-term therapies (step 3) for mild to moderate distress; medium-term therapy (step 4) for moderate to severe problems; and finally multi-disciplinary intervention (step 5) for severe, chronic, and complex difficulties.

The essence of the approach – and its attractiveness to the Government – is that increasing the provision of low-intensity (and cheaper) interventions for high-volume problems (mild-to-moderate mental health difficulties) will reduce the need/demand for high-intensity (and more costly) therapies, which can then be more appropriately reserved for the people who need them most (those with moderate to severe mental health problems). A belief that seems to underlie this strategy is that high-intensity therapies are currently being provided for people whose problems do not really require this level of intervention, thus misusing this resource and leading to unnecessarily high waiting times for all patients who require psychological therapy. The latest IAPT venture, “Commissioning a Brighter Future” (Department of Health 2007) proposes 10 major “pathfinder sites” across the country to trial service redesign according to the Stepped Care Model.

The agenda for the Government, then, is to increase access to psychological therapy without it costing too much, and in the hope that the improved services will subsequently pay for themselves through the reduced number of people with mental health problems claiming incapacity benefit. The resulting challenge for local services is to significantly increase access to psychological therapy without a great deal of extra resource...

In essence, this has been the aim of the Adult Psychological Therapies service of Selby and York (now part of North Yorkshire and York PCT). This service has been evolving into an integrated, multi-disciplinary department over the last seven years. Since 2005, the service has been contributing to the work of the Government’s IAPT programme and has been a pilot site for two projects from the scheme for the last 18 months. The first of these projects was to integrate the Stepped Care Model into the service’s referral allocation system (the second was to trial computerised cognitive behaviour therapy). The rest of this paper outlines the development of the Adult Psychological Therapies service, the operation of the Referral Allocation Team, and the results of the changes.

The Historical Context

Fifteen years ago, the psychological therapy services for working age adults in the Selby and York area consisted of around seven clinical psychologists and a separate psychiatry-led psychotherapy service consisting of a consultant psychiatrist with special responsibility for psychotherapy, five nurse therapists and one occupational therapist. For the Selby area, the therapy services consisted of a token half-day clinic provided by a junior psychologist.

The psychologists provided outpatient and inpatient services to the local psychiatric (two in existence at the time) and general hospitals. These services included diagnostic, neuropsychological, and other assessments and testing, as well as the provision of consultation and advice to the wards on the management of patients, and outpatient therapy. In common with other psychology services at the time, waiting times for outpatient therapy for general psychological problems hovered between one and two years and were self-limiting in the sense that GPs stopped referring once they felt that the wait was too long for the service to be of use to the patient.

St Andrews Counselling and Psychotherapy Unit accepted referrals from GPs, psychiatrists, community mental health teams and occasionally Social Services. Out patient individual counselling and psychotherapy, group psychotherapy and an intensive group psychotherapy day programme were (and continue to be) available. The orientations of the unit are predominantly psychoanalytic/psychodynamic and person centred.

The Internal Market

Under new leadership, and with the advent of GP fund-holding and the “purchaser-provider” contracts, the psychology services expanded significantly from the mid-1990s. New contracts for primary care psychology clinics based at GP surgeries were negotiated, providing funds to employ more psychologists. Counselling psychologists, counsellors, and psychosexual therapists were employed to see suitable patients in order to fill recruitment gaps.

The resulting increased availability of services contributed to a greater awareness of psychological interventions for common mental health problems. This and other factors led to a continuing cycle of increased demand followed by increased awareness and more demand as well as greater expectations, in terms of the range of problems referred. Initially, as demand rose, more psychology clinic time was purchased, but inevitably a ceiling - composed of the limit that GP practices were prepared to spend on the service - was reached.

During this GP fund-holding era, counselling in primary care had greatly increased nationally and locally, with many GP practices directly employing their own counsellors, or obtaining services for free or at low cost from counsellors in training. At the same time, the Psychology Services began offering primary care counselling services to GP practices. Clinical psychology services for adults were divided into a primary care section and an adult mental health section (providing input to psychiatric services, including a limited service into the Community Mental Health Teams [CMHTs]), which now meant that the psychology services had under its umbrella a number of different sub-sections, though the counselling, counselling psychology, and psychosexual therapy were managed through primary care psychology.

