



The changing face of counselling in primary care: **mental health and wellbeing in Ealing**

Ealing PCT was one of two IAPT pathfinder sites chosen to specialise in the delivery of services for black and minority ethnic clients. **Rosemary Rizq** outlines the rapid development and challenges faced by the service counsellors and their team



Ealing PCT serves a population of 330,000, with 83 GP practices. It is a socially diverse area in terms of socioeconomic status, deprivation and ill health, with some wards ranking amongst the 25 per cent most deprived in the country. A high proportion of Ealing's population is Asian, and in Southall more than 75 per cent of the population is from a black and minority ethnic (BME) community. Ealing is also home to between 13,000 and 15,000 refugees and asylum seekers. In past decades migrants from Poland, South Asia and the Caribbean have settled in Ealing. More recently, refugees have come from Somalia and other parts of Africa, Afghanistan, the Middle East and Eastern Europe. They commonly meet barriers to NHS access, in particular because of language, mobility, difficulties in registering with a GP and a lack of staff awareness as regards entitlement and cultural needs.

Meeting the mental health needs of such a diverse population is challenging for all service personnel, including counsellors, who have been an integral part of primary care mental health provision in Ealing for over 10 years. Ealing originally acquired a piecemeal counselling

service as a result of fundholding initiatives in the 1990s. During this period, individual GP surgeries in Ealing held their own budgets, and many employed counsellors according to the perceived need for their services within localities. Responding to the increasing public demand for counselling, West London Mental Health Trust and what was then known as Ealing Health Authority decided to start a service for non-fundholding practices as well. For some years, the two systems existed side by side, with some counsellors attached to individual practices and others employed by the Mental Health Trust. However, in 1998, the Government's NHS plan emphasised the role of clinical governance and equity of access for all primary care services, and this resulted in considerable changes to the way in which the counselling services in Ealing were managed and organised. Following the abolition of fundholding in 1999 and the publication of the National Service Framework for Mental Health, there was a radical reframing of primary care health services involving the introduction of primary care commissioning. In 2002, a number of counsellors who had been independently employed by GP practices in Ealing joined the existing counselling service from West London Mental Health Trust and integrated

into the newly formed PCT. In 2005 all the counsellors moved from self-employed status into employed status within a managed service in order to meet the governance requirements of the PCT. With the provider/commissioner split, the whole wellbeing service became part of a provider alliance, which has recently expanded to become Ealing and Harrow Community Services.

From 2004 onwards, counsellors started to work alongside new staff brought into the PCT, including primary care mental health workers (PCMHWs) who offered signposting and guided self-help for mild to moderate anxiety and depression. During 07/08, staff in the service included a service manager, a clinical lead, 12 part-time counsellors, psychotherapists and counselling psychologists, four gateway workers, seven PCMHWs and four cognitive behaviour therapists working from the mental health trust but located in the community, between them receiving 3000 referrals. Over 2000 of these referrals were for counselling alone, resulting in long waiting lists for patients: a clear signal that the service needed redesigning.

In 2007, Ealing PCT, together with West London Mental Health Trust, won a bid to become a 'pathfinder site' for the Government's Improving Access to Psychological Therapies (IAPT)

Year	Staffing complement
2007/08	<ul style="list-style-type: none"> ■ 12 Part-time counsellors ■ 4 Gateway workers ■ 7 Primary care mental health workers (PCMHWs) ■ 4 CBT therapists ■ Clinical lead ■ Service manager
2009	<ul style="list-style-type: none"> ■ 12 Part-time counsellors ■ 4 Gateway workers ■ 5 Vocational advisors ■ 7 PCMHWs ■ 37 IAPT low/high intensity trainees ■ 5 CBT therapists ■ 2 CBT clinical advisors ■ 3 Community development workers ■ 2 Advocacy workers ■ Physical health co-ordinator ■ IAPT lead ■ Clinical lead

Table 1: Ealing PCT Mental Health and Wellbeing Service staffing levels

programme¹ providing additional cognitive behaviour therapy (CBT) focused on delivering culturally-relevant mental health treatment and support for BME communities within Ealing. In 2008, another joint initiative between Ealing PCT and West London Mental Health Trust resulted in a further successful bid to become an IAPT expansion site². This led to the recruitment of 18 low-intensity and 19 high-intensity CBT workers in October 2008 and the integration of CBT and primary care counselling services (Table 1). In 2009, we launched the current Mental Health and Wellbeing Service (MHWBS) at its new headquarters in Uxbridge Road.

