Review of St Andrew's Counselling and Psychotherapy Service in York and proposal for the development of an integrated personality disorder service in York and North Yorkshire: final proposals following public consultation

1. Introduction

Over the past two years, York and North Yorkshire (YNY) services have been reviewing the existing St Andrew's Counselling and Psychotherapy Service. The review has involved a number of different steps; including, most recently, broad public consultation on our proposals. This paper sets out how we have developed the current proposal, our responses to consultation, and our final model for local personality disorder (PD) services and psychological therapies provision.

2. Why we are changing

A detailed review of mental health services in YNY demonstrated that there are gaps in the current pathway for people with PD. Some PD services were offered from St Andrew's; however they did not meet the full range of needs within the population which we serve.

In addition we found that access to psychological therapies services was unclear, with numerous points of access and no clear criteria for the various different small services which existed. Again, some psychological therapies were provided by St Andrew's, whereas others were provided by different teams.

To help us to understand what needed to change within our PD pathway, we first mapped out how people accessed the St Andrew's service, identifying where there might be unnecessary delays and hurdles for service users accessing the service.

We then held a series of meetings with key staff from York and Leeds, the York staff being primarily those involved in the St Andrew's service (though latterly this has included staff from a wider range of settings) and the Leeds staff from the specialist PD services. We worked with colleagues to better understand the current YNY provision for individuals with PD and the need for future provision. This stage of the process culminated in a workshop with a range of stakeholders in January 2013.

The workshop considered three options for further developing the PD pathway for YNY. The favoured proposal emerging from the workshop was the development of an integrated Trust-wide Leeds and York Managed Clinical Network, with the explicit undertaking that it should include local variation to reflect those elements of the existing service which are most important to service users and staff in YNY; and that it should fit with the current redesign of community services across YNY. It was agreed that this proposal would best support the wider workforce to work more effectively with people with PD. In addition it was agreed that the proposal would ensure equitable access to services; and will inform and build upon the existing evidence base for effective practice with this client group.

We have also consulted more widely about community services in YNY. Service users and the public told us that they want:

- **A clear and simple route in to services.**
- **Services that are connected up so people are not moved around or falling between gaps.**
- **A single assessment process so that people don't have to keep repeating their stories.**
- **Support to guide people through services.**

We are making changes to our community and mental health services to ensure that we respond to this feedback, whilst also delivering the savings that we (like all NHS services) are required to make.

We are putting into place:

- **A single access point into secondary mental health services, including for people in crisis who need more intensive support or inpatient care.**
- **Larger community teams, made up of staff with expertise in working with specific care groups, working together to meet complex needs.**

Since putting forward our initial proposal for changing St Andrew's services we have consulted further with service users, carers and other services (including voluntary sector colleagues) about our proposals, in the context of the wider changes in mental health services. Feedback about people's current experience of services is summarised below.

3. Feedback about current services

Your feedback

- **St Andrew's has been a fantastic service, we need to build on the best of this and help people to get this help quicker**
- **St Andrew's has been a life saver**
- **Waiting times have been a problem for St Andrew's**
- **Waiting times are a problem for IAPT services (in primary care)**
- **Community mental health teams (CMHTs) have been great at getting me back into work**
- **CMHTs focus on severe mental illness - people with PD don't always get service**
- **Hard to get help from psychiatrists**
- **It is the experience of some service users that they are being directed to particular treatments because of their diagnosis (eg people with PD directed to groups) even if this is not what they want**
- **PD diagnosis can make it harder to get services, you lose things when you are diagnosed**
- **Refusal to accept complex diagnosis not looking at past trauma**
- **York is less well funded for therapy than Leeds**
- **Desperate for psychological services in York**
- **We need to recognise the cultural diversity of York which is different from Leeds**
- **Need to clarify what primary care, secondary care and voluntary sector do**
- **Want to see a cultural shift away from medical model to more psychotherapy**
- **Be human, don't turn people into conditions**
- **Need more GP training – help them to "join up the dots"**
- **Having one GP as the person to connect with helps**
- **Worry less about "what is my remit, what are we funded for"**
- **Paid carers don't always know what help is available for people**

- **The stigma is high**
- **Need to work with people who don't want to engage with statutory services**

The final proposals outlined in this document respond to and reflect what we have heard through the consultation process. The paper also reflects the request for more detail about what we will actually offer and how people will access help.