Problems with the Old System

There were a number of problems with the delivery of services for working age adults at this stage, most of which can be attributed to the lack of integration of the three service providers (Primary Care Psychology, Adult Mental Health

Psychology, and St Andrews). Communication between them took place only when necessary. There was very little direct exchange of referrals between psychology and psychotherapy services. The two psychology services did pass referrals directly to each other, but there were often disputes and bad feeling over the sorting out of the “grey areas” between the sections. Essentially, there was a certain amount of distrust between these separate services, particularly the suspicion that the passing on of referrals by the others was more a “waiting list strategy” (or the “dumping” of the more difficult/ complex/ treatment-resistant patients) than a genuine wish to find the right service for the patient. This was heightened by the knowledge that all services were overloaded. In addition, there was a degree of the usual rivalry between separate services with overlapping remits, perhaps exacerbated between the psychology services and St Andrews by the old antipathy between psychiatry and psychology. There were anxieties from psychology about whether or not certain therapists at St Andrews were qualified to do the work they were doing and some psychologists were feeling deskilled hearing about the work St Andrews colleagues were doing. There was a lack of understanding in psychology of what psychiatric and psychotherapy services did and, equally, in St Andrews there wasn't much recognition of the range of work carried out in psychology. With the absence of connections between the services, there was no sharing of skills through training, supervision, or clinical dialogue. The result of this absence of real communication and liaison was frequent duplication of effort, with patients receiving multiple assessments across services and referral-on occurring only after treatment failure.

Lack of Proper Screening of Referrals

Within Primary Care Psychology, there was no proper screening of referrals, in the sense of using criteria to carefully consider whether this service – or, indeed, any service - was truly the best option for the patient concerned. This meant that virtually all referrals without a diagnosis of severe mental illness went straight onto the waiting list and would be taken off in a “taxi-rank” system of being picked up by the next psychologist who had a free therapy slot. With waiting times being so long, it was a not infrequent occurrence for psychologists to find themselves taking on a patient who had little chance of benefiting from the therapy, but who it felt impossible to deny a service to because they had been waiting for more than a year. Equally, it would feel impossible to refer on to a more appropriate service (St Andrews, for example) where the patient would have to wait all over again. This could lead to a frustrating and disappointing therapy experience for the patient and disillusionment for the therapist.

An attempted remedy by the Primary Care Psychology Section was the introduction of brief initial assessments for all patients, with the aim of making sure that they were suitable for the service, or else referring them on at this earlier point, to more appropriate providers. This system also had the potential advantage of discovering early which patients would not actually turn up for therapy, thus shortening the waiting list. While the initial assessments did improve the selection of patients to some degree, a lack of proper criteria and clear differentiation between this service and the others available still led to many inappropriate referrals ending up on the waiting list. In addition, the cost in clinical time of initially assessing all patients led to substantially less time for ongoing therapy and may actually have increased the waiting times for patients.

So, at this point, the results from the “purchaser-provider” developments were mixed. Many more patients were receiving a psychological therapy service - by the late 1990s, referrals had risen to four times what they were in the early part of the decade. However, most patients were still having to wait a long time - waiting times (often between three and six months during the heyday of GP Contracting) were rising and by 2001 had hit 18 months, with the level of referrals at that time indicating that this figure could only continue to rise. And, in addition, the lack of integration in the services meant that patients were still experiencing the frustration of inappropriate therapy, multiple-assessments, and referral-on after therapy failure.

