Mental Health and Learning Disabilities Research and Practice, 2008, 5, 5 -22

Withering Waits: The Development of a Referrals Management System within a Clinical Psychology & Counselling Service (reprinted)

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Abstract

This paper charts the implementation and development of a referrals management system within a secondary care NHS clinical psychology and counselling service over a period of approximately three years. The new system that is described has brought about dramatic reductions in numbers waiting for both assessment and therapy, as well as modest improvements in attendance rates at first assessment. Other changes have resulted from the new system, such as a more unified, transparent and collaborative approach, a move to more of a consultation model of assessment and an expansion in the breadth of clinicians' roles. The paper explores the challenge of having to continue to meet a demand that far outstrips the available resources. This raises dilemmas in clinical decision-making, in the positioning of the department in relation to referrers, and in maintaining an efficient service with minimal waiting lists without losing the depth and variety of work that are strengths of the department. These issues are discussed in the context of recent governmental policy and changing ways of working for applied psychologists.

Keywords: Referrals, Waiting lists, Psychological therapies, NHS.

National Picture

The reduction of waiting times has been a continuous government priority. The NHS Plan (Department of Health 2000) includes a commitment to reduce waiting times - the target for a first outpatient appointment being a maximum of 12 weeks (DoH 2004). Whilst there has been a general decrease in overall waiting times, waiting lists for psychotherapy services have remained extensive (DoH 2004). At least half of psychological therapy services surveyed in working aged mental health services reported a wait of between 10 and 23 months between referral and the start of therapy (Rezin and Gardner 2006). There are multiple causes for long waiting lists, including demand exceeding supply, poor management of waiting lists, inappropriate referrals and higher non-attendance rates in mental health and psychotherapy services than the average across all specialties (Hughes 1995; O'Loughlin 1990).

History of the Local Service

The provision of secondary and tertiary psychological therapies in Brighton and Hove is perhaps unusual in continuing to be provided for the time being largely through out-patient, psychological therapy services rather than via multi-disciplinary teams. Until January 2004, the Brighton and Hove Department of Psychology and Counselling (where the first two authors are the current and previous referrals managers) operated a sectorised system. Each 'sector' psychologist was responsible for a geographical area of the city and each had a separate waiting list for assessment and therapy.

Whilst this approach had some strengths - for instance clients could generally see the same psychologist for therapy whom they had seen for assessment - it also had many drawbacks. For example, sector psychologists often felt personally burdened and responsible for the waiting times, whilst being unable to reduce them. The range of therapeutic approaches available to clients was also restricted by the particular approach of each psychologist. There were a number of different psychologists to whom referrers could make enquiries, which allowed for inconsistency and confusion, rather than having a single individual with whom to liaise. A 'postcode lottery' also meant that clients could wait substantially longer in some sectors than in others. The wait from referral to the start of therapy could sometimes be as much as three years.

Introduction of the Referrals Management System

Development of Single Point of Referral

It was imperative to devise a more efficient system that would reduce the wait for psychological therapy and make the service more equitable. In 2003, the geographical sectors were replaced with a single point of referral through which all secondary and tertiary referrals into the department were processed. A single point of entry for referrals and clear referral protocols were two possible aspects of a well co-ordinated service identified by the government (DoH, 2004). In our department, a new post of referrals manager was established to administer this single point of referral. The post was held by a clinical psychologist within the team who was able to liaise with referrers, gather additional referral information where necessary, and make initial decisions about the suitability of referrals for the range of psychological therapies within the service. Unlike some other models (e.g. Brady and McDonnell, 2005) where a similar post-holder would not only receive referrals but also do all the assessments for a particular team, in this case the referrals manager used their knowledge about the expertise and interests of different team members to direct incoming clients towards particular clinicians for assessment. Furthermore, since the service was no longer divided up according to discrete sectors, each clinician's specialist expertise could be deployed according to clinical need rather than compartmentalized within geographical areas. A significant number of referrals could also be re-directed to other local services where clients could often be seen more quickly, whilst also accessing an appropriate service. Several new initiatives were developed to support this process, as described below.

Referral Criteria

Explicit referral criteria were developed giving the referrals manager a clear and transparent basis upon which to make decisions about client suitability. Copies were sent to all referrers indicating those people most likely to benefit from the service. These guidelines were linked to the Global Assessment of Functioning Scale (GAF) (APA 1994: 34). We suggested that GAF scores of between 21 and 50 were likely to be suitable for secondary and tertiary psychological services. This included 'serious symptoms' such as suicidal ideation, severe obsessional rituals (41-50) and 'behaviour influenced by delusions and hallucinations'. It also included 'serious impairment in communication or judgment' and 'severe inability to

function in social and occupational life' (21-30). By contrast, scores of between 51 and 70 were considered likely to be suitable for the primary care counselling service (PCC). This covered more moderate symptoms, such as occasional panic attacks, depressed mood and mild insomnia and minimal to moderate difficulties in social and occupational functioning. For all referrals not meeting the criteria, a letter was sent to the referrer containing our referral criteria and a list of key alternative local services.

