

Good going at the Doncaster IAPT

Doncaster is known for its horseracing. In 2006, a new race came to town – the Improving Access to Psychological Therapies (IAPT) programme. But how goes the running?

by Dawn White

Doncaster's IAPT programme was a new field entirely, with preset conditions and requiring an ability to adapt to change. As one of the first of two pilot programmes (the other being based at Newham), it had to deliver on the Government's 2005 manifesto commitment

to provide improved access to psychological therapies. The introduction of a stepped-care model for anxiety and depression (see figure 1), which was agreed in line with National Institute for Health and Clinical Excellence (NICE) guidelines¹, recommended

that psychological interventions, particularly cognitive-behaviour therapy (CBT), should be routinely offered to people experiencing common mental health problems.

The Doncaster IAPT programme built on existing primary care mental health provision, which included counselling. As operational manager for both the IAPT service and the Doncaster PCT counselling service, integrating both services while retaining and developing their separate professional identities was my priority, alongside managing the anxieties and uncertainties that some staff members experienced during the transition.

This article aims to provide insights into how the IAPT service and its case managers operated, and how they interfaced with the counselling service. Doncaster has two additional established providers of counselling services – Rotherham, Doncaster and South Humber NHS Foundation Trust (known as RDASH) and an external independent provider that works within the partnership. Through the past year, both providers have retained their original

referral pathways via the GPs in the practices where they are based. The three services are managed independently of each other and function differently.

Establishing the IAPT service

From the start, the IAPT service referral criteria were set to include the following:

- All patients with at least moderate depression, except those with a history of repeated treatment failure, psychotic features, personality disorder, primary drug and alcohol problems or significant risk.
- All patients with generalised anxiety disorder (GAD), panic disorder, simple phobias, social phobia, and health anxiety, except those with a significant suicide risk.

The operational principles of the service are straightforward:

- Provision of evidence-based low- and high-intensity CBT organised in a stepped-care system (see figure 1). Patients are offered the lowest intensity treatment option likely to produce benefit.
- The system is designed in such a way as to reduce bureaucratic obstacles (eg



gatekeeping, waiting lists) in order to facilitate rapid access to the most appropriate treatment options.

- Access points into the stepped-care model are kept to a minimum.
- Decisions about allocations to a particular step or worker are not made on the basis of outcome measures alone, but reflect a combination of these with level of risk, clinical judgment, history of and concordance with previous treatment and patient preference.

counsellor role, working bases and relationships, and patient pathways. To ensure equity and fairness to patients who had been referred for psychological therapy prior to the IAPT service, the first step was to centralise the waiting lists for counselling and offer people an alternative appointment with a case manager. Patients were provided with information explaining low-intensity CBT treatment and case management, enabling them to make an informed choice on which approach they

Systematic arrangements were put in place for patient assessments with case managers or senior practitioners as required. In order to accommodate the coordination of referrals to the three counselling services across Doncaster, the lead counsellor's hours were increased from 1.5 to 2.5 days, and additional responsibilities were incorporated in the role to provide duty management cover to the IAPT service one day a week. Case managers were assigned to GP practices across Doncaster,

coordinates a person's care from the point of a referral allocation, and monitors their recovery. The new pathway ensures that people receive the right intervention at the right time, with the right results, and that healthcare practitioners and external organisations work together to provide the most effective care. When a referral is received, the IAPT service manages the care pathway in agreement with the patient by allocating them to a case manager, cognitive-behaviour therapist, or

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IAPT impact on the counselling service

Prior to the introduction of the IAPT service, the Doncaster PCT counselling service had approximately 350 patients on its waiting list. Counsellors were based within GP surgeries in West Doncaster, and referrals to the counselling team were received directly from GPs. A total of 4.5 WTE counsellors (including 0.5 lead counsellor hours) covered 22 GP practices. The length of time from referral to seeing a counsellor varied from six to 24 months.

In parallel with setting up the IAPT pilot, we made a number of changes to the management and operation of the counselling service. These involved changes in managing the waiting list, the procedure for receiving new referrals, the lead

preferred. Those on the waiting lists were contacted first by their practice counsellor, who transferred them to the IAPT service. They were then contacted by the IAPT service offering an appointment with a case manager to start treatment within seven days. Ninety per cent opted to see a case manager; the remainder decided to stay on the list to see a counsellor or to decline both services.

