

# **New Ways of Working for Psychological Therapists**

## **WORKSTREAM FOUR**

**How psychological therapists can work  
collaboratively in Multi-Disciplinary Teams across  
Care Pathways**

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## Purpose of the workstream

1. Putting the user and carer experience at the heart of the workstream's objectives, the aim was to describe best practice models of multidisciplinary working for psychological therapists and models of effective care pathways using a stepped care approach. This focussed, for this stage of the work, on IAPT services and their interface with other services at both primary and secondary level.

2. Terms of Reference, included *two dimensions* to the work:

- Looking at operational models within IAPT services, and possibly testing CCTA and Lean thinking at a later date.
- Looking at the relationships / interface between IAPT services and other services both within primary care as well as secondary care.

## Introduction

3. The New Horizons consultation sets out a vision for mental health services from 2010 onwards; at its heart is the promotion of wellbeing and resilience. It presents a whole systems approach to mental health and wellbeing, focusing equally on public health and the delivery of services for whole populations. This broader approach to mental health necessitates greater collaboration at the local level across all public services that impact on people's lives.

4. The challenge for 21<sup>st</sup> century care is for the teams in each element of local health, community and social care systems to work collaboratively around the needs of people accessing their services. Clinicians and practitioners are increasingly required to work in multi-disciplinary teams that may span different services; this requires knowledge and understanding of what other services in the system offer and how they can help patients. Effective collaborative working also requires appropriate:

- leadership
- administrative systems
- communication
- culture/ behaviour
- training

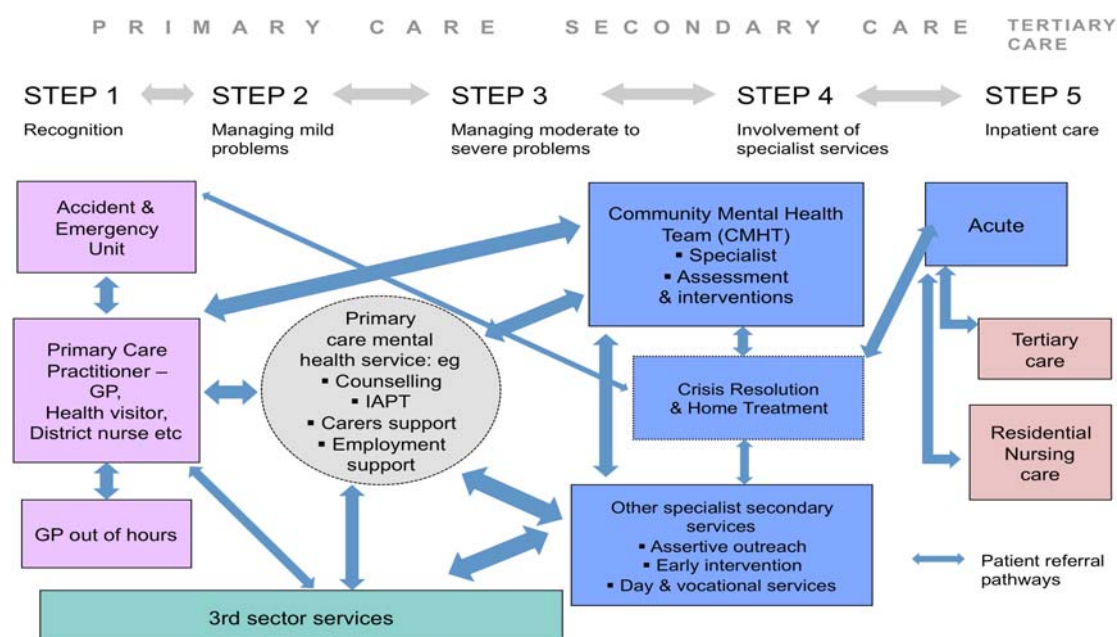
5. This report explores these five key areas, and others, to provide specific examples of positive practice in collaborative working for Improving Access to Psychological Therapy (IAPT) services. It draws on evidence collated from interviews (with IAPT service managers and practitioners) and site visits (including observations of team meetings).

## IAPT context for multidisciplinary working

6. IAPT sites provide services in the context of local systems of health, social and community care. Some patients who access IAPT services are also engaged in services in other parts of this system and some patients referred to IAPT sites need referring on to other services.