Pre-assessment Questionnaire

A pre-assessment questionnaire (PAQ) was sent out to clients who, from the referral information, appeared to meet our criteria. This was in two parts. Part A asked about demographics, preferred contact details, the involvement of other professionals, risk issues and about any children living with the client. It also prompted the client to highlight any concerns or particular service delivery issues for us to consider (such as access requirements or specific anxieties about attending). Part B asked about presenting problems, what had helped in coping with them, current relationships, occupational issues, drug and alcohol use, medication, previous therapy and what the client hoped to gain from the service. Whilst this part of the questionnaire was optional, most chose to complete it.

The questionnaire was developed through a process of discussion and revision within the team. We aimed to gather information that would be informative without being overly intrusive since, at the early stage of assessment for suitability, there was no guarantee that the process would go further. Consequently, there were no specific questions about family history or traumatic events in childhood. However, as in other studies that have used pre-assessment questionnaires (Denner and Reeves, 1997), we designed the questions to be sufficiently searching as to encourage clients to start to prepare for the assessment session and to begin considering their own therapeutic goals.

One of the other functions of the questionnaire was to assess motivation. Consequently, it was necessary to return Part A by a specified date in order to continue with the assessment process. Opt-in procedures for services were suggested in 'Organising and Delivering Psychological Therapies' (DoH, 2004), as were referral forms for GPs and psychiatrists. We also introduced the latter but reverted to unstructured letters for referrals when the forms seemed to restrict - rather than facilitate - the provision of information. If we received any information in the referral letter suggesting that the prospective client may not be able to read the questionnaire for whatever reason, then the questionnaire was not sent.

The questionnaire also allowed us to re-direct clients who could be helped by another service without going through the process of further assessment. For the majority, who went on to attend assessment sessions, the questionnaire provided useful background information for the assessing clinician. Finally, we sent a CORE (Core System Group 1998) with the questionnaire, which was helpful in identifying risk issues.

Allocating Assessments

Upon receiving returned questionnaires, the referrals manager allocated particular assessments to particular clinicians. A team consisting of clinical psychologists, counselling psychologists and counsellors possesses a broad range of skills and experience. A major advantage of having assessments allocated by one team member who has some familiarity with other team members' ways of working is that consideration can be given to establishing the likely best 'fit' between client and assessor. This model allows for the service to remain responsive to clients' needs, as well being able to play to clinicians' skills and developmental needs. In other models (e.g. Garry and Paley, 2006) a referrals manager presents referrals to a weekly meeting. In our case, monthly referrals meetings are focused more on referrals strategy. The 'forward looking' allocation of referrals to particular clinicians for assessment is also enabled through informal discussions with particular clinicians ahead of allocation, as necessary. This system also allows more flexibility when there are a large number of part-time staff who are not all working in the same place on the same days.

Client choice

If, based upon responses to the questionnaire, the service seemed suitable for the client, a letter was sent inviting the client to choose an appointment time and date. Previously there was often no choice since we had no information regarding our clients' preferences. The new system usually allowed for some choice of time, date or location, in line with government recommendations at the time (DoH, 2004).

Audit

Diagnostic audit codes were developed allowing assessors to indicate the client's main issues and to indicate severity using the GAF. Likewise, CORE forms given with the pre-assessment questionnaire and again after therapy facilitated outcome measurement. An audit of the pre-assessment questionnaire, performed by a trainee clinical psychologist, suggested staff generally saw it as a helpful assessment tool. Furthermore, whilst the referrals manager used it to help direct particular clients towards particular clinicians for assessment, assessing clinicians reported using it in different ways according to their therapeutic approach. For instance, in describing their own use of the questionnaires, clinicians with a more psychodynamic orientation tended to draw inferences from how the form appeared to have been completed. Similarly, those with a more solution-focused orientation tended to focus upon highlighting the resources people had identified as having helped them to cope.