To date, the IAPT service has received approximately 4,000 referrals – 96.3 per cent directly from GPs across Doncaster. GPs now have two referral pathways for patients, one via the usual secondary mental health services (when this is appropriate), and the other to the IAPT service for those experiencing common mental health problems.

and established bases within the designated surgeries. Case managers and counsellors were based within the same practice if surgeries were able to offer rooms. Surgeries that did not have extra capacity were allocated a case manager who would provide appointments in a community venue near the surgery. Prior to IAPT, GPs could refer directly to a practice counsellor or to the community mental health team (CMHT), who might then refer to a counsellor.

With the introduction of the IAPT service, a direct referral pathway to the service was introduced to GPs to enable them to offer the service model of case management to patients. A case manager provides therapeutic interventions, agrees care/treatment plans,

the counselling team (see figure 2).

Referral protocol to the counselling service

People can be referred for counselling by the IAPT duty manager or by case managers working within the service if they meet one or more of the following criteria:

- They are experiencing mild, moderate or severe anxiety or depression.
- They have been assessed by a case manager as potentially unsuitable for low-intensity CBT involving the depression recovery or anxiety self-help programmes, or computerised CBT (CCBT)².
- They have opted for counselling following a sufficient period of low-intensity CBT with no symptomatic response.

■ They have identified through case management unresolved issues that are impacting on their current coping methods and personal development.

■ Their referral after assessment following initial contact and discussion with the duty manager is deemed unsuitable due to the following:

- identification of issues that are historic or have a developmental nature that are impacting on current life difficulties
- relationship difficulties
- problems with adjustment (eg to parenthood, retirement, diagnosis of illness)
- low focus and low motivation towards

implementing changes

- a prolonged or complex grief reaction or other high level of emotional distress
- a high requirement for risk management
- a complex history, with significant risk and/or high impairment of functioning
- a number of previous interventions with unhelpful outcomes.

■ They can access either:

- brief focused counselling – three sessions, moving towards a CCBT intervention
- brief focused counselling – six sessions
- brief focused counselling – six to 12 sessions
- medium- to long-term counselling of 12 sessions upwards, with the

frequency of appointments agreed according to need

- group therapy – for self-esteem, confidence-building
- bibliotherapy and/or psychoeducational materials – tailored to need.

Challenges and opportunities

With the introduction of case managers and a stepped-care system, it became evident that unrest, insecurities, and scepticism were experienced at a local and national level by established professionals within different psychological fields, including counsellors. Most of the scepticism stemmed

from lack of knowledge of what case managers were providing and of how the stepped-care model functioned. Employment insecurity, feeling threatened by the new workforce, fear of redundancies and professional imitation were just some of the concerns.

One issue we encountered frequently was that the IAPT case managers would eventually replace counsellors. This has not happened, though very few referrals for counselling now come direct from GPs in the west sector of Doncaster. Instead, the majority come via the case managers. Figure 3 shows the referral rate to the Doncaster PCT counselling service during

Figure 1. The Doncaster IAPT stepped-care model

Level	Team/service	Level of needs/suicide risk	Range of interventions
5	Crisis resolution team	Suicide risk – high Risk to life and severe self-neglect	Medication, combined treatments and ECT
4	Mental health specialists (including crisis resolution team)	Suicide risk – high Treatment resistant, recurrent, atypical and psychotic depression Those at significant risk High complexity, high impairment	Medication, complex psychological interventions, combined treatments
Working in partnership with secondary mental health provider to deliver interface			
3	Primary care mental health service/counsellor/case managers/Graduate Mental Health Workers (GMHW)	Suicide risk – low/intermediate Severe depression PHQ-9 = >20 Moderate to severe depression PHQ-9 = 15-19 Moderate depression PHQ-9 = 10-14 Anxiety GAD-7 = >10	Medication, psychological interventions, social support. CCBT – Fearfighter, Beating the Blues, recovery programmes, counselling
2	Primary care team (GPs, practice nurses etc) Primary care mental health service/case managers/counsellors	Suicide risk – low/intermediate Mild depression PHQ-9 = 5-10 Anxiety GAD-7 = >10	Guided self-help, CBT, CCBT, brief psychological interventions, behavioural activation, medication
1	Primary care team (GPs, case managers, practice nurses, case managers etc)	Suicide risk – low Recognition	Assessment using PHQ-9 and GAD-7 and risk assessment tool when necessary

2006/07. Referrals were low over the first three months when the system was accepting only new referrals. Case managers then began to step up/refer some people into the counselling service after they had seen them. It is important that case managers know the skills and expertise of the counselling team to ensure that patients are referred appropriately.