7. The following diagram<sup>1</sup> presents a generic interpretation of the mental health care system, indicating where IAPT and other psychological therapy services fit within this system and typical referral paths between services.

Table 1



<sup>1</sup> NHS commissioning – a toolkit for providers of psychological therapy services Hurford, Robinson & Watson, BACP, 2009 (page 27)

8. In this context, practitioners in IAPT sites work in multidisciplinary teams which can include:

- Psychological Wellbeing Practitioners (trainee and qualified)
- High Intensity Therapists (trainee and qualified)
- CBT therapists
- Primary care counsellors
- Graduate primary care mental health workers
- Psychotherapists
- Clinical and counselling psychologists
- General Practitioners (in particular GP's with a special interest in Mental Health)
- Voluntary & community sector workers (commissioned by NHS e.g. Relate and cruse bereavement, MIND)
- Employment advisors

- Advocates for physical activity
- Community Development Workers
- Health Trainers
- Gateway Workers
- Occupational Therapists
- Arts Therapists

## **Methodology**

9. The group's initial work involved:

- Discussion within the group using their own experience of the development of IAPT and its introduction into different teams
- Gathering information available in the short-time scale that new IAPT services have been operating.
- Inviting teams to be interviewed
- Planning for group members to attend team meetings
- Identifying work that needed to be completed

10. The whole group took forward the above and conducted in-depth interviews with representatives from three IAPT teams Ealing, Haringey, and Knowsley and subsequently, different members of the group attended working meetings of the teams. Having reviewed the gathered information of the teams experience, the group synthesised the various factors that appeared to contribute to the success or otherwise of the service.

This gave helpful insight into three very different teams and how they operated. There were many similar issues and processes.

11. The group agreed that in order to make best use of the time it had available it would concentrate on highlighting general issues, and identifying Core Principles that had emerged, and possible next steps.

## **General Issues/Processes for IAPT Multi Disciplinary Teams which seemed to be helpful**

1) Having a Single point of access (SPA)

- SPA moved waiting lists from 350 to 50/55 in a short space of time.
- SPA avoided service user being pushed around the system-the service revolves around client and addressed their needs

2) Referral meetings-all cases logged and discussed, IAPT workers doing assessments, quick assessment and offer within a week.

- Sharing of experience-by having group/referral meetings
- Having clarity of need and response,

- 3) MDTs gave a place for Community Development Workers to input and identify gaps
- 4) Service Users were involved in satisfaction surveys-monthly meeting-and in recruitment process
- 5) Need for partnerships at all levels
  - Good links to CMHT via Gateway Workers who linked both ways.
  - Working closely on CBT improved networking and working together.
  - No exclusive working
  - Involvement of Occupational Advisors and health trainers
  - Example of Service that had developed from two teams with 6-7 staff to 35 staff early 2009 and would end with 70 staff in late 2009.
  - Service could be flexible and trans-cultural where needed.
  - The 'can do, young 'out there' staff', committed, with great enthusiasm helped.

**12. The teams interviewed had the following characteristics:**

- Based on competencies not professions
- Had IAPT workers that needed to interface with a range of other teams
- Practice that was based on evidence
- Had seen many clients with co-morbidity
- Were IAPT centric and embedded,
- Multiple skills working together

**13. Teams were facing the following issues:**

- Graduate and other workers in the team were leaving to undertake IAPT training this left real gaps for the rest of services.
- Teams need to have staff that reflected the population served, but this was not always the case. Haringey was an example of good practice in that it had changed its recruitment process to encourage applicants from Turkish and Kurd people for both Li and Hi trainee places to reflect its population needs.

- IAPT teams need to link with Psychology and Psychiatry colleagues at steps 3/4/5

**14. Core principles that seemed to contribute to successful IAPT team working** presented under five headings that represent the main themes identified in this report:

- 1) culture/ behaviour
- 2) training
- 3) leadership
- 4) communication
- 5) administrative systems

#### **15. Culture/ behaviour**

- 1) Teams worked in a collaborative and flexible way around the client and between teams in the local context
- 2) Teams where staff had respectful, hopeful and positive 'can do' approaches, and not 'it's not my job/role' approaches
- 3) The nature of Multidisciplinary working depends on where the team sits, the more co-location options the better
- 4) Teams worked and learned in a multi-agency context
- 5) Good links were important so IAPT was appropriately meshed in with other services, it was generally perceived as an added value service (not as a competitor), had developed real working relationships with other services (with regular meetings), and had clear protocols with them (especially around care pathways/referral)
- 6) There were examples of best practice such as the use of co working in Ealing with a Psychological Wellbeing Practitioner (PWP) and employment advisor providing a more focussed and client centred approach to what was important. The matching of discipline to setting in Knowsley with staff working in Cardiac service/third sector.