The feedback provided by clients to the trainee, who also conducted brief telephone interviews with a selection of clients, enabled us to clarify and amend some of the questions in the questionnaire. The number of clients interviewed was not sufficient to be widely representative; however, it highlighted that a small minority of clients had reported completing the CORE strategically, apparently in order to try and elicit a more active response from services. Whilst this hints at underlying difficulties in relying too heavily upon this type of pre-assessment tool alone, we nevertheless continued to take high-risk ratings on the pre-assessment COREs very

seriously and prioritised these clients for assessment. Where appropriate we also referred them for psychiatric support. Importantly, the COREs were not used in isolation when making decisions regarding the prioritisation of clients for assessment. Instead they were read within the context of other risk information provided by clients on the questionnaire, such as previous suicide attempts and the presence of children living with the client. Likewise, other relevant information provided by the referrer was used to provide a full picture.

Evidence from Comparable Service Interventions Elsewhere

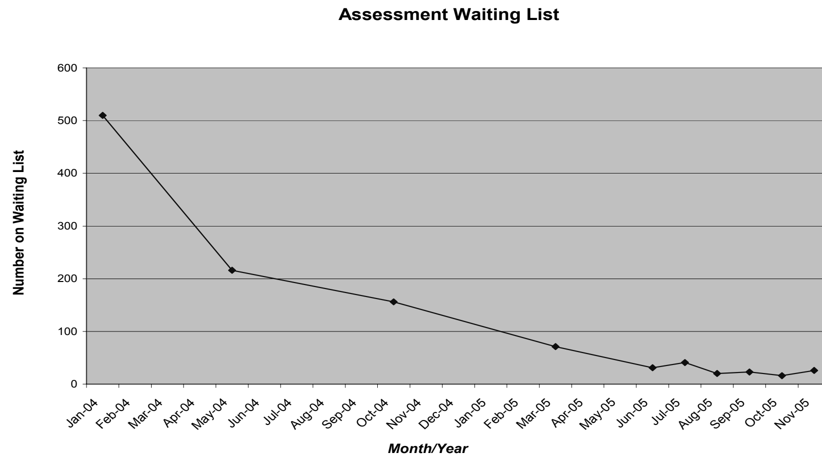
Previous studies have shown that the effect on attendance rates of sending opt-in forms and questionnaires has been somewhat mixed. Some studies found no significant effect on DNA rates for initial appointments from sending opt-in forms with information leaflets (Ambrose & Ormond, 1996) or from sending a ten-page questionnaire (Markman & Beeney, 1990). On the other hand, Denner and Reeves (1997) and Eynon (1993) both reported that the use of a pre-assessment questionnaire helped reduce DNAs. Various forms of client opt-in, whether by asking clients to send in a return slip indicating their intention to attend (Anderson & White 1994; Green & Giblin 1988), asking them to telephone (Chiesa, 1992) or offering a choice of appointment together with asking for confirmation of attendance (Reid & McIvor 2005), all reduced non-attendance rates. Amongst the waiting list strategies listed in the paper 'Organising and delivering psychological therapies' (DoH 2004) are opt-in procedures via contacting the service for an appointment and opt-in procedures via questionnaire.

Results - Impact of New System

Numbers Waiting

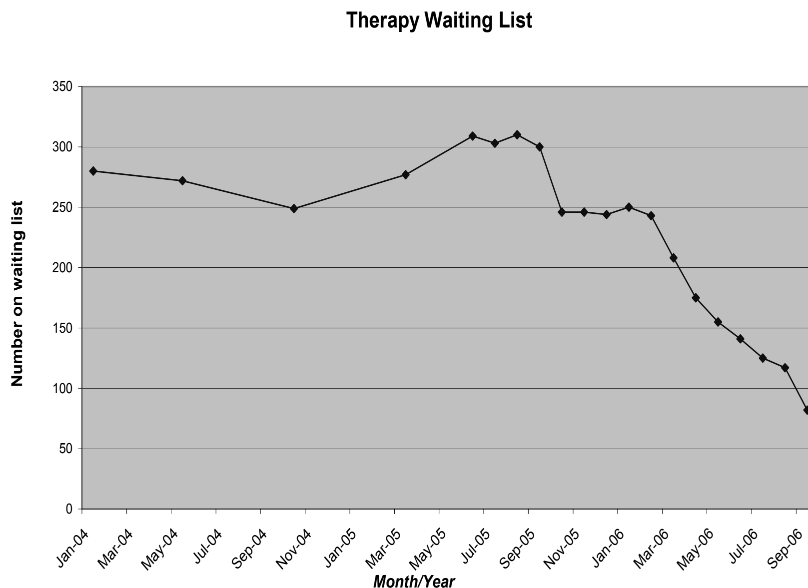
Figure 1 below, shows that the number of people waiting for assessment has dropped from 510 to around 20. Under the new system there has been a reduction in the number of people waiting for assessment by some 95 per cent. This has remained stable over time because the new system allows for the flexible allocation of clinical time to either assessment or therapy, depending on need. The wait for a first assessment has dropped from 18 months in one of the old sectors, to approximately 16 weeks, and sometimes less.