When people have considered the Doncaster model and how IAPT interfaces with the counselling team, some have expressed concern that patients will become confused if they have more than one 'helper' or see more than one person for treatment. This has been our experience: Do patients get confused if they see their GP for one appointment, and then go on to see a practice nurse or a physiotherapist? Why should mental health services not work in the same way to provide a seamless service in which patients can be contained instead of being returned to their GP? Each professional sees a patient within their professional training and competency, providing particular set of skills and interventions as necessary. Thus to date, patients have a number of benefits:

- they have more treatment options available
- they have more control of where and how they would like to be treated
- they are more informed and educated about their conditions
- they can access low-intensity CBT programmes within their own homes
- they jointly monitor their symptoms of depression and anxiety
- they move up and down the stepped-care model according to their symptoms, self-scoring clinical measures, and choice

- they are the agents of change
- they may see a case manager and a counsellor at the same time or sequentially, and this has worked well (see box).

Impact of the IAPT demonstration site

Counsellors are no longer restricted by long waiting lists.

- Counsellors have more scope in providing a flexible and accessible service.
- The counselling service has been able to set up a back-fill facility to cover staff absences due to

particularly to address gaps in service provision that have been identified, eg for clients with eating disorders.

■ Counsellors have started to work in non-traditional ways, for example incorporating CCBT and/or bibliotherapy materials, thus extending the therapeutic relationship to enable clients to gain further insight into or understanding of their situation.

- Counsellors and case managers provide presentations to general practice teams at in-house

as commissioners, directors and senior managers are considering the sustainability of the IAPT service and the future provision of mental health services, I hope Doncaster's experience has provided an insight as to how an integrated mental health service might look – seamless and flowing with the patient/client at the centre. Counsellors and case managers can work side by side collaboratively, and not compete. The Doncaster IAPT service clearly demonstrates that mental health services can provide a

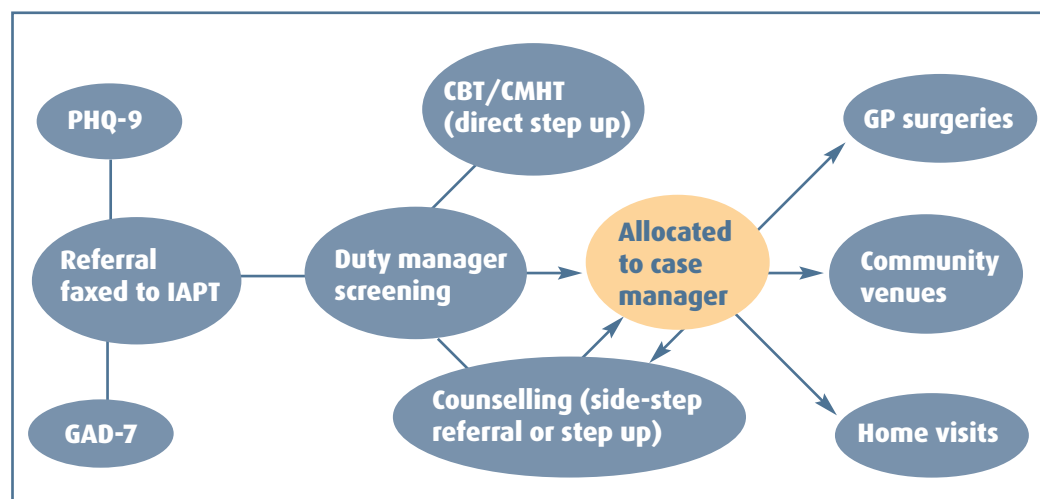


Figure 2. The IAPT programme referral process. Most referrals come from GPs, along with Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder (GAD-7) assessments that are completed by patients

sickness.

- Appointments can be offered in various community settings, thus increasing accessibility and being more responsive to individual client needs.
- Case managers retain contact with the patient, offering support until the counsellor has an available appointment.
- Patients can access counselling immediately if risks determine this.
- Counsellors are planning the introduction of further group work within their practices and working with case managers.
- Counsellors are developing new areas of interest,

training sessions.

- Counsellors and case managers provide a therapeutic package according to the needs of the individual, and based on stepped care.
- Counsellors and case managers are providing a seamless, succinct, holistic therapeutic service that contains people within planned and agreed care pathways.

The future

From the outset, the launch and development of the Doncaster IAPT demonstration site has been a continual process of training and learning. Now,

continuum for collaboration and patient treatment melding together primary care and specialist mental health services.