4. Our response to consultation feedback

Our commitments in response to consultation

- **We recognise that St Andrew's provided a highly valued service for those people who accessed it. We have done everything possible to retain the key elements of the service, whilst improving the PD pathway**
- **In response to initial consultation we have identified further funding to provide group psychotherapy in our community services.**
- **We will continue to involve and consult with service users and carers as we develop the new model and review how it is working**
- **We will share openly what we are doing and how it is going**
- **We will support people earlier rather than them having to get worse before getting help: our focus is on preventing crises**
- **We will be doing further work looking at therapy services in primary care (IAPT, counselling and primary care mental health) to see if we can improve how they work together so people don't fall through service gaps**
- **We are including new posts in our community teams to work with people with PD; and to help to build knowledge and expertise about PD and complex psychological needs within the teams.**
- **We will keep under review whether there is any shortfall or gap in what we are able to provide; and we will share information about this, including waiting times**
- **We will work closely with other organisations so that we can signpost people to different services based on their choices and needs**
- **Worrying about where people's needs are best met will be our problem and responsibility, not the GP's or service user's**
- **We are supporting our staff through these changes, offering training, mentoring and opportunities to raise concerns**
- **We will be clearer about what we will offer in the new model of services**
- **We will fully evaluate the impact of the changes we are making and involve the people using these services in any future redesign. The evaluation will be part of the broader community services evaluation as detailed in the project implementation plan and will measure our success against three key questions:**
- **What impact has the redesign had on the quality of the services provided by LYPFT?**
- **What impact has the redesign had on the LYPFT workforce?**
- **What impact has the redesign had on the efficiency of the service?**

Examples of some of the tools we will use in evaluating the model are as follows:

- **Service User and Carer Survey**
- **Staff Culture Survey**
- **Recovery Approach Audit**
- **Team time tracker, which measures key staff activity, ie time spent in face-to-face contact with service users, administration, travel and supervision**

- **Caseload, weighted to reflect service user needs**
- **Analysis of cluster distribution, which describes number and proportion of different needs-led clusters being seen by the services**
- **Performance reports, measuring the service user journey, including ease of access, waiting times, how people move through and around services, inequities in accessing services and transition to other services.**

5. What our new services will deliver

We need to deliver a service that meets the full range of service user needs, within the resources available to us. There needs to be equity and fairness in how we do this. Our services are needs-led, not diagnosis-led: people will be offered evidence-based interventions based on their needs and preferences.

The St Andrew's service currently provides a 3.5 day intensive group therapy programme, run as a Therapeutic Community. It also provides psychological therapies, mainly (but not exclusively) at steps 3 and 4. The psychological therapies component of the service provides types of one-to-one and group interventions that are currently not routinely provided elsewhere in York's secondary care services, eg specialist interpersonal/ psychodynamic therapies. These constitute a 'non-CBT' pathway for service users with complex problems.

From our consultation with services users, other agencies and the public, it is clear that people were most keen to hear in detail what the new service configuration would offer; this section therefore responds to specific questions raised and describes our plans in much more detail.

5.1 Specialist Services

- **A two-day Therapeutic Community**

In consultation people asked:

- **Will the therapeutic community stay remain at 12 months?**
- **What is the rationale for reducing the therapeutic community from 3.5 days to 2 days? Will this increase risk?**

The aim of a therapeutic community (TC) is that the whole community works to run the service and members take on jobs and responsibilities with the staff to make this happen. Members make decisions about how the service works by voting, through a show of hands. It is this democratic way of working that is at the heart of the community's life and this helps to give people a sense of empowerment, choice and responsibility that may be missing in their lives. The community helps with learning more about relationships and how to feel more effective in communicating, as well as with learning new skills or refreshing the ones that people might feel they have lost.

Diverse Pathways, the current Leeds service, meets one day per week and the day involves talking, sharing and doing tasks together that give people different learning opportunities.