Figure 1. Assessment Waiting list



As indicated in figure 2 below, there have been similar decreases in the number of people waiting for therapy - from 280 to 86. This number has continued to fall and at the time of writing was less than 50. The waiting time for therapy has continued to reduce and is currently approximately six months. Waits for different therapeutic approaches vary slightly according to the availability of particular clinicians and the skills mix at any one time. Since most clinicians in the department can use multiple therapeutic models, and since many cases are potentially responsive to more than one therapeutic approach, there is usually no significant discrepancy between clients waiting for different types of therapy.

Figure 2. Therapy Waiting List

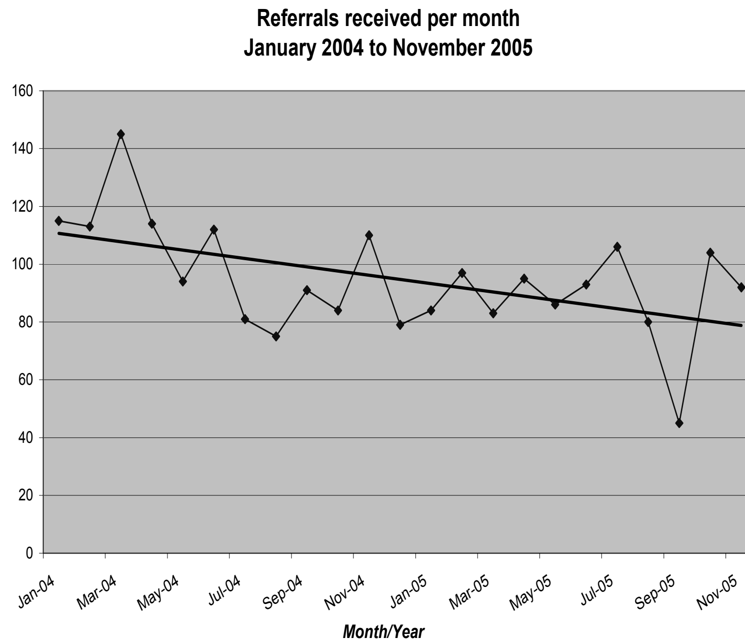


Referral Rate

The number of new referrals received in the department has also decreased under the new system (figure 3). This number continues to fall.

Based on our transparency in relation to waiting times, referrers now have a very clear idea of how long clients may have to wait for psychological therapy. Similarly, through regular liaison and by repeatedly sending out referral criteria alongside information about other services, referrers appear to have begun to develop a much more informed view about suitability for this service and about the options available in terms of local service provision.

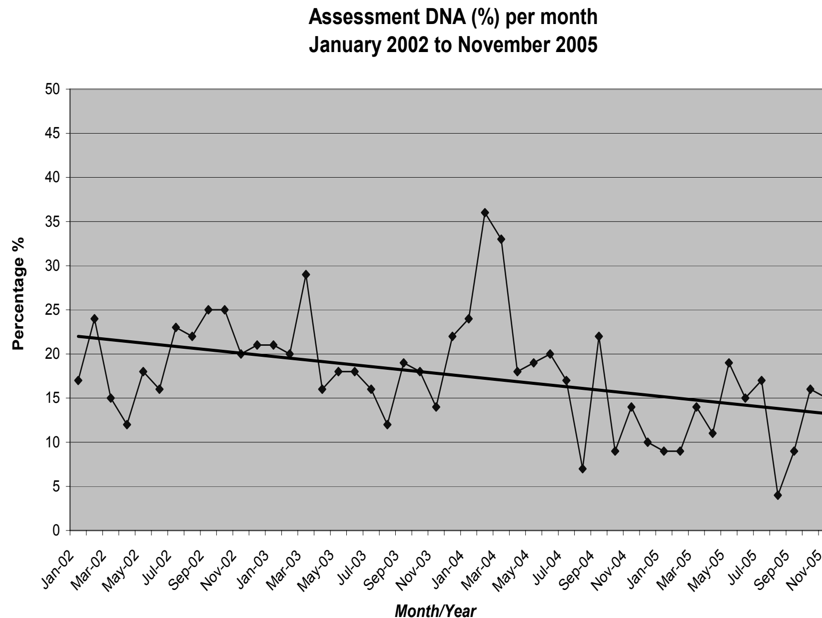
Figure 3. Referrals Received per Month from January 2004 to November 2005



