**Health Overview Panel**  
29 January 2015

**Pathways into mental health services in Kingston: a review of the referrals into the Kingston Wellbeing Service (Improving Access to Psychological Therapies element) and the Kingston Community Mental Health Service**

Report by Director of Public Health

<table>
<thead>
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<th>Purpose</th>
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<tr>
<td>In January 2014, Councillor Julie Pickering raised a query at the Health Overview Panel (HOP) about whether people in Kingston are receiving a timely and joined up service for their mental health needs, and in particular whether mental health referrals to Kingston’s Wellbeing Service and Kingston’s Community Mental Health Team are appropriate.</td>
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<td>At the HOP it was agreed that the Director of Public Health would present a report to a future meeting of the panel. The attached document reviews referrals to both the Kingston Wellbeing Service and the Community Mental Health Team.</td>
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<table>
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<tr>
<th>Recommendations</th>
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<tr>
<td>The Panel is requested to consider and discuss the report.</td>
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Pathways into mental health services in Kingston: a review of the referrals into the Kingston Wellbeing Service (Improving Access to Psychological Therapies element) and the Kingston Community Mental Health Service

Authors: Stephanie Royston-Mitchell, Helen Raison, Sarah Brown
Acknowledgements: Mary Lineage, Rhona Trotter, Iona Lидington, John Levy, Brian Roberts
1 **Purpose of Review**

This review explored whether patients are being appropriately referred to the Community Wellbeing Service (providing IAPT psychological therapy services and substance misuse services) or the Community Mental Health Team (providing other mental health services, excluding IAPT and substance misuse).

This report does not cover other performance such as waiting times or quality issues.

Specifically this review aims to:

- Clarify referral pathways and criteria for Kingston Community Wellbeing Service and Kingston Community Mental Health Teams
- Provide details of the number, type and appropriateness of referrals to both services
- Explore whether the referrals between Kingston Wellbeing Service and Community Mental Health Teams are appropriate and timely.
2 Introduction

In order to improve the local response to adults with mental health and/or substance misuse issues, a process of service redesign and procurement was implemented by Kingston Clinical Commissioning Group (formerly NHS Kingston) and Kingston Council Mental Health and Substance Misuse Commissioners.

This included combining the Improving Access to Psychological Therapies (IAPT) Service and Adult Community Drug and Alcohol Services into one tender for a new integrated Kingston Community Wellbeing Service (KWS), and the re-design of Community Mental Health Teams (CMHT) in order to simplify access for GP’s and service users.

Kingston Wellbeing Service (providing IAPT and substance misuse services)

IAPT provides a range of psychological therapies, often known as “talking therapies”, for people with anxiety and depression. Many GPs want to be able to direct patients to relevant psychological therapies at an early stage, as a way of preventing the deterioration of mental health. IAPT psychological therapies involve a person talking to a trained therapist, either one-to-one, in a group or with their wife, husband or partner. Types of psychological therapy that are approved for use within the NHS include:

- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Brief Dynamic Interpersonal Therapy (DIT)
- Couple Therapy for Depression
- Counselling for Depression
- Behavioural Family Therapy & Cognitive Behavioural Family Interventions
- Eye Movement Desensitisation and Reprocessing (EMDR) Therapy

The procurement process was carried out between February and September 2012 and the new service provided by Central and North West London NHS Foundation Trust and Camden and Islington NHS Foundation Trust commenced on the 1st April 2013. The new service comprises a Gateway Service providing a single assessment and referral pathway for psychological therapies and substance misuse, and a Treatment Service providing substance misuse treatment interventions and psychological therapies.

The service is also developing a range of wellbeing activities. These include peer mentoring and support, constructive practical activities, education, training and employment support and a community links service to promote integration into the local community.

The criteria for referral to the IAPT service are in Appendix 2.
Community Mental Health Teams (CMHT)
A Community Mental Health Team (CMHT) consists of a group of different mental health professionals who work together to provide specialist mental health services to people living in a particular area.

Community Mental Health Teams are an NHS service who provides more specialised mental health support for people who are experiencing difficulties that cannot be managed in primary care. This includes people with depression and anxiety where cases are complex or the person has problems with treatment adherence. Most cases of anxiety or depression should now be seen by the separately commissioned IAPT service.

