Stepped care: the Cardiff Model

Waiting lists are a perennial bugbear of counselling services. **John Cowley** explores a radical new approach aimed at turning this around

Counselling services throughout the HE sector deliver their services in a fairly homogenous manner. They tend to be unconstrained in the length of time that they see students, they frequently use assessments as a method of 'triage' and risk assessment and then students are placed on a waiting list. By January every year the mailbases buzz with questions asking if demand is higher than usual and expressing concerns regarding the waiting list.

Additional staffing resources are usually difficult to come by and when they do come it is an enormous temptation to bolt on more of the same in an attempt to reduce waiting times. Using this model of reactive decision making, the impact on waiting times has always been minimal, leaving a residual feeling that the waiting list is an impossible issue to resolve.

I have had lots of opportunities over the years to discuss waiting lists with my own and other colleagues and a common response is that their average numbers of sessions is around four to five, around the same statistic as for other HE services quoted in AUCC surveys. My own service here at Cardiff University fits that profile perfectly. We are well regarded by the students and university and are embedded within the structure and contribute systemically and reactively to many aspects of the university's functions.

I had come to question whether this commonly held model in fact was sustainable in the next five to 10 years. Lawyers, when describing to me the duty of care for which university counselling services are responsible, said that we are there to provide an 'educational service'. Why then do counselling services, my own included, attempt to deliver a service that mirrors or in some case rivals what should be provided by the health service?

Of course the answer is because the level of support in the NHS or the community is so difficult to access. This is true. However, how equitable after April is it to have students on a long waiting list with little or no hope of being seen before they go home for the summer vacation? If we collude with the lack of resources in the NHS by mopping up their shortfall whose needs are we serving? Of course counsellors enjoy a challenge and for experienced counsellors it can be in working successfully with challenging clients. Anecdotally counsellors talk about the worsening mental health of students. This may be true; or is it possible that the constraints placed on community mental health teams (CMHT) mean that those who would have been seen 10 years ago in the CMHT are no longer seen because the focus has turned ever more to the severe end of the mental health spectrum?

Most university counsellors will say that they do short-term work and that there is scope to see students for longer if need be. Often they add that short-term work is less satisfying and they enjoy longer-term work. An interesting calculation is to work out the percentage of sessions used by clients seen for 10 sessions or more against the total sessions available/offered by the service. I was shocked at the result – approximately 30 per cent of clients used nearly 50 per cent of available sessions! As I strive to provide a service that has equal access, this is difficult to accept.

Given the confidential nature of counselling and the triangular relationship that exists between client, counsellor and supervisor (usually external), longer-term clients potentially become an impenetrable mystery for the manager. External supervision is desirable and I support that; however, such a remote relationship with the paying organisation is quite strange. It is not often that we have to pay someone for a service that someone else gets which we never see, and unless it is contracted that way from the start there is little objective feedback. Supervisors generally dislike being placed in the position where they have to evaluate and report back on the

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quality of the counsellor. It is difficult therefore to get a satisfactory answer to questions regarding an individual counsellor's long-term work with clients while others remain, not always patiently, on the waiting list.

Finally, I do regard the advent of practice-based commissioning (PBC) in England and in the NHS as a major potential threat to university counselling services. In essence the NHS in England can now employ consortiums to deliver mental health services. These consortiums could include counsellors, psychologists and third sector organisations getting together and delivering a range of services at different levels of intensity, demonstrating effectiveness through the use of CORE.

Time to change

So what is that to do with HE and FE? I wonder how long it will be before the management team of a successful consortium will begin to consider what other commercial activities and opportunities they might move into. I suspect that there would be a commercial opportunity to offer colleges and universities the equivalent of an EAP. I am certain that for finance directors the appeal of the added value of monthly performance statistics, 24-hour phone counselling, robust outcome measures and short-term interventions – probably CBT in line with the NICE guidelines – and using systems in line with lean thinking, would have huge appeal no matter how 'embedded' we believe ourselves to be.

When we think of where the jobs are in counselling they are workplace, health and education. Workplace and health have embraced the concept of short-term therapy and outcome measures and in that respect they are ahead of the game leaving education vulnerable and exposed.

The first step

It was against this changing landscape nationally that in the summer of 2006 I decided it was imperative to open the counselling service to an internal review of our activity. My intention was to examine all aspects of our delivery to determine whether it was effective or could be done better according to evidence and practice from elsewhere. I was also of the firm belief that if there were to be major changes in practice they were to be achieved most effectively if others were involved in the planning.

Believing if you do what you have always done you will get what you always get, I made a decision to remain for the most part uninvolved in the research and analysis of the existing process, especially in the initial stages. I invited the deputies to plan a counselling service beginning with a blank sheet of paper and find out how other services in education, the NHS and the commercial sector operate.

I was happy for my colleagues to come back and say the way we operate is fine if that was the case or to say we need to do something radical in addition to introducing CORE, to which we were already committed. Either way I would know that the issues and processes had been scrutinised by competent trusted colleagues and this would place me in a strong position to defend the delivery model.