DNA Rates

The number of assessment appointments missed without notice (DNA) has seen a small but important reduction (figure 4). This may have been due to the greater choice now offered to clients in terms of the time, date, and sometimes location, of their assessment appointment. It is also likely to have been due to the introduction of several new gateways in the pathway from referral to first assessment during which process the suitability of the service for clients is assessed. A degree of motivation is required of a client who is obliged to take an active role in engaging with the service by responding to the questionnaire and then following up on the invitation to contact the department to arrange an assessment appointment. Depending on the outcome of this process within the context of the information gathered from previous notes and contact with other services it may be possible to suggest other services that are more appropriate for the client at the time. For instance we might suggest the client seeks the support of a drop-in service if this seems more appropriate

Figure 4. Assessment DNA (%) per Month from January 2002 to November 2005



Transparency

When operating a number of semi-autonomous sectorised systems, clinicians, for many reasons, could be guarded about their waiting lists. Under the new system, the team shares the same waiting list. This appears to have facilitated more openness and a shared sense of ownership amongst the team. It has also allowed us to promote transparency about the waiting time incurred to clients and referrers in a more objective way.

Accepting the reality of long waits has been clearly a source of distress for referrer, client and assessor alike. However, as a result we are now very clear about the actual capacity of the service to see clients and have been able to convey this information clearly and confidently to referrers and commissioners. Based upon frequent discussions within the team this seems like a much healthier position since clinicians report feeling less driven by the illusion that working ever harder would somehow make the waiting list, and the discrepancy between demand and resource, more manageable. Nor is the reward of the work undermined by the guilt incurred by optimistically promising a service that could not realistically be offered within the foreseeable future.

Working with Referrers and Managing Change

The referrals manager is now positioned in much closer contact with referrers. This has been an illuminating and challenging process in its own right. For instance, old tensions have been brought to light, which, in turn, has provided the opportunity for working more actively with inter-service conflict in a system where open communication, for many reasons, can be problematic. Similar issues have been described by others; for example Tulett, Jones and Lavender (2006) discussed a number of ‘challenging issues’ involved in communicating with referrers. These included confusion

over the purpose or nature of the psychological therapy service as well as a lack of clarity about referral criteria and the process of referring.

On occasion, our attempts at greater clarity and transparency about waiting times met with anger and complaint. Likewise, meeting with Community Mental Health Teams has, on occasion, tended to highlight old struggles and the enduring status of stereotyped notions of clinical psychology. It also became clear that many referrers had not developed an in-depth knowledge of where best to refer. The tried and tested referral pathways have been difficult to change and, rather than seek guidance, some might continue to follow these well-worn routes positioning psychology as a 'triage' service. In some quarters, use of our criteria has also had limited uptake. However, we accept that the prospect of familiarisation with yet another complex set of criteria is unlikely to appeal to a busy GP.

Alongside these tensions, the increased contact with other services has led to a degree of rapprochement; this reflects the experiences of others. For example, Brady and McDonnell (2005) identified the involvement of GPs in the evolution of a new referrals and assessment system as being critical to its success. In our case, GPs have welcomed the opportunity to meet to discuss referral criteria and to contribute to conversations in which a local 'map' of psychological services is being established. Some GP practices also responded very well to letters informing them that the service is struggling with a significant backlog of cases. When referrers know just how much demand exceeds capacity, it invites some understanding and highlights the case for change.

Working with Clients' Reactions

Although our waiting times are now within more acceptable limits, it has only been very recently that the waiting time for therapy has started to reflect the major reductions in numbers of people waiting. When waiting times are best described in terms of years rather than months, as has been the case, the process of assessment inevitably becomes the focus of some particularly difficult feelings.

For clients, understandably, this can involve marked disappointment, shock and anger. For example, being made aware of a wait of several years for therapy, especially when one's hopes are high and one's sense of need acute, might well act as a powerful trigger to the resurgence of underlying feelings of worthlessness or abandonment in times of distress. Indeed, the feedback from assessors has suggested that much of the work in recent assessment sessions has been around just these issues.

Likewise, the effect upon staff has also been considerable. Exploring the rigours of working through these emotionally charged issues has been a central feature of much discussion and peer support. It has also been an explicit focus within the various meetings that have evolved in order to support and develop the new system. The remit of these meetings has been to think about the strategic development of the service as well as to reflect upon the emotional effects of the way we work.

Moving Towards a 'Consultation' Model

There has been a shift in thinking away from treating 'assessment' as an automatic conduit to a place on the therapy waiting list. Instead, assessment sessions have increasingly been used as discrete consultations in their own right. The goal has been both to assess suitability and to consider alterative treatment options in relation to up-to-date information on local service availability. The experience of the team has been that that this process could be a powerful intervention in itself, which has mostly been accepted and welcomed by both staff and clients.

