'The Reading model': an integrated psychotherapy service

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This article describes the principles and structure, staffing and training of an integrated psychotherapy service for the people of West Berkshire and South Oxfordshire (Reading, Henley, Wokingham, Newbury and Didcot) a population of 530 000.

The service is integrated internally as a joint out-patient and therapeutic community service that can provide psychodynamic psychotherapy across a wide range of length, intensity and styles. Externally it is integrated with the general adult psychiatry service, referrers, social services and community mental health teams.

Principles of service development

A five day a week therapeutic community had evolved at Fair Mile Hospital to serve West Berkshire since the early 1970s. The out-patient psychotherapy service in West Berkshire opened for referrals in September 1985. Designed to service a population of 530 000 living in West Berkshire (Reading, Newbury, Wokingham) and South Oxfordshire (Henley, Wallingford, Didcot) we sought to embody four main principles of service provision.

Firstly the range of treatments offered should attempt to reflect the potential depth and breadth of referral patterns. This means that the service design has to respond to the demands of today as well as actively anticipate those of tomorrow. Referral depth describes the numbers of referrals and their pattern both geographically and over time; many factors appear to influence referral, some obvious, some mysterious. Referral breadth describes the possible range of diagnoses and problems that individual patients, couples or families present. This model of service evolution allows for a two-way process of education between ourselves and the referrers.

Although the psychotherapy and psychology services are managed separately we work together in providing a range of therapies. Usually cognitive–behavioural treatments are provided by psychologists in community mental health teams (CMHTs) or in GP fund-holder practices. We have joint teaching sessions to share both the pleasures and perils of our different models of therapy. The psychosexual clinic is open for two sessions a week and one therapist has cognitive–behavioural training while the other has a psychodynamic background.

Recent service developments include acquiring room and equipment for family therapy, a project aimed at working with the parents of young adults with schizophrenia, and plans to start group work with couples. A rise in forensic referrals in recent years has led us to develop plans for a new Consultant post to be shared with Broadmoor Hospital which we hope to establish in 1997.

Secondly, in order to be able to fulfil the first principle, the staff group need to be able to work flexibly. This requires a choice of highly motivated individuals with medical, nursing and psychology backgrounds to form the core team supported by a wide network of sessional workers who bring varied training and cultural backgrounds to enrich the service. Managerial commitment to resourcing high levels of supervision, personal development, higher training and academic input is essential to the quality of the service and to the maintenance of a happy, hard working staff team.

Thirdly we would want to underline the need for overt patient advocacy. It is important to seek patient feedback and participation in planning. It may be a reflection of the success of this that patients and staff from the past now run "Friends of Winterbourne", a voluntary support network. The ethos of psychotherapy as person and relationship orientated needs to be reflected in the overall running of the service as well as in the way treatment is negotiated.

Lastly, in such a large geographical area, it was necessary to construct a "circulatory" model of service. The central "heart" in Reading contains both a five day week therapeutic community and the main out-patient service. But staff members, "the blood corpuscles", travel to community mental health teams and other out-patient facilities across the catchment area for assessments, supervision, staff groups and therapies on a weekly basis.

Service provision and staffing implications

At present the range of treatments offered is demonstrated in Table 1. Many patients benefit

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Table 1. Range of treatments

Individual	
– brief-term	(6–18 sessions)
– medium-term	(18–50 sessions)
– long-term	(50+ sessions)
Group	
– mixed	
– specialist e.g. theme or gender specific	
– preparatory for the therapeutic community	
Therapeutic community	
Psychosexual	

Table 2. Staff group

- 2 Consultant Psychotherapists
- Psychotherapy Service Manager (I grade nurse)
- Clinical Nurse Specialist (H grade nurse)
- 5 Nurse Psychotherapists
  - 2 'G' grade
  - 2 'F' grade
  - 1 'E' grade
- Principal Psychologist – 5 sessions*
- Registrar on Oxford Rotation
- Senior Registrar – general psychiatric rotation*
- Senior Registrar – specialist psychotherapy rotation*
- 1 Receptionist
- 2 Secretaries

*These posts are currently vacant.

Table 3. Team trainings

Completed
- Diploma in Group Psychotherapy – Goldsmiths College
- Diploma in Psychodrama – Oxford
- MSc Transactional Analysis – Middlesex
- Institute of Group Analysis Qualifying Course
- Certificate in Psychodynamic Psychotherapy – Oxford University Department of External Studies

Currently in training
- MA in Psychotherapy – University of Kent
- Diploma in Arts in Psychotherapy – London
- Diploma in Group Psychotherapy – Sheffield

Table 4. Courses from which student attachments are accepted

- University of Reading – Counselling MA, Diploma or Certificate
- Regents College – MA in Psychotherapy and Counselling
- Institute of Group Analysis
- University of Sheffield – Diploma in Group Psychotherapy

from a package of treatment combining two or more modalities or from being able to return for another "bite" after digesting their first therapy. The staff group is shown in Table 2 and the variety of trainings of members of the team in Table 3. The ethos means that all high quality trainings are respected. Any service asked to meet the needs of 500 people a year will require a wide range of treatment options and it is clear that different trainings suit different staff members. Team meetings to discuss all assessments allow all patients to benefit from that richness as we seek good patient-treatment "fit". Table 4 shows which courses/trainings we most regularly accept student attachments from.