#### **16. Training**

- 7) Teams where integrated team training took place and opportunities for discussion about supervision supported teams during a period of transition and aided working together during the huge learning curve
- 8) Teams that have a range of professional, multidisciplinary skills and competencies available

#### **17. Leadership**

- 9) Teams that have central control by the team manager along with freedom to act for the individual

10) In teams visited it was clear that the leaders' personal style influences the team culture which in turn is crucial to how the work gets done.

11) Teams appeared to be working in a flattened operational management way that enables decision making.

### **18. Communication**

12) Teams that have clarity about what the IAPT service is.

13) It is clear that some teams had spent time to enable staff to conceptualise the service they were developing, and they shared enthusiasm for its development. This had enabled discussion amongst the team to help sort out issues.

14) Importance of synergy and an understanding across the team so that

- clinical and other workers were aware of each others roles,
- high intensity & PWPs/trainees shared information and worked together.

### **19. Administrative systems**

15) Clear pathways that were based on the stepped care model and an understanding of the use of screening, triage, access, and seeing the right person first.

16) New IAPT teams needed initially to focus on service design, operational management and the context in which they would work

17) Teams needed to understand and be clear about access, referral criteria, and information systems and how to best use systems, such as PC-MIS

18) Improving client choice, access and information was an issue for further work for some teams.

### **Group Visits to teams**

20. Visits were carried out to enable greater understanding of how MDTs worked in practice. The main focus was to look at the introduction and development of IAPT through the experience of three IAPT teams. The teams were from

- Ealing PCT
- Haringey PCT
- Knowsley PCT

21. The teams were chosen to reflect different settings, location, and ease of access for gathering information and undertaking the site visits in the short timescale available and had the added benefit that group members were

familiar with the PCTs and services. It was also understood that there was a history of collaborative working.

**Knowsley team - May 2009,**

**Premises:** Knowsley Health and Wellbeing Whiston Primary Care Resource Centre.

The team now operates within a modern Primary Care Health resource centre and other community sites and was initially developed out of a secondary care trust and placed within the PCT in 2004. It developed its model around a stratified stepped care model

Barry Foley and Malcolm Allen met with Sandra Jackson and colleagues from the team and wider services. The visit involved observed discussions at a regular team meeting on the following,

- Team Brief
- Administration
- Discussion on protocols
- Identifying correct step/therapy/stepping up
- Serious case review
- Planned updates
- Other business items

This team meeting brings together IAPT and its partners which consisted of: Primary Care Mental Health Lead, IAPT service, Listening Ear voluntary counselling service, YWCA, Alcohol service, Cardiac and Stroke services and Weight Management service and service user representatives, Secondary care, and commissioners. The meeting continually enhances links and strengthens the holistic approach towards working with clients.

There was opportunity for the team to discuss admin, clinical, training / supervision and other issues, and for colleagues to meet and team build. The IAPT HI and PWP trainees although recruited by the PCT, are placed within these IAPT partner services. As part of the IAPT service they are integrated into the programme alongside a range of professionals who provide evidence based therapies and consist of: CBT therapists, psychological therapists, Interpersonal Psychotherapists, .and GMHW. The service strength is that it allows for a broad range of therapies to be offered so meeting local needs and so supports shared referral protocols and therefore a seamless service provision across steps 1-4, which is within the lead IAPT service, and step 5 being within specialist services. The team also hold other meetings including assessment/triage sessions. All workers called the IAPT data set.

The service places all therapists / workers in sessions within GP's practices and health resources centres; this also supports the interface / relationships with the GP and other colleagues and is a positive commitment to local needs, and to enable easier access to the service.

## IAPT Haringey Team - June 2009

Jane Rosoman met with Eric Karas, Director of Psychological Therapies from the Mental Health Trust and Michael Rooney the IAPT team leader and colleagues from the team. (Dorian Cole the IAPT Service Manager was on Leave)

**Premises:** Currently this is a traditional site in the Mental Health Trust (St Ann's Hospital). The IAPT service appears to be working alongside the existing primary care service delivered by the Mental Health Trust within Mental Health Trust premises; thus the impression received was more secondary care than a community primary care service. Dedicated IAPT accommodation is planned and step 2 workers attend local surgeries on a part time basis and are based in community settings including libraries.