At the HOP meeting in November 2013 South West London and St Georges Mental Health Trust (SWLSTG) reported that they had simplified access to Community Mental Health Teams by developing a single point of contact for referrers, service users and carers. It was noted that services are provided in a newly refurbished building at Tolworth Hospital and that clinics are also provided in some GP clinics in order to match the previous service locations. They also reported that service users may be seen at any GP practice or at their home.

The CMHT does provide psychotherapy for people who need long term work, but they no longer provide psychological therapies (this Trust stopped providing an IAPT service at end March 2013).

The criteria for referral into the CMHT are in Appendix 3.

3 Review Method
In order to review whether people in Kingston are receiving a joined up service for their mental health needs, a review was undertaken. Information on referral numbers, inappropriate referrals and interface meetings was requested from Kingston Wellbeing Service (KWS) and SWLSTG (for full details see Appendix 1).

4 Findings

4.1 Overview of referral activity in both services
The KWS IAPT service received a higher number of referrals during its first year of operation by a new provider (n=4,308), than the IAPT service operated by SWLSTG in the previous year (n=3,719). Of these referrals, over 3000 are from GPs and over 800 are self-referrals.

The KWS IAPT service received nearly four times the volume of referrals compared to the CMHT – the CMHT received 1228 referrals in 2013/14. Although the referrals to CMHT have risen slightly between 12/13 and 13/14 this was not driven by GP referrals, which have remained stable.
In the past year (13/14), and based on the views of the providers, the proportion of inappropriate referrals to the KWS was low at 2.5%, whilst the proportion of inappropriate referrals to the CMHT was higher at 9.0% (see Tables 1 and 2). The reasons for a referral being inappropriate are considered in more detail below. In the previous year the CMHT estimated that 8% of the referrals it received were inappropriate.

Tables 1 and 2. Overview of referrals into each service including inappropriate referrals

Table 1: Referrals in 2013/14

<table>
<thead>
<tr>
<th>Service</th>
<th>Year</th>
<th>Total referrals</th>
<th>GP referrals</th>
<th>Inappropriate referrals</th>
<th>Proportion of inappropriate referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>KWS (IAPT)</td>
<td>2013/14 (full year)</td>
<td>4308**</td>
<td>3264</td>
<td>Not provided</td>
<td>N/A</td>
</tr>
<tr>
<td>KWS (IAPT)</td>
<td>1/4/13 to 31/1/14 (10 month)</td>
<td>3633</td>
<td>Not provided</td>
<td>89* all referrals (of which 66 from GPs)</td>
<td>2.5%*</td>
</tr>
<tr>
<td>Kingston CMHT</td>
<td>2013/14 (full year)</td>
<td>1228</td>
<td>840</td>
<td>110*</td>
<td>9.0% *</td>
</tr>
</tbody>
</table>

* (% across all referrals not just GP referrals) ** Data provided by IAPT service lead psychologist. The final total referrals for 13/14 was recorded in performance data as 4,484.

Table 2. Referrals in 2012/13

<table>
<thead>
<tr>
<th>Service</th>
<th>Year</th>
<th>Total referrals</th>
<th>GP referrals</th>
<th>Inappropriate referrals</th>
<th>Proportion of inappropriate referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston CMHT</td>
<td>2012/13</td>
<td>1185*</td>
<td>841</td>
<td>95</td>
<td>8%</td>
</tr>
<tr>
<td>Kingston CMHT IAPT</td>
<td>2012/13</td>
<td>3719</td>
<td>Not known</td>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

*Provided by SWLStG
** SWLStGMHT performance data held by KCCG

4.1.1 Referrals to CMHT

Activity
The CMHT service report is shown in Table 3.
The number of Kingston referrals to CMHT has risen slightly by 42 referrals between 2012/13 (total 1185 referrals) and 2013/14 (total 1228 referrals).

The number of referrals to the North CMHT is consistently higher than to the South CMHT. The proportion of inappropriate referrals is also consistently higher to the North CMHT than to the South (North 12/13 8.5%, 13/14 10.3%, South 12/13 6.8% 13/14 7.4%).

The proportion of inappropriate referrals to both North and South CMHTs was higher in 13/14 (9% n=110) than it was in 12/13 (8% n=95) but the significance of the difference has not been tested, and it is only a difference of 15 inappropriate referrals.