As always, our aim was that the client should feel heard and understood. However, in providing a consultation, our goal was also that clients should also receive useful formulation and ideas about services and resources that could be accessed relatively quickly, especially if this was a priority for them. Typically, the options ranged from recommending more of what had worked already (e.g. making use of trusted sources of support, exercise, relaxation) to suggesting reading material, recommending psycho-educational or self-help groups, advice services (e.g. supporting a return to voluntary or paid work, or housing advice), primary care counselling, or approaching other providers of psychological therapy.

Others have described the development of similar, more time-efficient, ways of working. For instance, Denner and Reeves (1997) used a taped, single session consultation with a six-week follow-up in a CMHT. Similarly, Tulett, Jones and Lavender (2006) described offering up to three sessions with two or more clinicians forming a reflecting team in a primary care setting. Interestingly both studies reported positive outcomes suggesting that these were effective approaches that were valued by most staff, clients and referrers alike. The difficulties they highlighted were related to training staff to work in a new way, the effects of leaving too long a gap between the consultation and the follow up alongside the perennial issue of lengthy waiting lists.

Changing Traditional Ideas of What the Service Offers

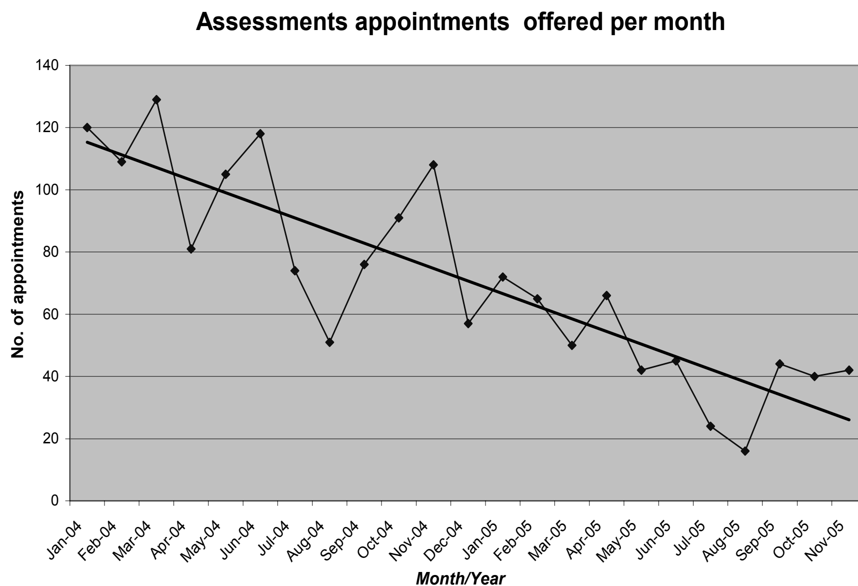
The change to a more consultative and indirect role was difficult to establish since it required a different kind of thinking and an orientation to a different kind of service. Recognizing that many clients could benefit from some form of very brief intervention elsewhere could be a difficult shift, especially for those accustomed to accepting most people onto our own therapy waiting-list. Bringing about the changes gradually, and operating the consultation approach alongside, rather than instead of, a traditional therapy approach, helped at an emotional level. Having an agenda-less meeting, known as an 'open space' meeting, as well as other new meetings, provided opportunities to process some of the emotional impact of the changes. Adopting a more consultative practice is likely to have challenged hidden fantasies of omnipotence on the one hand, and aroused strong guilt feelings on the other. It offered both a sense of hope that we might be able to operate a more efficient service, as well as a fear of losing the depth of the work and of facing change and unfamiliarity.

At a more practical level, introducing the new system has involved reconfiguring resources and investing significant time in negotiating the

process of change. For instance, establishing the referrals manager role has meant relinquishing the equivalent of at least one half-time clinical post. Referrals management meetings also require staff to dedicate more of their time to the referrals process. Nevertheless, Figure 5 (below) counters the hypothesis that if we were simply to do more direct clinical work, rather than actively manage the referrals process, we would reduce the waiting list. In fact, the new system has allowed us to keep the assessment waiting list manageable - whilst dramatically reducing the therapy waiting list - despite clinicians now offering far less assessment appointments.