The local team set up in Highgate which is the prosperous end of the Borough was not visited. The intention is to base IAPT in the east side of Haringey which has far less provision historically.

**Interface Issues:** Weekly meetings take place between the primary care team from the Mental Health Trust and the IAPT team. This is a clear example of joint working and protocols have been shared. The existing service from the Mental Health Trust and the IAPT service commissioned from primary care are now integrated through a Partnership agreement. The strength of this joint team is that they cover the range of common mental health problems and have staff who can offer not just CBT but a range of psychological therapies.

Partnerships including working with the voluntary sector include NAFSIYAT (an Intercultural Therapy Centre) Derman (a Turkish, Kurdish Community Organisation offering a variety of Health and Social Care services to residents of Hackney and Haringey) and the African Caribbean Leadership Council, which provides a variety of counselling and therapy services for people of African and African Caribbean background.

However, to set up a new service in a relatively short time frame required an initial focus on planning and delivery to meet the targets set for IAPT. Developing wider external relationships will follow.

The commitment to both services is evident and it is along traditional, professionally developed lines. Whilst the patient voice was not heard in any of the discussions on that day it is understood from our expert by experience, relations are good and they are frequently consulted. Counsellors and psychotherapists are very well integrated into the Mental Health Trust Team. IAPT have some counsellors working in GP practices. They also have Community Development Workers.

Relationships with General Practitioners are excellent. There is a very active GP collaborative which is a sub group of the Local Implementation Team (LIT). This group of GPs with a LES (local enhanced scheme which an additional payment to GPs for mental health) has been closely involved in all the developments and ensure GP colleagues are informed about recent changes.

## **Northolt & Greenford (part of Ealing PCT) - June 2009**

### **Key points discussed in meeting with Team Leader Erika Glockshuber**

- Premises are in open plan office behind GP practice. Clinical work done elsewhere.
- IAPT seen as an opportunity to strengthen the team and grow from 8 to 35
- The MDT and different modalities of therapy benefits choice, appropriateness of therapy and ultimately outcome
- All referrals are discussed at a MD referral meeting
- There is work inter-team to build the team/ teams (see some examples from team meeting below)
- There is work intra-teams, for example to build team working with GPs they are holding workshops (a collaboration with the service manager, a GP Lead and a Psychiatrist) and sending a bulletin to GPs
- There is also an area network of counselling service providers including NHS, voluntary and community sectors which the Team Leader engages with

### **Observations in team meeting**

- Demonstrable mix of new vision through new workers and the benefits of experience in longer standing members of the team – this has led to some creative and workable solutions such as a shared administration system for keeping a calendar of team member's locations and the introduction of a new service for patients (self-esteem group)
- Evidence of good inter and intra team communication necessary for good team working
- Inter-team building examples: meetings including representation from the different internal teams, a newsletter and discussion of a team building day
- The team manager was very specific in communicating information and feedback from commissioners, for example about clinical governance requirements. The team manager was also very specific in giving positive feedback
- There was a visitor to the meeting from the voluntary sector who gave a presentation – a demonstration of linking with other partners in local service provision

### **Outcomes: In addition to the above the group observed that**

22. In the teams visited the leaders' personal style influenced the team culture which in turn was crucial to how the work gets done. It appeared that no one professional group could claim to be the lead profession. Important meta-competencies were:

- Holding the values and ethics of public service that build transparent, diverse and inclusive workplaces
- Strategic thinking that scans the complex environment anticipating crises and opportunities and promoting innovation.
- Engagement with people, partners and organizations in creating a shared agenda and delivering results.

- Operational management that supports organizational effectiveness and sustainability by ensuring that the management of information and knowledge is a responsibility at all levels.

23. There appeared to be a lack of a proper shared understanding of a 'stepped care' model. Within various NICE guidelines, there are different 'steps' for different conditions. There seems to be an assumption that there is a common understanding of 'steps' as describing a clinical service. It's worth emphasising the following points:

- that IAPT services are configured very differently - both in terms of their positioning within the matrix of other mental health services (primary and secondary) as well as in terms of their internal organisation.
- What seemed to be the case is that no particular configurational model was the right one or the best one.
- However, what did seem to be important was that IAPT was appropriately meshed in with other services, was generally perceived as an added value service (not as a competitor), had developed real working relationships with other services (with regular meetings), and had clear protocols with them (especially around care pathways/referral).