The reasons for inappropriate referrals are discussed below, and whilst these figures are not a major concern there is scope to reduce inappropriate referrals.

The move of IAPT services to another provider has coincided with a small increase in the number of referrals to the CMHT, but the referrals increase is not driven by GP referrals which have remained stable (but have not dropped).

Referrals from other sources to CMHT have increased. We do not have the information about who the other providers are, nor how many referrals came from the KWS, although we know there are referrals sent from the KWS to the CMHT.

### 4.1.2 Referrals to KWS IAPT service

**Table 4. Numbers of referrals to IAPT from GPs, self referral, CMHT and Substance Misuse Team**

<table>
<thead>
<tr>
<th>Care Pathway - Source of Referral</th>
<th>No. of Referrals</th>
<th>%</th>
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<tbody>
<tr>
<td>GP</td>
<td>3264</td>
<td>75.8</td>
</tr>
<tr>
<td>Self</td>
<td>809</td>
<td>18.8</td>
</tr>
<tr>
<td>CMHT</td>
<td>177</td>
<td>4.1</td>
</tr>
<tr>
<td>KWS Substance Misuse Team</td>
<td>58</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>4308</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: SWLSiG Mental Health Trust CMHT
The KWS IAPT service report they received 4,308\(^1\) referrals in 2013/2014. Three-quarters of referrals came from GPs. Nearly one fifth were self referrals and only 4\% (n= 177) referrals came from the CMHT.

The number of people entering psychological therapies in the same timeframe is lower at 2,160, reflecting a wait time between referral and entering the service, and also that some people opt out of receiving the service. Further exploration of this is outside the scope of this report, but is being followed up at performance management meetings with the provider.

We have not reported referrals by practice in this report.

4.2 Inappropriate referrals

4.2.1 Kingston Wellbeing Service (KWS)

The Kingston Wellbeing Service estimates that 2.5\% of referrals are inappropriate\(^2\). That is 89 referrals, of which 66 were from GPs. This is a low percentage. There is some scope to reduce this further as shown in Table 5. It is noted that the service had to manually review all patient records to determine if they were inappropriate for this review.

Half of all inappropriate referrals were because the patient was too young i.e. not within 3 months of their 18\(^{th}\) birthday (these are sent on to Child and Adolescent Mental Health Services). Other reasons were that a patient had substance misuse needs/homeless (were referred to substance misuse team), were already under SWLSTG (these patients can then be discussed at interface meetings) or were out of area. Much of this can be solved through education of referrers.

Table 5: Reasons for inappropriate referral from a sample of 38 referrals to KWB (IAPT)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Referrals for individuals under the age of 18.</td>
<td>50%</td>
</tr>
<tr>
<td>Substance misuse and multiple needs e.g. homeless, safeguarding</td>
<td>15%</td>
</tr>
<tr>
<td>Already in contact with SWLSTG or requiring referral to SWLSTG</td>
<td>13%</td>
</tr>
<tr>
<td>Out of area</td>
<td>10%</td>
</tr>
<tr>
<td>Already receiving help elsewhere</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>No psychological problems</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

\(^1\) The figure 4,308 was reported to this review by the local service, although the numbers referred for psychological therapies in the KWB service performance report is 4,484.

\(^2\) This is in the opinion of KWB service, and has not been externally audited.
It appears that over half of referrals are for children and should have been referred into the children’s mental health services. A smaller number were for substance misuse which is a service provided alongside IAPT, and so could be re-routed into that service. 13% were already in contact with SWLSTG, but we do not have more detail about these cases. An audit would be required to elicit more detail. 10% were out of area.

Other referral issues raised by KWS

- A total of 177 referrals have been made by the CMHT to the KWS during the year 2013/2014. The vast majority of referrals from CMHT are complex, have personality issues, are moderate to high risk, and are very often difficult to engage. Substance misuse clients in IAPT can often be similar.

- IAPT service states that it is careful to ensure that CMHT cases are well managed, requesting CMHT support when necessary, whilst ensuring GP referrals of less complex patients are also managed in a timely manner, and not delayed by the prioritisation of CMHT referrals.