Counsellors: part of an integrated service

In the MHWBS, we have been determined to seize the opportunity to develop innovative ways of working and to offer a genuinely integrated primary care mental health service which breaks down traditional barriers to multidisciplinary working. Rather than working in isolation, counsellors and psychotherapists now form a central component of each of three local teams that all include a team leader, clinical advisors for CBT; wellbeing advisors (low-intensity IAPT workers) and PCMHWs offering guided-self-help and signposting for mild-moderate depression and anxiety; high-intensity IAPT trainees and CBT therapists offering CBT; and counsellors offering brief interventions (six to 12 sessions)

for a variety of psychological issues such as depression in the context of relationship problems, trauma, refugee and dislocation issues, postnatal depression, work-related stress and health anxiety. Importantly, rather than insisting that counsellors re-train and integrate CBT principles into their clinical practice, the PCT has ensured that counsellors continue to offer a variety of models of practice, including psychodynamic, humanistic and integrative. This variety is highly valued in the service, not only as a means of ensuring patient choice, but also because counsellors, GPs and mental health commissioners recognise that not all patients require or are appropriate for CBT.

The MHWBS has established a strong partnership with Twinings, a social enterprise that offers support for people experiencing stress at work and advice on returning to work or undertaking further skills training. Vocational advisors from Twinings attend referral meetings and liaise with mental health practitioners where referrals indicate employment issues. Partnerships with voluntary

sector agencies mean that we can signpost to women’s domestic violence counselling and support, advocacy services and support for carers. We also have the services of community development workers, a strategic role that links with voluntary sector providers, identifying and working to fill gaps in mental health provision for BME communities. Finally, we are determined to have the patient voice at the centre of our service. Everyone referred to the service is invited to attend bi-monthly service representative meetings, chaired by a service representative and a carer. We have noticed that our patients are very willing to participate in these events and are helpful in pointing out to us where they think the service can be improved. Patient representatives are also consulted about policies and protocols for the service and help in the design of promotional literature.

The MHWBS has implemented a number of programmes to address the complex mental health needs of people within Ealing. These include:

- A self-esteem psychoeducational group in Greenford. This is linked to a therapy group provided by psychotherapy trainees from Metanoia, a local psychotherapy training institution
- Computerised CBT packages for use at home or at a number of accessible sites, including GP practices
- Books on prescription, available through local libraries
- A gay and bisexual support group, offered by Anchor Counselling Service in partnership with the MHWBS
- Smoking cessation service
- 'Choosing health: Food to feed your mind' local cookery groups to support healthy eating.

Further initiatives are aimed at supporting people with mental health

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issues in Ealing's BME communities and improving accessibility, since referrals have been consistently much lower for people from these communities than for the white communities. These initiatives have included:

- Group work to support those with mild-moderate depression, in partnership with local voluntary service provider, Asian Family Counselling
- Translating material for BME communities: a booklet describing the different psychological therapies that are available has been translated into Punjabi, with further translations planned for the future
- Staff recruitment: five staff who speak a range of Asian languages have recently been recruited to the MHWBS
- Psychoeducational and counselling group work, offered in Arabic, Farsi and Kurdish to Middle Eastern clients.

Single point of access for referrals

Working in local teams has meant radical changes to the way mental health professionals work together. Previously counsellors and psychotherapists were working largely in isolation in GP surgeries, with little contact with the rest of the service. Referrals for counselling were collected and administered by a central booking service, while referrals for other disciplines each had their own separate systems. This resulted in a cumbersome and unnecessarily complex referral system for patients, and a lack of co-ordination between referrers and mental health practitioners. GPs in Ealing were keen to see a single point of access to the new mental health service, ensuring a more streamlined referral system across all disciplines and localities. Now, all referrals to the MHWBS are made on a newly-designed single referral form. On the basis of the referring GP's locality, referrals are sent to one of the three local team centres, usually by email. Referrals are logged onto computer spreadsheets and discussed at a weekly interdisciplinary referral meeting where they are allocated to the most appropriate practitioner in the team.

Case study: 'stepping up' to counselling*

Ada was referred to the MHWBS by her GP for help with mild depression, and she attended an initial assessment with a PCMHW. During the meeting, she described her main problems as sleeping difficulties and anxiety, revolving round her financial situation and problems with her son. As she started to discuss these issues, however, she revealed that, as a child, she had witnessed her father being physically abusive towards her mother. To get her mother's love and attention she said she had begun purging and vomiting, behaviour that continued until adulthood. Another significant event was the death of her boyfriend from a drug overdose some years previously. Ada reported feelings of deep guilt and shame as he had not been a regular drug user and she had provided him with drugs on that occasion. The incident had caused her such distress that she had tried to harm herself and was subsequently sectioned under the Mental Health Act. At the end of the session, Ada said that she needed help to cope with the anxiety arising from these issues in her past. The PCMHW felt that Ada's case needed to be 'stepped up' following the assessment, and discussed it with the team at their next referral meeting. It was felt that Ada was currently functioning reasonably well, and did not need any immediate psychiatric help. Her care was passed to one of the counsellors, and Ada was offered a three-month period of brief focal therapy.