Threats and Opportunities in the “New NHS”

Major NHS restructuring is a risky time for “talking therapies”. Inevitable financial pressures raise the possibility of resources being diverted into services higher up the Government’s priorities or more in the eye of the voting public. With the advent in 1997 of the new Labour Government’s “New NHS,” the Head of Psychology and the Consultant Psychiatrist responsible for psychotherapy services were aware of the potential threats, but also saw an opportunity to enlist Government thinking to implement changes which would both make local services more secure and bring about important improvements. A useful Department of Health review entitled “NHS Psychotherapy Services in England” (1996) had stressed the need for local co-ordination of counselling, psychology and psychotherapy provision. In addition, two key themes of the New NHS vision were “Integration” and “Multi-disciplinary Services” (e.g., *The National Service Framework for Mental Health 1999*; *Organising and Delivering Psychological Therapies 2001*; *Treatment choice in psychological therapies and counselling 2001*).

A “joined-up” Service

With these factors in mind, the heads of service opened discussions about how the two psychology services and the psychotherapy centre could work more closely together. Initially, there was considerable suspicion between staff in each service, with each fearing take-over or exploitation to solve waiting list problems. To begin with, senior staff from the different groups met to discuss the referrals they received and the similarities and differences between them. The idea was to see if there was scope for exchanging referrals which were more suitable for the other services, and to consider a possible future merging of teams.

The meetings were conducted in a spirit of goodwill and as the senior staff became more comfortable with each other it was clear that it was possible to reach a consensus on the best route for most referrals. The discussions revealed distinctions between the patients who were more suitable for each of the services and, as a result, some broad referral criteria started to emerge. The obvious usefulness of the meetings facilitated the move to making them a weekly occurrence. A meeting was set up for all the staff of the three services to discuss integration and the resulting open discussion helped generalise the growing spirit of cooperation throughout this emerging new team. One of the worries expressed about the merger was that it would lead to the loss of the individual identities of the

different parts of the service. It was stressed from early on, therefore, that in fact it was the separate identities of the parts of the service and the different skills they possessed that was the main strength of the new venture. The merger was agreed and the Adult Psychological Therapies Department was officially formed as part of Mental Health Services in April 2001.

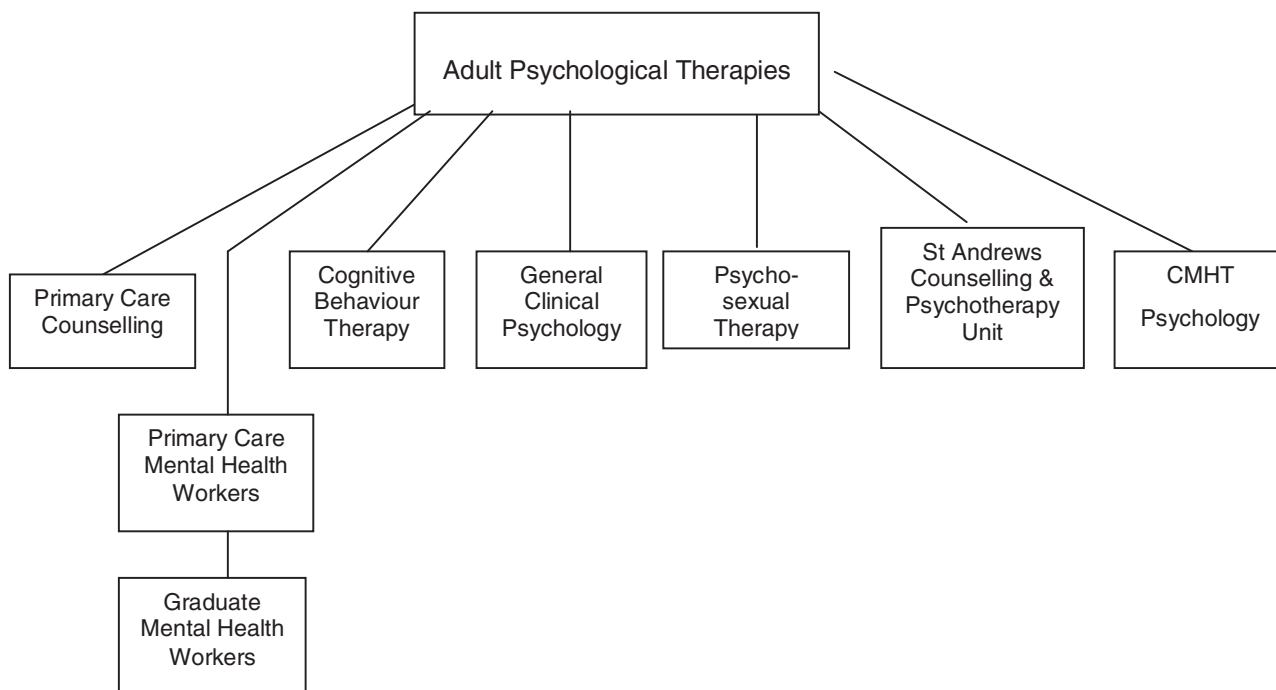
The meetings between senior staff continued and developed into what is now referred to as the Referral Allocation Team (RAT) meeting which has now become the central integrating mechanism of the service and the driving force for any further changes. The Team meeting is non-hierarchical and the open and fluid discussion of the issues which emerge from consideration of “grey area” or more controversial referral decisions, has proven a fertile ground for service development.