- Many IAPT clients are requesting counselling, often if CBT is not appropriate or desirable. Clients are given information about low cost counselling services in Kingston but not all can afford this. To address this problem, KWS take on a number of trainee Counselling Psychologists and Trainee counsellors on placement, providing them with supervision under honorary contracts, but we are not able to provide nearly as much straightforward counselling as is required, and other options such as GP based counsellors should be discussed.

- Streamlining referral to Kingston Bereavement Service for bereavement counselling would be beneficial.

4.2.2 Kingston Community Mental Health Team

The Community Health Team provided a narrative on the issue of inappropriate referrals and some key points are:

- There is variation in referral practice between GPs and they may on occasion refer a client to CMHT who is best suited to the KWS, if they are unsure what to do.

- Many referrals from KWS to CMHT are because an element of risk has come to light. CMHT suggests that an option is for the referral to go through a senior KWS professional before a decision to refer. Contacting KWS staff who have asked for a discussion about the client can take some time.
- CMHT reports being asked to screen for potential conditions such as ADHD, and Asperger’s unless there is a detailed history, and to see acutely depressed or anxious patients because the KWS waiting list is long.

- Patients with drug and alcohol issues inappropriately sent to CMHT are referred on to the Substance Misuse service within KWS.

- Access to notes between the Kingston North & South CMHT teams and KWS is an issue.

### 4.2.3 What happens to inappropriate referrals?

SWLSTG reported that all inappropriate referrals would be returned to the referring sources. However they also noted that if a referral is sent to them when it should have gone to KWS they will advise the GP and pass the referral directly to the KWS rather than bouncing it back and that discussions arising from this can help educate the GP about who to refer to. GPs are also educated about who to refer to through Liaison meetings with Community Consultants and through Consultants attending various GP practices for clinics when new referrals might be discussed.

The KWB (IAPT) service reported that they refer patients onwards to the most appropriate provider, and to CMHT if required. The issue of communications was raised as an ongoing area to work on.

### 4.3 Pathways and Interface meetings

Meetings between SWLSTG and the KWS started in February 2013. There were 9 meetings between February 2013 and August 2013, and key topics have been:

- Joint working
- Access to records (IG sharing)
- Management of inappropriate referrals.

There were no interface meetings between September 2013 and February 2014. Dates were proposed, but both providers reported it was very difficult to find a time that the relevant people could all make. In addition, some of the original members of the group from both KWS and SWLSTG have left, and Dr. Burns left the group to take up a different role. These meetings have since restarted.

Referral pathways and joint working arrangements are agreed at these meetings.
4.4 Views of GPs

An informal discussion with GPs at the Council of Members found that GPs have varying experiences and understanding of the referral routes into IAPT and CMHT services. All GPs are familiar with the IAPT service and felt they knew when to refer people to it. The main issue for GPs was being clear about where to refer more complex patients, for example those with depression combined with other problems such as eating disorders.

5 Conclusions and Recommendations

The volume of IAPT referrals that used to be seen in SWLSTG has now shifted to the KWS service and there is nothing to suggest that there is significant duplication of activity in the IAPT service and CMHT. Over 4,000 referrals per year are received by IAPT, and only 2.5% are considered inappropriate.

The number of patients seen at CMHTs has risen slightly between 12/13 and 13/14, but this is not driven by GP referrals which have remained stable. The number of inappropriate referrals to CMHT is estimated at 9%, and inappropriate referrals from GPs are higher in the north of the borough compared to the south.

All providers state that they will pass all relevant inappropriate referrals between their services, rather than sending the referral back to the GP. All providers have highlighted snagging issues around communication and patient information sharing. CMHT believe they have some patients referred to them who are more appropriate for the KWS IAPT service. The interface meetings are crucial for ensuring joined up care, and it is important that, now these have been reinstated, they continue.

GPs and other referrers are familiar with the new KWS as well as the CMHT, but would benefit from ongoing awareness and education about the criteria for each service, and more guidance on what to do with complex patients.

Recommendations

1. Commissioners should seek assurance that the provider interface meetings have resumed and will continue regularly
2. All providers should share referral criteria for each service more widely
3. Solutions to the sharing of information on patients should be sought
4. Providers should develop a system for flagging inappropriate referrals.
5. Service issues should continue to be addressed through performance meetings and Clinical Quality Review Groups.
Appendices

Appendix 1: Information requested from both services for this rapid review

Referral questions

- Total number of referrals to the service
- Number of referrals by GP practice
- Referral criteria for the service
- How many of the referrals were deemed to be inappropriate by the service?
- What happened to the inappropriate referrals?
- Any variation in GP referrals?
- Key themes.