Case study: sharing patient management*

John, a man in his early 40s, was referred to the MHWBS by his GP who was concerned by John's acute psychological distress and aggressive behaviour. John was assessed by a gateway worker, who found that John had been sexually abused as a child by several people. He said that his feelings of anger and resentment had been growing for many years and his aggression towards the perpetrator of the abuse had now developed into homicidal threats, which alternated with suicidal thinking and planning. John had been aggressive since his teens, often getting into street fights. He had had several relationships with women over the years, and had four children with different partners. His current relationship was supportive, but he said that he found intimacy frightening and tended to react with violence to his partner's wish for physical closeness. At work, too, he had been increasingly aggressive towards colleagues and he had recently lost his job. At a referral meeting, the gateway worker discussed her concerns about John's behaviour and the risk issues he presented to himself and others. The team felt that John might benefit from a psychiatric referral to the local community mental health team (CMHT), as well as ongoing counselling to work through some of the long-standing issues connected with his history of sexual abuse.

John received 10 weeks of counselling together with regular support from the gateway worker to help him maintain contact with the CMHT. During this period, John was also referred to the vocational advisor for help with considering future employment options.

*Client details have been altered to protect confidentiality.

Self-referral has just been introduced into the service, so that people wanting help for mild depression and anxiety can telephone a helpline to speak to a local IAPT wellbeing advisor. Some of these individuals will then be referred to counsellors in the team.

Interdisciplinary work

Working in local teams has meant a more streamlined approach to

'stepped care', as recommended in the National Institute for Health and Clinical Excellence (NICE) guideline on depression³. NICE suggests that patients are offered access to therapies that are appropriate to individual need and the intensity of the presenting problem. People who are referred for mild-moderate depression and offered one-to-one psychoeducational advice and guided self-help by wellbeing advisors

can be 'stepped up' for counselling where it becomes clear that more complex issues need to be addressed, as in the case study: *Stepping up to counselling*, above. Others may benefit from the input of several different staff within the team, e.g. support from a gateway worker offered alongside group work and employment advice from vocational workers (see the case study: *Sharing patient management* below). We have found that regular team meetings in conjunction with informal email groups (particularly useful with part-time staff) encourage counsellors and other team members to communicate more effectively with each other, and to provide a faster, more effective service for patients.

Links with West London Mental Health Trust

Interdisciplinary work includes collaboration with our colleagues at the West London Mental Health Trust. Regular meetings occur at every level, from service managers and clinical leads to local team members. The gateway worker role is especially significant in this interface work, and gateway workers attend local referral meetings at the community resource centres in order to pick up referrals that are suitable for primary care and act as links for joint work. This work has highlighted a lack of longer term therapy for those whose psychological problems fall outside the remit of IAPT provision but do not meet the clinical threshold for referral to secondary care services. In order to facilitate recognition of these and other complex clinical issues, joint training initiatives are carried out by all members of the MHWBS team, including counsellors, to help health professionals within primary care recognise and refer a range of mental health problems.

Data collection and service evaluation

The advent of IAPT has been a challenge for the service. Not only has the influx of a large number of new staff required considerable managerial and organisational change, but the routine data collection systems and software required by the IAPT programme have introduced a new standard of evaluation into

the service. All IAPT workers take a number of clinical outcome measures every session, including scores for depression (PHQ-9)⁴, anxiety (GAD-7)⁵, social phobia (social phobia inventory)⁶ and other measures relating to work and social adjustment. Counsellors in the service were concerned that they too would have to undertake the same amount of data collection each session. However, there was recognition by both clinical and managerial leads that this level of data collection was burdensome and would require time and training to introduce. The debate over whether sessional data collection may actually be counterproductive in the context of an ongoing therapeutic relationship continues, and the possibility of counsellors moving to completing the full set of measures for inclusion in the IAPT data set is being considered. At present, counsellors provide regular activity and social inclusion data as well as clinical outcome measures, which are taken at the beginning and end of the counselling contract only. These measures include PHQ-9, GAD-7, CORE-10⁷ (a global measure of psychological distress), and a final client satisfaction questionnaire. From 2008/09, we worked hard to produce a streamlined IT data collection system for each local team. Each of the three teams now has a part-time administrator to input data so that activity and clinical outcomes for the teams can be recorded and evaluated alongside those recorded via the patient case management information system (PC-MIS) software of the IAPT programme. We provide monthly activity and outcome reports to the PCT alongside IAPT outcome data. Since the launch of the service in January 2009, it is clear that referrals are on a rising trajectory, with an overall total of 318 referrals to the service in January, rising to 490 in March.