The Development of Clinical “Teams”

The Adult Psychological Therapies Service (APT) now consists of seven clinical teams (see Figure 1), with much clearer referral criteria to differentiate between them. These criteria (for inclusion and exclusion) were developed through team discussions of grey area referrals in the RAT. Three of the teams have already been mentioned – St Andrews Counselling and Psychotherapy Unit, Primary Care Psychology, and Adult Mental Health Psychology. Over the years, and with the addition of the other clinical groups, Primary Care Psychology has become General Psychology - a more specialist resource that now deals with more complex and chronic problems. ‘Adult Mental Health Psychology’ is now ‘CMHT Psychology’ and the team psychologists only work with patients who are currently being seen by the CMHT. All four CMHTs now have a half-time clinical psychologist. The CMHTs have tightened their criteria and now only see those patients currently experiencing “moderate to severe mental illness.” This has led to more people with chronic and personality problems/ disorders being seen by St Andrews and the General Psychology Team. The increased demand for Cognitive Behaviour Therapy in the last few years led to the formation of a separate Psychologist-led team and the service now also offers training placements for the local university-based CBT course for mental health professionals, as well as supervision for psychiatric registrars locally. With a recent expansion of Primary Care Counselling services, this new team has emerged and a Head of PC Counselling appointed. This service originally provided counselling to just a few of the local GP practices and a limited general service to the practices which did not have their own counsellor. In 2004, the PCT decided to expand services to enable all practices to have their own counsellor and this extra service was to be provided by APT. Now APT provides around 50 per cent of all the primary care counselling in Selby & York. The five Primary Care Mental Health Workers (PCMHWs) for Selby and York have joined the department as another team, and four graduate mental health workers (GMHWs) are another recent and welcome addition to the clinical staff. The longer waiting times now are for medium to long-term services, whereas those who can benefit from more short-term focussed interventions – primary care counselling, or brief CBT with the PCMHWs – can be seen quicker, as can those who can benefit from voluntary sector services. Now the skills of counsellors, psychotherapists, cognitive behaviour therapists, PCMHWs, GMHWs, and clinical psychologists are being used to maximum effect thanks to the careful

matching of patients' needs with the particular psychological therapy most likely to benefit them. It is also worth noting that counsellors, psychotherapists, cognitive behaviour therapists, and PCMHWs are now doing work that used to be done almost exclusively by clinical psychologists working in adult primary care services

Figure 1 The Adult Psychological Therapies Service of Selby and York



The Stepped Care Model

From 2005, The Referral Allocation Team began to adopt the Stepped Care Model and adapt it to fit the existing system, as outlined in Figure 2.