Indeed the point is made by the government that 'service modernisation relies upon staff – especially those in clinical posts – having the time and space to redesign and re-organise their services' (DoH, 2004). Despite this, a lot of the indirect work that psychologists do is at risk of being thought as an 'overhead' in a world in which workforce productivity and payment by results are paramount. This risks losing sight of the many complex processes that ensure the quality of direct clinical work, and also risks marginalizing psychologists who may seem relatively expensive as therapists *if* the other roles that we take on are excluded from the equations. Some of the thinking currently emerging from the New Ways of Working process suggests that clinical psychologists have important roles to play in promoting effective service planning, and providing training and organisational consultancy (Onyett, 2007). This is likely to require us to develop and strengthen our leadership skills (Cate and Coak, 2006) so that we are in a position to step up to clinical leadership positions where we would be able to make the case to commissioners for more carefully considered and indirect work (Foyle, 2007).

Figure 5. Assessment Appointments Offered per Month



The new system has seen changes in the workload balance of many psychologists in the department away from largely direct clinical work and towards a broader range of work, such as developing specialist services,

systems management, clinical supervision, consultation, and inter-service liaison. There has also been more engagement with GPs, CMHTs and other mental health services. This makes the work more varied and interesting, reduces the likelihood of burnout, and makes use of the breadth of clinical psychology training. The team has spent more time together and has been able to appreciate one another's ways of working. This has been reflected in more joint assessment sessions, referrals management group discussions, team-building days, reflective groups and presentations on areas of specialist interest. This new feel to the department, further diversified and enriched by new staff with different skills, has been liberating even though previous role identifications have had to be modified.

Whilst these changes have been positive, it is has also been important to ensure that many of the valuable aspects of the previous identity of the department have not been lost. Historically, the department has created a solid psychotherapeutic base through creating several specialist therapy services and investing in extensive continued professional development for staff (CPD). The team consists of clinicians who are experienced in delivering both a breadth and depth of therapeutic approach. This has enabled us to offer effective medium to long-term interventions to people with significant difficulties. To have thrown out this rich 'bath water' in the interests of producing efficient 'short-term only' babies would have been a sad loss for clients and clinicians alike. The Department of Health (DoH, 2004) does recognise that therapies can be too short to be effective (as well as unnecessarily long) and suggests that this can happen not only when arbitrary restrictions are placed on treatment length but also when clinicians are insufficiently trained.

Towards the Future

An Overview of Maintenance and Development

At the time of writing, the referral rate and the number of people waiting for a service have declined and have continued to fall. Consequently, we have begun to implement maintenance strategies to make best use of the skills in the department.

Our experience suggests that the following factors are likely to be important in the long term:

- Accurate assessment of the client's needs and suitability for the service.
- Accurate identification of the place of the service on the 'map' of local psychological therapies.
- Promotion of co-working with other agencies.
- Keeping up-to-date on local service context and alternative referral pathways.
- Keeping up-to-date on government recommendations and current clinical guidelines.
- Making best use of the shifting skills base within the team.
- Balancing the above with CPD needs and individual preferences.

In order to maintain and develop this service, we recognise that numerous issues will need to be addressed. These are discussed below.

Service Capacity

It is clear that an accessible service has to work within its resources. Inevitably this involves setting quotas so that demand does not outstrip resource in a way that creates an unacceptably long waiting time. Realistic quotas must be based upon an accurate appreciation of service capacity. We established this by asking clinicians to estimate the amount of time they dedicated to direct clinical work given the broad range of activities they might undertake in an average week. We found that the actual direct clinical time available was about half of their 'gross' working hours. Having established an average treatment length of, in this case, 30 sessions, it was possible to estimate how many clients could be treated per year. In our case, demand (in terms of referrals per month) outstripped actual capacity by a ratio of 16:1. This baseline figure might then be used to regulate the number of referrals accepted and to support a case for acquiring more resources based on readily available data.

Dilemmas of Inclusion and Length of Therapy Contract

In a situation in which demand repeatedly outstrips resource, the risk is that certain client groups, who are perhaps either too complex or else too 'straightforward' for time-limited secondary care psychological therapy, may be unable to access the service. For example, it may be that the most distressed, those least familiar with local systems (such as refugees and asylum seekers) and the least literate, find it most difficult to access a system that requires one or more 'layers' of opting-in.

Another potential casualty may be in terms of the depth of work we undertake. For instance, one suggested solution has been to adopt a primary care model to secondary care work and to offer a fixed, small number of sessions as a maximum; irrespective of presentation. Not only might this serve to propel the 'revolving-door' of repeated referrals, it may not be favoured by many clinicians who, for instance, have acquired extensive experience and expertise in longer-term work. Furthermore, in our experience, whilst the severity threshold for the psychological services has risen, the complexity of the work has increased accordingly. Consequently the length of time necessary to work with clients to achieve meaningful results has grown. Inevitably, this leads to a reduction in the actual number of clients the service can see each year whilst simultaneously avoiding a waiting list.