The "heart" of the service is an important focal point for the staff team, setting standards and providing impetus. The presence of a five day week therapeutic community in the same building as the main out-patient department has benefits for both aspects of the service. The house has the feel of being lived in because of the therapeutic community presence. This means that there is more noise and activity than a normal out-patient department might expect but staff and patients alike find this reassuring and warm rather than intrusive. Sometimes the out-patients become aware that there are other patients getting more from us than they are, this invariably leads on to useful material in therapy. Therapeutic community patients also have fantasies about, and envy out-patients. Again this provides rich material to work with. The department has a family feel in which differences are acknowledged and explored as a part of the whole. It sometimes feels as if the presence of the therapeutic community means that confrontation pervades the corridors, such that the building can never become a detached ivory tower. This is important not only for internal dynamics but also for relationships with outside agencies.

The therapeutic community allows us to offer a local NHS intensive psychotherapy to patients who have a combination of longstanding mental illness and personality problems, who have often survived appalling abuse, and have substance abuse and/or forensic histories. Such people place great demands on any adult mental illness service and our capacity to accept them into a containing treatment package undoubtably enhances our standing with colleagues in psychiatry and local GPs. It also means that the staff learn to deal with this patient group effectively, including learning to cope with their own countertransference issues, as part of a team. This undoubtedly increases their ability and confidence in dealing with higher levels of distress and disturbance in out-patient groups when they may be on their own.

All the staff team work in both out-patient and therapeutic community aspects of the service

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during the week, although for varying proportions of their time. This provides unique training opportunities and also flexibility in staff utilisation in crises. For example it was possible to staff the therapeutic community through a period of long-term sickness by shifting sessions from out-patients but when the build up to the Gulf War meant that we were required to offer group leader support to a variety of groups in the community it was the small group leaders from the therapeutic community who responded. In a relatively small service under the pressures of large demand such flexibility is a great benefit.

Responding to patients: democracy and advocacy

Pressure from the therapeutic community patient group means that we are not allowed to become complacent about issues of patient rights and advocacy. Patient representation in decision making is seen as important and the in-house user group of staff and patients hold responsibility both to flag up problems and solve them. To achieve egalitarianism while maintaining a psychodynamic framework for therapy is a great challenge but it can create an environment in which patients feel, and can demonstrate, greater empowerment. Given that so many of the people we assess have been cruelly disempowered in the past it may be that this ethos is essential for a complete treatment environment.

The out-patient service sometimes appears to act as a container for the therapeutic community in which the nature of the work and the force of both transference and countertransference issues can lead to a feeling of chaos spilling out. Some staff are involved in the therapeutic community at a supervisory level only, while working in the out-patient department for the majority of the week. Their presence allows for a thorough digestion of the staff's experience of the drama of therapeutic community transference and countertransference issues. By allowing staff to work in out-patients for some of the week they have opportunities to contrast their experiences with those in different arenas. There is an ever-present danger in therapeutic community work of staff being invited to act-out with or on behalf of the patient group. Supervision, containment and a staff sensitivity group attended by all core team members help the staff group stay focused on their therapeutic task. These supervisors can be safe holders of group projective identifications and, of course, there are some aspects of communications that can only be understood in retrospect. Not only does this supervision enhance the quality of the Therapeutic Community treatment generally it particularly enhances the capacity of staff to contain patients on the programme and this in turn improves our relationship with referrers.

It is easier for managers and purchasers to be involved in the therapeutic community programme for a day than to demonstrate to them exactly what happens in out-patients. Their understanding and appreciation of therapy has been a crucial aspect of a climate which has allowed us to continue to improve the service in a generally hostile NHS world. Senior managers, business managers, non-Executive Directors and referrers have all become supporters of the Therapeutic Community after their visits. Patients are empowered by the opportunity to talk to such authority figures and are proud to be a part of preserving and improving the service.

Management, research and audit

The management team consists of two consultants and two senior nurses. They meet once a week to deal with the day-to-day issues as well as forming strategic vision. Ideas then go to the fortnightly business meeting for whole team discussion. While each team member brings a unique dimension to the work we also use a dynamic understanding of the team as a group. In a service that provides both individual and group psychotherapy, the individual and the group in the staff team's own experience is important. The core team have a one and a half hour sensitivity group run by an external group analyst each week. Of course, this is by no means always a comfortable experience but none the less is essential to the healthy functioning of the team as a group with shared ideals, standards and goals.

The department is committed to psychotherapy research and plays an active role within the Society for Psychotherapy Research (UK). A wide range of data is collected for each patient and outcome studies are planned in both out-patients and the therapeutic community. Meanwhile multidisciplinary audit is facilitated by a two-monthly meeting. One of the key standards of the service is the amount of face-to-face patient contact time each staff member has in proportion to their educational and supervisory needs. Those staff still undertaking training divide their time between face-to-face contact and other tasks in a 50 : 50 split. Senior, trained staff usually have supervisory, education and/or management commitments and therefore spend between 20–40% of their time directly with patients. Senior staff also have time for continuing professional development (doctors) and study leave (nurses). Members of the team who attend conferences feed back to the core team the following week. Being clear about the standard for face-to-face patient

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contact has allowed us to be exact in agreeing contracted activity.

Finally it is only possible to run such a service if the day-to-day administration is of a high calibre. The two secretaries and the receptionist play an integrative role within the service, keeping track of the patients in the system, coordinating all our timetables with each other and with the many other departments with whom we interact.

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