Interface/pathway questions

- What information is available for GP’s/individuals to inform them about which service to contact/refer to e.g. publications, training etc that is in place
- Details of any protocols that are in place between Kingston Community Wellbeing Service and South West London and St George’s Mental Health Trust to manage referrals/joint working
- How many interface meetings have taken place?
- What are the key issues at the interface meetings?
- What has been resolved at the meetings?
- Future plans/developments with GP’s.
Appendix 2 Referral Criteria for Kingston Wellbeing Service – IAPT services

- 18 years of age upwards (anyone within 3 months of their 18th birthday will usually be seen)
- Registered with an RBK GP
- Clusters 1-4 and some of 6 (e.g. mild to moderate eating disorders)
- Suitable for treatment within an IAPT service, where the focus is on:
  - **Anxiety disorders:**
    - PTSD (mainly one-off trauma, and not (usually) cases such as victims of torture who may need CMHT/Specialist Service combined treatment
    - Health Anxiety
    - Phobias
    - Generalised Anxiety Disorder
    - Mild to moderate OCD
    - Social Anxiety/Phobia
    - And related anxiety difficulties
    - Stress management
  - **Depression:**
    - Acute, recurrent
    - Ante and Post-natal depression (priority group)
    - Depression that is the cause of couple difficulty
  - **Mixed Anxiety and Depression**

Short to medium term treatment (Average 6-8 sessions, up to 16 for some therapies)
Mild to moderate presentations (reflected in psychometrics and/or the clinical impression and target problem)

Non-psychotic and not unstable bipolar

Not using substances, or using but still able to use therapy

Able to attend regularly and consistently (too many referrals to allow frequent DNAs)

Not in acute crisis, actively suicidal or seriously self-harming
Appendix 3 Referral Criteria for Kingston Adult Community Mental Health Teams

Taken from section 5 of the operational policy

The CMHT primarily offers a service to adults of working age with mental health problems that require assessment by a specialist mental health professional.

New referrals for service users over the age of 75 years in Merton, Sutton and Wandsworth, and 65 years in Kingston and Richmond should be referred to the specialist services for older people.

Service users who have reached the age of 75 years in Merton, Sutton and Wandsworth, and 65 years in Kingston and Richmond will continue to receive mental health services from the CMHTs until such a time as their needs are assessed as having changed due to their age and adult services are less able to meet their needs. Transition of care to services for older people will then be planned via the CPA process.

Each borough has developed a detailed policy on the Fair Access to Care Services (FACS) and the eligibility for community care arising from this. As a result of a partnership agreement with the boroughs the Trust will have responsibilities in operating this guidance for those clients requiring social care and residential placements. See Trust wide clinical policy Fair Access to Care Services Policy (TWC41) as an accompaniment to the local authority specific borough detailed policies.

Agreements are in place relating to the transition from child and adolescent to adult mental health services and from adult mental health services to services for older people. Interface agreements between adult mental health services and mental health services for deaf people, forensic services and addiction services are also available on the Trust Bulletin Board in the Policies and Procedures Section. It is an expectation that at any transition all safeguarding issues will be handed over in such a way as to ensure appropriate safeguarding plans remain in place and are reviewed.

NICE guidance and local care pathway thresholds, specifications and protocols must be used to determine thresholds to secondary care in order that:
- Service specifications with commissioners are clear and CMHTs are commissioned and resourced to be effective for the target population.
- Stepped care operates providing people with the most timely and effective treatment in the least stigmatising setting.

People who might need more ongoing specialist care subject to regular review include:
- Persistent mental disorders associated with significant disability or complex needs, predominantly major psychoses such as severe schizophrenia and bipolar disorder.
- Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive multidisciplinary follow up using outreach.
- Any disorder where there is significant risk of self harm or harm to others or where the level of support required exceeds that which a primary care team or PTiPC could offer.
Disorders requiring skilled or intensive treatments (e.g. CBT, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.

- Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983 as amended by the 2007 Act), except where these have been accepted by an assertive outreach team.
- Severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by a specialised psychotherapy or personality disorder service. (Based on MHPiG 2002)

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