Communication

It is essential that communication with referrers continues to be clear and helpful. Regular liaison with CMHTs has been shown to lead to better referrals (Rezin and Gardner, 2006). Referrers need to have the relevant information to enable them to make good referral choices earlier on and to have a better understanding of the way that psychological therapy services work. One idea is to provide referrers with a newsletter containing up-to-date waiting-time information and descriptions of what our service provides. Another idea (provided by a referrer) is to produce a 'map' on a single piece of A4 in order to clearly distinguish and describe different services. Other vital information for referrers would include suitability criteria for each service, clear referral pathways and signposts to more detailed information

about each service including a contact telephone number. We have found that even simply discussing this idea has meant that important inter-service conversations have taken place providing the opportunity to sort out long-standing assumptions and misperceptions around 'who does what with whom'.

Perhaps even more important is the development of robust relationships with referrers so that we can take a collaborative position given our shared perspective on the imbalance between resources and demand. 'Organising and developing psychological therapies' (DoH, 2004) repeatedly emphasises the importance of co-ordinating psychological therapies and of building partnerships between different service providers, with community mental health teams (CMHTs), and with the voluntary and independent sector. Since we re-direct a large proportion of clients to these other providers at various stages of our contact with them, we need to build mutually trusting relationships with them. It is essential to be able to talk through potential referrals in an open, constructive way, to know what sort of cases are suitable for each particular service and to have up-to-date information about the nature and length of the likely wait for other services to discuss with clients.

Pragmatic or Clinical Decision-Making?

We are aware that, in avoiding developing another long waiting list, our solution involves imposing manageable limits on access to longer-term individual therapy. Within these limits it is clearly contingent upon us to be appropriately selective and to make responsible use of very scarce state resources. However, the accounts we share amongst ourselves about our decision-making often reveal a difficult tension between clinical need and financial management. On the one hand our decisions not to take some people on for therapy are clearly justifiable because a traditional psychological therapy approach is unlikely to help everyone. Many clients could also benefit from consultations, brief therapy or other community-based services. We also recognise that therapy is not a modern panacea and that brief interventions can also be effective. More philosophically, we can also comfort ourselves with community psychology and social constructionist perspectives that locate problems less in the individual and more in social inequalities and power relations.

However, it can sometimes be difficult to know the extent to which our clinical judgments are influenced by pragmatic considerations about the availability of resources. Traditionally, we have seen ourselves as clinicians and not as financial managers, but if Lord Layard's proposals (Centre for Economic Performance, 2006) to significantly increase access to psychological therapy are implemented, the picture might change altogether. For example, many who may currently appear 'unsuitable' for therapy could become potential candidates for the suggested short-term interventions. If we also have to face competition with other therapy service providers, as seems more likely with the change to practice-based commissioning, how might this further change our 'clinical' judgments about the suitability of clients for psychological therapy? Judgments made by therapists whose living depends on having enough private therapy clients are likely to experience very different pressures on them, which may lead to more inclusive decisions about 'suitability' than those working in the heavily over-burdened NHS. These observations suggest that we cannot fully

divorce the pragmatic from our clinical decisions however much we would like to maintain the 'purity' of our clinical role. This is clearly another inherent conflict that requires ongoing debate and reflection.

Conclusions

The decision to set up a single point of referral with a dedicated referrals manager and referrals team has been generally successful. The team is in a good position to ensure that we remain responsive to the dilemmas created by an imbalance of demand and resource without entirely sacrificing the depth and range of work on offer – although this continues to be a risk. Upon reflection, we have found that being ‘too busy’ to think strategically or to respond adaptively simply risks accumulating further long waiting lists, resulting in distress for clients and clinicians alike.

The changes that have taken place in waiting-list and referrals management echo broader changes in the type of work the department does as well as in its relationship with referrers and colleagues in allied services. We believe that this has resulted in a positive shift towards greater openness, collaboration and better communication which has led to greater critical evaluation of departmental functioning and a keener sense of our place on the ‘map’ of services. This has highlighted the shortfall of local service provision. However, rather than quietly accumulate long lists of clients waiting to be seen, we have been able to adapt our clinical approach, to make informed comments about the level of unmet need, and to consistently report on the imbalance between demand and resource in the interests of supporting effective, needs-led commissioning.

Acknowledgements

We would like to acknowledge the huge amount of work by Dr Philip Dodgson, Dr Brenda Roberts, Ms Nicola Champion, Dr Margie Callanan, Ms Kerry Mandal, the referrals team and the administrative team that has gone into making this referrals system work. We would also like to particularly thank Ms Frances Brownrigg for her support with the preparation of the graphs.

This article previously appeared in Volume 4, No 1 and it has been reprinted due to an error in the earlier edition.

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