The proposed YNY model incorporates a two-day TC as part of the Leeds and York service, with direct management and leadership through the Leeds and York Managed Clinical Network. The two-day model reflects the importance attributed to a longer TC as we have developed this proposal locally. It maintains the therapeutic components most valued by St Andrew's service users.

We recognise that some people are concerned at the reduction in our TC from 3.5 to 2 days. However we do believe this will still deliver a safe and effective service; there are various different therapeutic community models

in operation, ranging from one day per week to one example of an inpatient model. We will ensure that we match individuals with the right intensity of therapeutic work as part of an overall support package, taking account of risk and safety.

Details of how the TC will work in the new model are still being developed; we will involve service users in developing this detail.

The therapist leading the TC will also work collaboratively with the integrated community hubs, helping to ensure that we are able to respond all people who are appropriately referred to our services, according to need.

- **Dialectical Behavioural Therapy (DBT) Skills Group Training**

DBT Skills Groups will also be delivered in YNY as part of the new service, with direct management and leadership through the Leeds and York Managed Clinical Network. The staff managing the TC will also deliver this service element.

The current Leeds network offers DBT informed skills training. This aims to help people to learn new skills to help them cope when they feel suicidal, or want to use self-harming or life threatening behaviours to manage distress. DBT recognises that people develop such ways of coping due to experiences in their lives which could be described as 'invalidating'. This may include abuse, neglect or other kind of personal trauma.

There are four sets of skills covered:

- **Mindfulness Skills**
- **Interpersonal Effectiveness Skills**
- **Emotion Regulation Skills**
- **Distress Tolerance Skills**

In Leeds, groups occur on one day of the week, with mixed gender and women only groups. Each group is facilitated by two staff members. Groups occur in nine weekly sessions called modules, designed to be like attending a course. Within DBT, routine clinical outcome measures are collated, allowing for rigorous service evaluation.

Details of how this will be delivered in York are still being developed; and we will involve service users in developing this detail.

5.2 Integrated community teams

It is clear from NICE guidance that community mental health teams (CMHTs) have a key role in assessing and treating people with personality disorders and complex psychological needs. Within our new community service we have therefore ensured that we can provide the following:

- **Building knowledge and skills in working with PD and complex psychological problems within teams**

We will achieve this by having expert staff from the existing St Andrew's service working within our teams, providing support, training and supervision.

We will also enable staff to undertake further training in working with PD through the nationally accredited PD Knowledge and Understanding Framework (KUF) awareness level training. This programme is delivered predominantly by a range of staff from within the existing LYPFT PD services, alongside service user co-facilitators, and has been positively evaluated over the past 18 months.

The Leeds and York Managed Clinical Network will deliver dedicated training of this nature to a number of

cohorts in the York area which are most likely to require support when working with PD. We envisage training and supporting approximately 160 staff per year and we believe this will have a significant systemic impact.

We do not envisage that this will have any additional resource implications as existing KUF resources will be deployed to achieve this.

- **Access to therapy in community teams**

Many questions about this were asked in our consultation events, summarised below:

- **Will there be less psychological therapy?**
- **How will this address the problem of waiting times?**
- **Where will I get therapy from?**
- **Will access to therapy be joined up so I can move from one to another without a gap?**
- **Will there be a limit to how much therapy I can have?**

We acknowledge that therapy resources in York are less (per population) than in Leeds; these services are separately commissioned so we are not in a position to shift resources. Because there are limits to our resources we can never guarantee that people will always have therapy for as long as they want, or that they will be able to move from one therapy to another. However we will always make decisions about the duration and type of therapy in collaboration with the service user.

We aim to reduce waiting times and inequities in waiting by working more flexibly in larger teams; to save time by reducing multiple assessments and by reducing bureaucracy; and to build skills in working with PD so that more staff are able to help to support people before, during or after therapy.