### **Next Steps:**

#### *Pilot sites on collaborative services*

24. It was suggested that 4/6 pilot sites undertake further work to develop thinking on MDT working, to test out the wider IAPT team including IPT and other evidence based modalities and how this relates to non IAPT work and workers.

- To explore MDT/Teams including the use of CCTA and Lean thinking and three teams are already engaged three more teams needed.
- The relationship between IAPT and non-IAPT services: clarity of roles, function and how best to use all staff in stepped care.
- To understand Stepped Care Model which identifies roles that support each step. An example of which is set out in table 2.
- To review recruitment of staff from local communities through flexible entry to posts and to training, including undergraduate roles and access courses.
- To consider the impact of recruitment into IAPT and other local services.

**NWW: WORKSTREAM 4 – FINAL DRAFT**

TABLE 2 Example of a Stratified -Stepped Care Model - Knowsley PCT..

Please note that the diagrams/models in this section of the report are to enable and encourage discussions

	Step 2	Step 3	Step 4	Step 5 Secondary M.H.
Intervention	Graduate Mental Health & low intensity worker offering: assessment, sign posting, case management, cCBT (FearFighter), Book prescription, Medication management, Manualised therapy & Sleep Hygiene	Psychological therapists & High intensity workers, offering: assessment, sign posting, case management, psychological therapies: Brief CBT (by CBT therapists) Eclectic Psychotherapies. Employment support (links to job centre plus/ condition management / Retain / Regain across all steps)	Specialist therapists & CBT therapists offering: assessment, case management, CBT and Interpersonal Therapy. EMDR, Substance Misuse Specialist Nurse therapist offering recovery & progression.	Specialist Mental Health assessments & treatments EDT team offering: psychological therapies, inc. CBT, Integrative, EMDR.
Psychometric Scores	PHQ-9 5 > 9 CORE10 <14 GAD-7 0>10 EPDS 10>12 & Q10=0	PHQ-9 10 >19 CORE10 15 >19 GAD-7 11> 15 EPDS 12>19 & Q10=0-2	PHQ-9 19 + CORE10 20 > 24 GAD-7 15 + EPDS 19+ & Q10=2-3	As previous but with risk items scored.
Common Mental Health condition	Mild to moderate Anxiety inc. Panic, social anxiety, phobias. Mild Depression, Sleep problems.	Moderate / moderate to severe Anxiety & Depression, Post traumatic reaction, Complex grief, Interpersonal issues, work related stress,	Severe Anxiety based conditions Panic, Agoraphobia, PTSD, GAD, Somatoform, Phobias, OCD. severe depression.	SMI, Complex / treatment resistive disorders, PD.
Functioning ability	Minimal impact upon regular functioning, e.g. work, social, personal, sleep, diet. Minimal avoidance/inactivity.	Moderate impact on functioning - work, social, personal, sleep, diet.	Moderate / severe impact upon functioning with more complex needs.	Significant impact upon functioning / complex needs.
History	Little past occurrence of symptoms with minor severity.	Previous recent episodes with moderate severity.	Longer history of condition or recent complex onset.	Enduring condition or complex onset
Risk using TAG	Minimal suicidal ideation, No intent. TAG = 0>4	Low/moderate suicidal ideation/ intent. TAG 5> No "Severe".	Low/moderate suicidal ideation intent. TAG 5> No "Severe".	High Suicide Risk

## ANNEX 1

### Membership

#### Joint convenors:

Barry Foley	Co-chair, Senior Workforce Consultant
Malcolm Allen	Co-chair; CEO, British Psychoanalytic Council
Jane Rosoman	Clinical lead, Mental Health & Wellbeing, Ealing PCT
Ellie Kavner	Head of Systemic Psychotherapy, Tavistock and Portman NHS Trust
Vicky Franks	Consultant Psychotherapist and Vice-Dean, Adult Department, Tavistock and Portman NHS Trust
Fenella Lemonsky	Expert by Experience
Louise Robinson	Healthcare Development Manager, BACP
Laura McGraw	Nurse consultant
Steve Humphries	Associate Director NWW/Consultant Psychiatrist until March 2009