The Referral Allocation Team (RAT) System

Referrers can refer patients to any section of the Psychological Therapies Service. The referrals are screened by an experienced therapist within that section on a weekly basis and any additional information in the system about the patient is collected (for example, previous psychology/ psychiatric case notes). If it is clear from the information available that the patient has been referred to the appropriate section the client will then be offered assessment or placed on the waiting list depending on the current availability of therapists. In instances where it remains unclear Life History Questionnaires are sent to patients, or further information is sought from referrers. Where allocation, referral-on, or referral back to referrer with advice about alternative sources of help is still unclear, the referral is taken to the RAT and discussed. A decision will be made to allocate the referral to a particular section of the psychological therapies service for assessment, refer on (for example, to the CHMT), refer back to the referrer with advice about alternative

ways of managing the patient, or individual/ joint assessment by members of the RAT will be offered to the patient to assess and review treatment possibilities. Potentially controversial referrals (for example, where there is a history of complaints against services, or a pattern of several previous referrals with poor outcomes) or referrals where other complex judgments may be required, are routinely passed to the Referral Allocation Team.

Figure 2: APT and Stepped Care

Step	Level of clinical distress	Method of care	Clinicians
1	Sub clinical	'Watchful waiting'	GP
2	Very mild	Guided self-help Psycho-education	PCMHWs GMHWs Primary Care Team
3	Mild-moderate	Short-term therapy (CBT, counselling)	PCMHWs Primary Care Counsellors
4	Moderate-severe CBT	Medium term	Clinical Psychology, CBT service St Andrews, PST
5	Severe/Chronic/ Complex	Multi-disciplinary approach needed	CMHTS, St Andrews, Clinical Psychology, CBT (schema focussed) (therapy if indicated)

In APT, assessments are carried out by the most experienced clinicians, which is in contrast to the trend in some of the pilot sites introducing the Stepped Care Model, especially the sites focussing mainly on the high volume, low-intensity interventions.

Case Examples illustrating the System

Case Study 1 - 25 year old female

Referral information - Referred by local voluntary agency. Client highlighted as emotionally vulnerable, having a difficult history and difficulties in relationships with family and peers. Recently left home to live on own and had increased her drinking.

Issues at Referral - Already engaged at local voluntary service for young people aged 16-26). Support worker for independent living also in place. Requesting

support to come to terms with past experiences and work on relationships and self-esteem

Structure of Input - Following discussion, the Referral Allocation Team wrote to the referrer explaining that exploratory therapy was not appropriate at present, but that support was the priority, which she could continue to receive through the voluntary agencies already involved or at other local voluntary counselling agencies.

Re-referral - Client re-referred one year later with sustained stability in accommodation and occupation. Request for exploratory therapy

Referral Allocation Team Input - Client asked to complete a questionnaire designed to give information on current and past problems, key relationships, and life events, and to elicit preferences for therapy style. Discussed at referral allocation meeting and further information obtained from referrer. Client offered assessment with representatives from psychology and psychotherapy to decide on most appropriate therapy and clinical psychology was offered and accepted.

Case Study 2 - Female, 34

Original Referral Source: - GP

Reason for Referral: - 'Complicated medical history,' 'stressed and frustrated rather than truly depressed,' 'abnormal obsession with food,' 'negative childhood experiences,' 'repressed memories.'

Originally Referred to - Primary Care Counselling

Referral Path: - Completed questionnaire. Referral passed to RAT. Indications from referral letter and questionnaire that brief individual therapy would not be appropriate but may be suitable for longer-term exploratory work, given complexity of presenting difficulties and past experiences. Agreed assessment by Adult Psychotherapist at St. Andrew's.

Outcome - Seen twice for assessment which resulted in the patient agreeing that intensive group work could be most appropriate treatment, given interpersonal nature of current psychological difficulties. Patient offered and accepted intensive Group Programme at St Andrews.

Case Study 3 Male, aged 46

Original Referral Source - GP

Reason for Referral - 'Depressive symptoms over a number of years. Has not found antidepressants or counselling helpful.'

Originally referred to - CMHT

Referral Path - Not deemed appropriate by CMHT – ‘not experiencing moderate to severe mental illness or requiring specialist team intervention’. Passed to RAT. Initial assessment offered by St. Andrew’s Adult Psychotherapist.