Psychological expertise

Organisational changes in the MHWBS have meant changing roles for counsellors and psychotherapists, many of whom have extensive training and primary care experience and who hold additional clinical or senior academic positions elsewhere. This level of experience has been recognised within

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the service, and counsellors are called on to offer their training and clinical expertise in a variety of ways.

- *Assessment:* Counsellors and psychotherapists have considerable experience in complex assessments, and play a crucial role in the weekly interdisciplinary referral meetings. Where referrals clearly point to a complex attachment history, self-harm issues, borderline personality disorder or a history of trauma, neglect or abuse, counsellors are usually asked to assess the individual. In addition, counsellors may be called on to provide advice and guidance to GPs on mental health risk issues in primary care.
- *Reflective practice:* The IAPT project has meant that a large number of new and relatively inexperienced mental health staff need support to manage issues and problems arising from their clinical work that are not discussed in case management supervision. While their role is geared to managing mainly mild-moderate depression and anxiety, in reality we have found that many staff often have to deal with more complex and sometimes disturbing cases, and need a protected space in which to manage their feelings and concerns. In 2008, we piloted the use of a 'reflective practice' group for PCMHWS, facilitated by one of the counsellors. This was so successful that counsellors have now been asked to set up and facilitate several groups for the new

- IAPT workers to prevent burn-out and provide support for ongoing clinical work. This is being rolled out across the service during 2009.
- **Supervision:** Counsellors and psychotherapists are also seen to have a well-developed model of clinical supervision. Along with other disciplines, they lead supervision groups for the PCT's clinical supervisors, who include health visitors, district nurses, school nurses and managerial staff. These interdisciplinary groups offer a regular forum to explore and reflect on supervisory and practice issues together, and to establish common professional ground between colleagues from different parts of the PCT. The counsellors' therapeutic skills in group work and problem-solving have been essential to developing this role within the service.
 - **Training:** Counsellors also have a role in training colleagues to use counselling skills and to understand more about the dynamics of psychological distress. They have been part of joint training within the Mental Health Trust, providing input for GPs on managing risk within primary care. Many also have links with training organisations, and are able to provide clinical supervision for counsellors, psychotherapists and counselling psychologists on placement in the service. From September 2009, six new psychotherapy trainees will be invited to take up clinical placements at our headquarters in Uxbridge Road, complementing the work of IAPT trainees and learning about work within primary care.

Complex cases

With the rise in referrals, one of the challenges facing counsellors in the MHWBS is the increasing number of patients presenting with complex, co-morbid or long-standing psychological problems that do not match the criteria for either CBT or secondary care services. An audit in 2008 examined a random sample of clinical scores (PHQ-9, GAD-7 and CORE-10) taken at assessment for patients referred for counselling over a six-month period. Nearly a third (31

per cent) of CORE-10 scores fell into the severe category, indicating a very high level of general psychological distress, while 46 per cent of the GAD-7 scores also showed anxiety levels within the severe category. A more even spread of clinical severity was seen in the PHQ-9 depression scores, with equal numbers of clients presenting with moderate, moderately-severe and severe distress. However, 26 per cent of the sample scored for elevated risk of self-harm or suicide. Many of the problems presenting in these more severe cases included:

- Complex co-morbid conditions – e.g. depression and anxiety in the context of a history of sexual abuse, trauma or neglect.
- Borderline personality disorder, usually involving extensive multidisciplinary support and ongoing management.
- Unexplained medical symptoms, frequent attenders.
- Complex inter-generational relationship/social problems.
- Parent-child attachment problems, e.g. postnatal depression.
- Risk issues, including sub-clinical eating disorders, substance abuse, self-harm and suicidal ideation/ attempts, usually in the context of a long-standing history of depression, relationship problems and/or social deprivation.

As the IAPT service develops and increases in capacity, we anticipate that our IAPT wellbeing advisors and CBT therapists will take more of the referrals for anxiety, depression and other mild-moderate mental health problems. This means that the remaining referrals are increasingly likely to include these complex psychological problems. We are currently exploring the possibility of developing a small, medium-term psychotherapy service so that referrals for these more complex cases, which fall outside the remit of IAPT, can be treated over a longer period (e.g. 30-40 sessions) while remaining within primary care.

The future

The MHWBS is still developing. We face a number of challenges, including lessening the stigma associated with mental health problems; increasing

access for older people and younger men within Ealing; improving perinatal mental health; developing services for medically unexplained symptoms and pain management and contributing to the public health agenda on obesity and coronary heart disease. Counsellors and psychotherapists have shown that they have an important and developing role to play in the service, integrating with other professional disciplines and members of the primary care team. However, we are not complacent: we know that in a time of increasing competition and constant change all team members need to continue to develop new ways of working to meet the challenges ahead. The past year has been a time of rapid expansion and rising demand for our service; we need to consolidate our achievements and work towards our goal of a comprehensive primary care mental health service that meets the needs of the population in Ealing. ■

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