The lead counsellor's view

Kathleen Green, the lead counsellor with the Doncaster IAPT programme, comments on her experience during 2006/07:

I have worked with several clients after they have seen a case manager and, in my experience, their psychological awareness has been raised such that they have greater insight into their unresolved issues, which enables quicker

'Most of the scepticism stemmed from lack of knowledge of what case managers were providing and of how the stepped-care model functioned'

engagement – a requirement for brief focused counselling. Other counsellors within the team share this view. When people have not seen a case manager, I now have a wider choice of interventions that I

counselling team. Other feedback from the counsellors is that they have a sense that some of the clients they see after case management have more complex presentations, which might

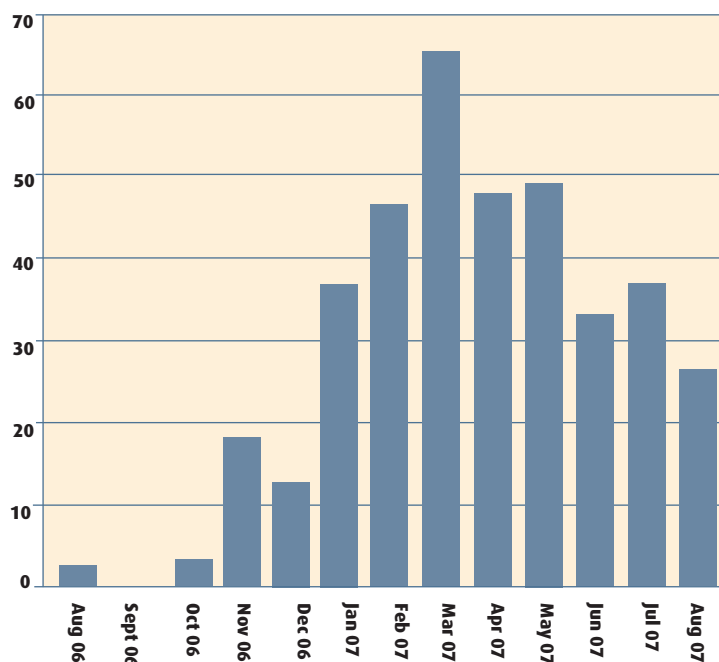


Figure 3. Numbers of referrals to the Doncaster PCT counselling service

can provide at different stages of the therapy process. At the more severe end of the scale, I am able to offer long-term counselling for those who have experienced childhood abuse or trauma. We have discovered that some people prefer to be seen by an NHS counsellor rather than being referred to a specialist service, as it avoids the stigma that can be associated with accessing such services. A recent audit of our practice counsellors has shown that some currently have a high percentage of clients with this history – highlighting the demand for a more discreet service that is placed within a generic

normally be seen within the secondary services by a psychologist or psychotherapist. To accommodate this demand, a more integrative approach is required that incorporates different ways of working, including psychodynamic approaches. Thus the workforce profile of the counselling team is changing, and certainly, with future recruitment, Dawn and I will be considering selecting counsellors with specific skills to meet the requirements of the counselling tiered model.

Dawn White has been the IAPT Primary Care Mental Health Team Manager and

Feedback from people seen by a case manager first

- They felt contained and not worried since if one intervention did not work, another type of help would be offered.
- Those who experienced different approaches did not find that they conflicted with each other.
- They preferred to have support from the onset of referral rather than being placed on a waiting list.
- They did not feel that they were being rushed into getting better.
- Some reported that they preferred not to discuss issues in the past or start counselling straight away, and that the case management approach was a good way of introducing them to the therapy process.

Feedback from people seen by a counsellor first

- 'Moving to see a case manager indicated that I was getting better and was part of my recovery journey.'
- 'A case manager offered a different structure – different support. I had goals and increased my activity.'
- 'Seeing a case manager reduced my dependency and increased my coping skills.'
- 'The case manager offered a lot of information and available options to me.'

IAPT operational manager since 2005, having previously been employed as facilitated self-help manager, responsible for delivery of the CCBT project in Doncaster. Dawn began her counselling career in 2000 as counselling coordinator in a voluntary sector service in the centre of Sheffield, progressing to manage this service. In 2002, Dawn set up a counselling service within a Sheffield GP practice, working as a primary care counsellor, prior to its becoming a managed PCT counselling service. She has also provided counselling for children and young people, and mentoring and clinical supervision for counsellors

at different stages of their professional development.



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Counselling and Psychotherapy Journal), the quarterly journal of the Faculty of Healthcare Counsellors and Psychotherapists. For more information about this division of BACP, or to subscribe to HCPJ, contact Julie Camfield, Divisional Administrator, on 01455 883381, or email julie.camfield@bacp.co.uk or visit www.fhcop.org.uk

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