The range of therapies available to service users is largely determined by evidence-based care pathways, which are based on NICE guidelines as well as local capacity and expertise. In addition to these, it is important to be guided by the evidence on working with PD, as service users in secondary care may present with multiple, co-morbid diagnoses and may be seen by locality teams. All decisions about care (including therapy) will be taken in collaboration with service users

Existing psychological therapists/clinical psychologists are able to provide the following specialist therapies (actual level of capacity is limited and in each area varies):

- **CBT; including schema-focused cognitive therapy and acceptance & commitment therapy (ACT)**
- **Psychosocial interventions for psychoses**
- **Mindfulness based cognitive therapy (individual and group based)**
- **Psychological interventions based on Dialectic-Behaviour Therapy**
- **Interpersonal Therapy (IPT) for Depression**
- **Systemic/family therapy (including couples-based therapies)**
- **Compassion-focused therapy**
- **Psychodynamic therapy**
- **Cognitive-analytic therapy (CAT)**
- **EMDR (Eye Movement Desensitisation and Reprocessing Therapy)**
- **Specialist group therapies**
- **Neuropsychological assessment and rehabilitation**
- **Functional analysis for challenging behaviours**

The evidence base also indicates that, for talking therapies, the therapeutic relationship is as significant

as therapeutic modality in determining outcomes, so thorough consideration of who may work well with a particular service user, based on the likelihood of an effective working alliance, is important.

- **Group work in community teams**

In response to initial consultation we have identified further funding to support the maintenance and transfer of existing group psychotherapy into teams. These expert staff from St Andrew's will deliver groups for people with complex psychological needs and support staff to develop further group work.

- **Support with daily living and vocational work**

In Leeds, this is provided through the 16-week Journey programme. The aim of Journey is to provide group members with the skills and knowledge to actively engage in creating an individual balance of activity, which promotes health and wellbeing. It works with people on the understanding that what people do in their daily lives has a direct impact upon their health and how they feel about themselves.

[1]The provision of formal DBT (individual therapy with telephone support and group skills training) will depend on the availability and training of suitably training clinicians in hubs. A formal programme of DBT is not currently available. DBT skills groups will be accessible for some service users via the personality disorders care pathway.

YNY services have a well-established vocational pathway, staffed by occupational therapists and band 3 support workers, which will be embedded into the redesigned locality team model. This pathway also has links with York St John University, work placement training opportunities and access to meaningful activity. Each locality hub will have 0.5 wte support worker and 0.5 wte band 6 occupational therapist trained to deliver the elements of the Journey programme.

- **Specialist Case Management**

There are a number of service users with PD who present with high levels of distress and significant risk issues. Their lifestyles are often characterised by chaos and it is difficult for mental health services to offer meaningful containment and engagement. This can lead to avoidable acute admissions and out of area placements. It is widely believed that specialist, psychologically-informed case management is required to actively engage these clients, develop meaningful relationships and strategies for safety and containment.

We are proposing to have two band 6 clinicians per hub who will develop and maintain specific specialist skills in PD. Management and leadership will remain with YNY services, through each locality hub.

The band 6 care co-ordinators will work with an active caseload of service users who are appropriate for an intensive case management approach. The caseload will be capped at a level of 10-15 to reflect complexity. In addition, a band 7 clinical lead in the locality team will 'champion' the PD pathway. (This is a new allocation of resource to the PD pathway). This role will also ensure that allocation of referrals to the identified integrated PD intensive case managers is appropriate. This will allow the locality teams to experience the benefits of ring fencing specialist case management of PD.

There is an understanding that the mainstay of PD assessment and intervention will be with locality hub care co-ordinators; and the intensive case managers will provide assessment and work with a caseload that meets specified criteria defined by the PD network. The OT and HSW resource identified in each hub to deliver the

Journey programme will provide 1:1 OT specific work for the intensive case managers, and also a means of peer support.

Supervision will be provided by the therapist leading the YNY therapeutic community. Additional supervision will be available from the integrated psychotherapy resource in the locality hubs in YNY. A reflective forum will also be facilitated. Training and ongoing practice development will be supported by accessing PD network development days and support from the band 7 practice development worker.