Outcome - Patient assessed over 3 sessions; clear indicators of a preference for learning thinking and coping strategies. Referred to CBT and was placed on waiting list according to date of original referral.

“Opting-in”

Another factor contributing to lengthy waits is the number of patients who will not actually attend for therapy when offered an appointment, but who nevertheless occupy a place on the waiting list. One way to address this problem in APT has been to ask all patients referred to the service to “opt-in” (by returning a reply slip) and this procedure has been in place since January 2002. On average, some 21 per cent of patients do not opt-in and so are discharged without being seen. A further development, in 2006, was the introduction of a further “opt-in” letter for patients who have been on a waiting list for a long time to check that they still wish to be seen. Again, some 42 per cent of those contacted did not opt-in and so were discharged. Obviously, the latter strategy is only of use when waiting lists have become long (for example, over nine months).

The Impact of the New Department

Eighteen months after the start of the regular Referral Allocation Team meetings, a third of all referrals were either being referred-on to other services or returned to the referrer with advice on management. Referrals-on were usually to CMHTs, local addiction services, or the good selection of voluntary sector agencies available locally (for example, where “supportive” services were indicated, rather than therapy). The most problematic of the waiting times – those of Primary Care Psychology and the CBT Service - had been halved from 18 months to nine months. The CMHT Psychologists’ waiting times for all but one of the teams had been reduced from over a year to a few weeks. The waiting times for the other clinical teams varied between a couple of months for some Primary Care Counselling lists and six months for individual or group psychotherapy.

Today, the reduction of the waiting times for clinical psychology has been maintained at nine months for General Adult Psychology and a few weeks for CMHT Psychology. Referrals to General Adult Psychology have steadily reduced from 727 in 1999 to 411 in 2005, probably resulting from a combination of the re-education of referrers and the expansion of the range of alternative services within APT. Psychotherapy patients usually wait no longer than six months and there is no waiting list for the PCMHWs. Self-help resources for patients have been greatly extended by the GMHWs, a clinical team whose potential contribution is still to be fully tapped. Referrals to Primary Care Counselling have mushroomed since this service was expanded and they are now receiving up to 1200 per year (from just 190 in 1999) and have waiting times which fluctuate, depending on the referral patterns of the various GP practices, between a couple of weeks to up to eight months. The longest waiting times currently are for the CBT Service, referrals to which have risen from 47 in 1999 to 130 in 2005. The waiting time for standard

CBT is between nine and ten months, but the wait for the longer-term Schema-focussed work is around a year.

Another fruit of the development of this integrated, multi-disciplinary service is a happier, increasingly skilled workforce. “Happier” as result perhaps of a clearer sense of role, of using one’s skills in the most productive way, the respect and comradeship of colleagues from other disciplines, and a sense of common purpose. For APT, working together has led to very popular joint workshops, across-discipline clinical supervision, across-discipline assessments, the development of sophisticated risk assessment skills, greater awareness of, and uniformity in managing, child protection issues, and greater understanding and awareness of Care Programme Approach issues in co-working clients still receiving input from CMHTs.

As suggested earlier, the challenge for local services presented by the Government’s response to Layard could be described as “to significantly increase access to psychological therapy without a great deal of extra resource”. This has certainly been achieved in this service in terms of many more patients receiving the most appropriate service more quickly. However, the developmental changes which led to this had already been set in motion prior to Layard and would have been achieved without involvement in the IAPT programme. This was an evolutionary process willingly contributed to by all parts of the service. The continuing challenge posed by the Government is to bring waiting times down to 18 weeks, mainly by increasing the less intensive interventions for mild to moderate problems by extending the work of less highly trained staff (e.g. graduate mental health workers); the hope is that this increase will be paid for by a decreased need for highly trained staff. This change is more revolutionary than evolutionary and the results may be more difficult to predict: waiting times will come down initially, but will they stay down over time? Ethically, while it is clearly better to get help to patients quicker, will the greater use of less highly trained staff to achieve this lead to more problems in the long run?

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