I suspected that we would arrive somewhere in the middle of the change continuum from no change to radical. It is also worth noting that counsellors at Cardiff represent a wide range of modalities and as such, the model

needed to fit the theoretical approach of nine team members.

One step at a time: the Cardiff Model

After a year of discussion and planning we embarked in September 2007 on a radically different model of service delivery; one that will, I suspect, provide us with considerable challenge and will continue to be a source of interest. It represents a drawing together of many different examples of good or innovative practice into what we are calling the Cardiff Model. My intention in this article is to describe the Cardiff Model at the point of launching it, and produce an update next summer after a period of operation. Hopefully this will give the reader a sense of organisational change over a year.

In terms of our mission this has become more pragmatic and our role is to provide equal access to counselling for all students so that they can be free enough from psychological distress to engage in the process of learning and maximise their potential.

This in many ways adopts a minimalist approach and expectation and matches EAP philosophy as well as satisfying the comments made by university lawyers with regard to duty of care that 'counselling services are there to provide an educational service' – not mirror and often exceed NHS provision. At this point, I can sense colleagues shuffling uncomfortably as this is a significant departure in belief for many.

In essence we are adopting a stepped-care model using an initial session of solution-focused brief therapy, a range of other psychological therapies such as bibliotherapy, groups and CD ROMs, followed if need be by some additional counselling using the counsellor's preferred modality which will be case managed, and finally CORE will be used to determine effectiveness. Another significant shift is away from a central waiting list to each counsellor operating their own waiting lists.

The process for the student will start by completing an online questionnaire. The questionnaire utilises the Bristol Online Survey (BOS) software. This is a purpose-built survey package used to capture client details. The package is secure and has been checked by our Data Protection Act compliance team and they are reassured that it is fit for purpose. We are encouraging students wishing to use the counselling service to complete the online questionnaire in as much detail as possible. The questions have been designed to enable the client to begin their therapeutic process at that point, beginning the process in a solution-focused way by asking what needs to be