- **Housing and Resettlement Support**

The existing Leeds Network has been supported by the provision of dedicated housing and resettlement staff employed by Community Links, a third sector partner. Within current YNY it will not be possible to establish a similar dedicated resource; however we have an established mental health housing officer and a supported housing pathway. The community teams currently have integrated social workers and Support, Time and Recovery (STR) workers, employed by City of York Council and North Yorkshire County Council, who can be accessed for social care assessment and on-going housing support. The redesigned community model in YNY is integrating a number of support worker roles into the locality hubs, employed by both health and social care, that could provide some of the functions of support with establishing and maintaining a tenancy. There are also some third sector housing support options that could provide some input into this function.
We therefore propose that housing and resettlement support is provided through this pathway. Governance will remain with YNY services although close collaborative working will be essential.

It has been proposed that the hubs or PD network offer specialist supervision to these posts to enhance provision and maintain joint working between agencies; we will give this proposal full consideration in developing details of working practices.

6. How people will get access to services

For now, the new single point of access is only into secondary services. We are rolling this out gradually to ensure we have got it right; and are working closely with GPs to make sure that they are happy with the new access point. It will be fully operational for all YNY services by April 2014.

Our single access point will also enable people to access to Crisis assessment, intensive home treatment and inpatient beds if this is needed.

All service users will have a holistic assessment that looks at all of their needs and strengths. From this a care plan will be agreed in collaboration with the service user. If someone is acutely unwell or overwhelmed, the assessment can be completed over a period of several contacts with only essential information being taken at initial contact

If therapy is part of someone's agreed care plan then they will go directly onto a therapy allocation list, so the single point of access will not add an extra step. In fact, people will be seen sooner for assessment rather than just being on a waiting list for therapy. We can then talk to people about how we might support them if they do have to wait for therapy. If someone needs therapy but does not meet the criteria for specialist secondary care services, our staff will ensure that they are redirected/signposted to an appropriate service, rather than just being sent back to the referrer.

7. Service User Involvement

The proposed model requires service users to be actively involved in the delivery of the service and in service evaluation. An extensive range of service user involvement initiatives have been developed across Leeds PD services and we intend to make involvement a key element of the YNY PD model.

From the regional PD Pathway Development Service we support an involvement initiative already based in York and funded via the regional Pathway Development Service budget. Creative Personalities is an arts-based project which has engaged significant numbers of service users from York and across the region; and building upon this we propose to establish Emergence North, linking to Emergence, a national service user-led organisation which has been involved in advancing a better understanding of PD. We will aim to develop a range of service user-led initiatives and envisage that the service user consultants, employed by Emergence, will be key to taking this forward and to adding to the overall credibility of the services provided.

8. Staffing changes

Into Community Teams

Working collaboratively with psychological therapy professional leads, it has been agreed that those St Andrew's psychological therapies staff who provide secondary care interventions which are consistent with the agreed new community services model should be included in the integrated community hubs. This will help to ensure equitable access to therapies for all service users based on need; and that psychological thinking is embedded in the teams.

The proposals are therefore:

- **That the 8b psychotherapist works across the two integrated community hubs, providing equity of access across all services**
- **That the 8a group therapist posts are incorporated into the community hubs, (there will be some reduction in capacity in this resource, required to address savings targets which we must meet; however incorporating the posts into the bigger teams will allow capacity building across broader team members).**

Into York Specialist Personality Disorder Pathway

The proposed staffing requirements to deliver the Leeds and York Managed Clinical Network elements of this model are as follows:

- **1 wte psychological therapist band 8a**
- **1 wte nurse therapist band 6**
- **1 wte therapist band 7**
- **Admin support (to be confirmed through admin review, currently underway)**

These resources are being identified from within the existing St Andrew's establishment. Other elements of the model will be delivered through the YNY locality model.

Only one post currently providing specialist psychological therapy will be completely lost from the psychological therapy service in York.

9. Conclusions and recommendations

The final proposed model identifies significant benefits for service users with PD and complex needs. It provides robust governance arrangements and opportunities for staff skills development. The proposal reflects and addresses the key concerns raised through the three consultation events held from October-December 2013. It proposes a Leeds and York Managed Clinical Network which integrates some of the core elements of the model across the Trust; with specialist case management within locality teams.