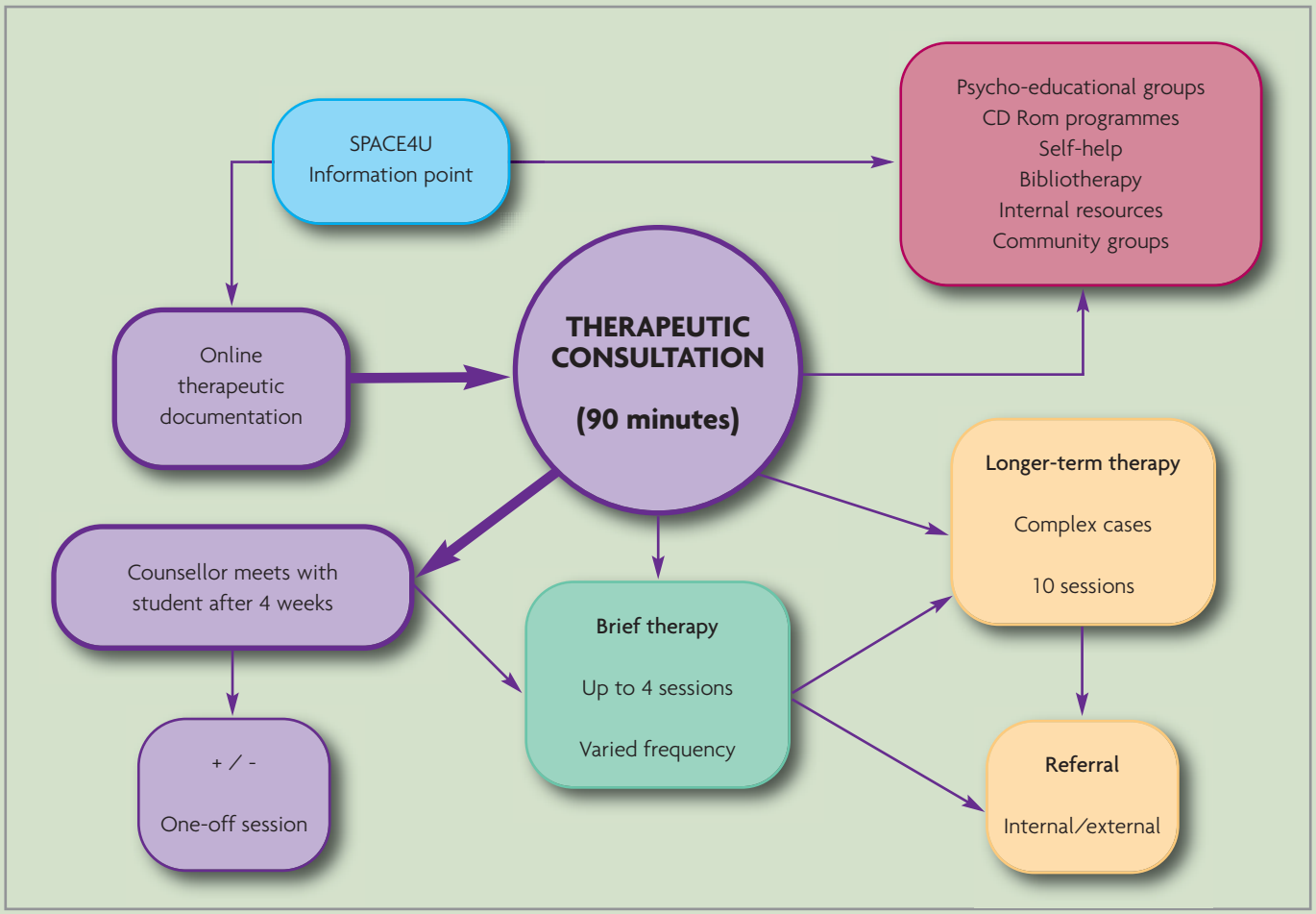

Figure 1: Cardiff University counselling service, the Cardiff Model

different and encouraging the possibility of change. This is in direct contrast to CORE which is problem focused.

Of the 70 or so responses so far, all have been very positive and the clients thus far appear to have engaged in reflective narrative. Inevitably, there will be students who will feel uncomfortable about submitting online and then they can submit a paper version, but online is the preferred option for us. The BOS survey package provides data in graph form that will be useful for reporting. These submitted forms will be downloaded daily and a referral meeting will be held weekly.

Students who require a face-to-face meeting with a counsellor outside the appointment are seen in a brief meeting called 'space for you' (Space4U). These are 15-minute information meeting and will not be counselling sessions. At these, a student may be helped with their form or referred to their GP, borrow a self-help book, or check whether it would be appropriate to refer themselves for counselling. It is also an opportunity for counsellors to signpost a range of other student support services such as the student advisory service or the mental health advisor. Having piloted these over the last few months, they seem useful, popular and happily sufficient.

Once the client 'Online self referral questionnaire' has been reviewed at the weekly referral meeting the students are contacted and offered a 'Therapeutic consultation' (TC). The TC is central to the model and is a 90-minute session. The counsellor will work in a solution-focused way. At the end of the session, the client may be referred to a psycho-educational group, book prescription scheme, CD ROM etc and will have a second follow-up appointment made for 15 minutes in four weeks' time. The significance of the TC is based on the work of Talmon[1] who found that 78 per cent did not require additional sessions after this initial input.

When the student returns s/he will complete the second stage CORE form and will be asked 1) What was helpful from the TC? and 2) How did they do that? What needs to happen now? and finally ascertain whether they need additional sessions. If so, the client will be offered up to four further sessions where the counsellor may use a solution-focused approach or their own modality.

Should the counsellor and client feel at the end of the third session that there would be further benefit from additional sessions beyond the fourth session, it will be referred to the case management team who will discuss the reasons with the counsellor and look at the CORE results.

The case-management team and counsellor will decide on a care plan. Extensions are regarded as exceptions and the counsellor will be working towards an ending or a referral on to primary care services or to the university mental health advisor for a different kind of support.

Accountability

Case management is broadly an unfamiliar concept in FE/HE, yet is standard practice in primary care and EAP provisions where it is common for an EAP counsellor to convince the case manager of the business benefits of continuing to work with a particular client. I imagine that case management will be one of the most difficult aspects of the model to manage well.

Case management, outcome measures and a personal waiting list all place new expectations and accountabilities on counsellors working in this model. In order to encourage transparency, as many as possible of the team will be involved at different times in the process. Much of the work of the counsellor is carried out away from any kind of organisational accountability and this model requires a high degree of trust and a mature team. It requires a team with a shared vision built out of consultation and dialogue and it requires leadership built on trust, open communication and respect.

A risky enterprise?

The Cardiff Model is not without risks. These have been carefully weighted against the benefits both short term and long term. Short-term benefits, it is envisaged, will include the most effective use of existing resources and as we are constantly being encouraged to adopt lean principles this should be positive for the service within the wider institution. It is hoped, if the mathematical modelling is correct, that we should reduce waiting lists considerably and in doing so, provide equal opportunity and access for all students wishing to use the counselling service.

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Discussion about the Cardiff Model and working practices has enabled debate on professional topics and issues in a way that would have been difficult to achieve otherwise.

The risk is that the model comes apart at the seams and does not work at all. Given the careful thought and planning that has gone into the conceptual model and the wide consultation, the risk has been minimised; but it is still a risk. At worst, we can revert to the old model and accept that some students will not be seen because of the waiting time. My guess is that we will have transformed the service into a forward-looking one that is fit for the future.

Will the model be the same in 12 months? I doubt it; however, we will have tried something different that does seek to meet the challenges being posed to the wider counselling profession. Other services may seek different solutions to these issues but the concerns posed in the introduction are ignored at your peril. ■

John Cowley is head of counselling at Cardiff University. He is deputy chair of BACP, a past chair of AUCC and is a BACP fellow. He can be contacted at cowleyj@cf.ac.uk

Reference

1 Talmon M. Single session therapy. San Francisco, CA: Jossey-Bass; 1990.