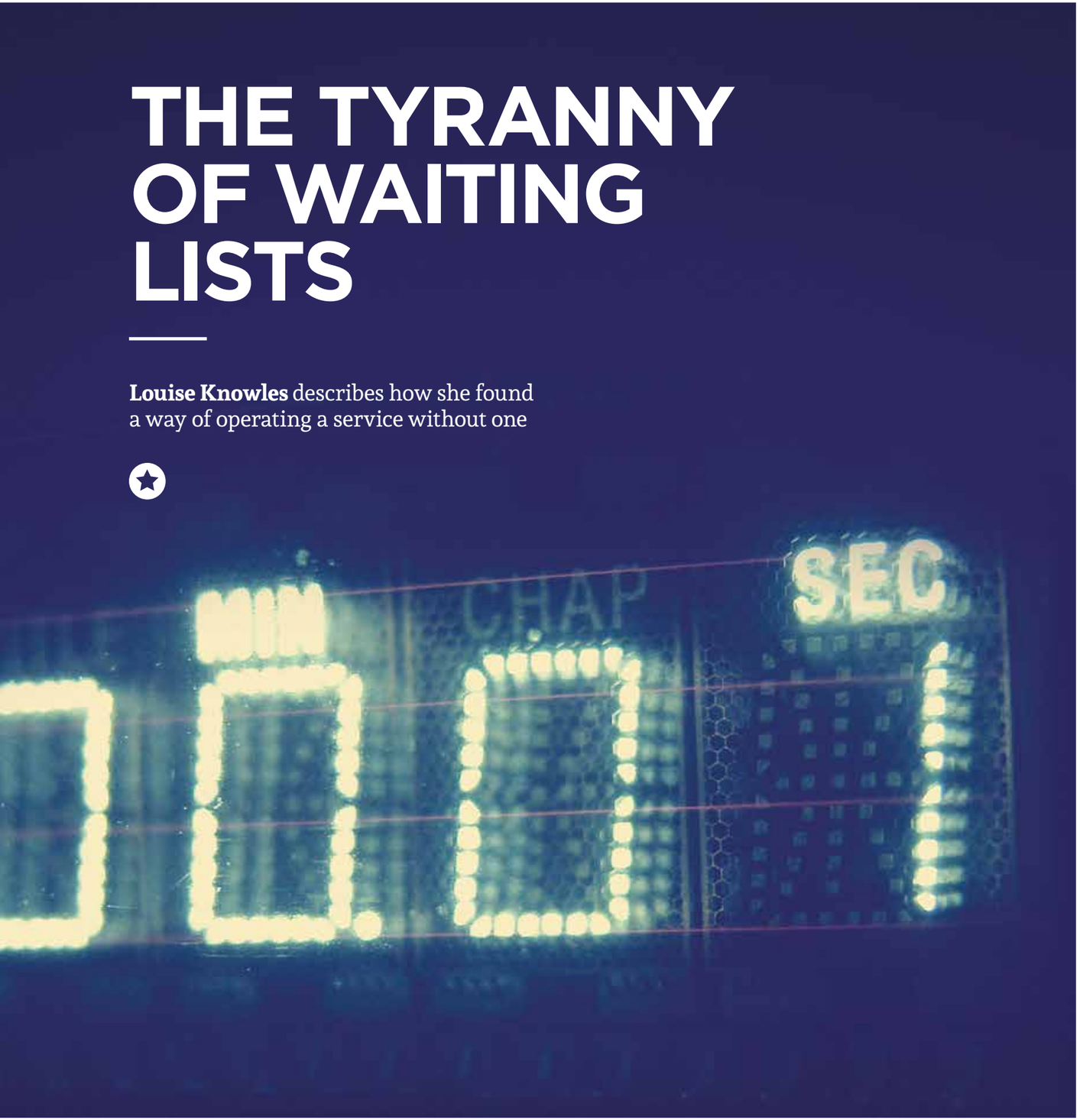
THE TYRANNY OF WAITING LISTS

Louise Knowles describes how she found a way of operating a service without one



Over the last couple of years, the Counselling and Psychological Wellbeing Service at the University of Sheffield has undergone some significant remodelling. By bringing together creative thinking within a process orientated methodology, we have eliminated the need for a waiting list for face-to-face counselling. We have also, I believe, made a real improvement to the service our students are receiving.

I began my role as the Head of Service in February 2012, during one of the busiest times in the academic calendar. In line with the overall increase in student numbers, the service was seeing a year-on-year increase in clients. With demand outstripping supply, this was managed, in the main, through the use of a waiting list. The process and procedures that were in place were complicated and time consuming. There were also a number of routes into the service. These were designed to help students gain access, only to be met with a frustrating delay in the students being seen. By default, rather than by design, the service was focused on preventing clients from gaining access to the service. Staff and students found this approach extremely stressful, with neither being able to focus on the needs and limitations of the other. I was concerned for clients who were already distressed and often at breaking point, being put on a waiting list. I was also concerned about the ongoing impact on counsellors struggling to meet the impossible expectation of reducing the list.

The key challenge I faced during those first few months in post was, 'How do I creatively bring into line my theoretical and clinical understandings as a psychotherapist and my goal as manager in running an effective and efficient service?'

Moving focus from service to service user

For more than four decades, outcome research into psychotherapy and counselling has informed us that the theories and techniques of therapy have very little to do with the success of therapy.[1] It is the relationship itself and the client's perceptions and experiences of the relationship that are the most important factors in bringing about therapeutic change.[2] If as a service we take these findings into consideration then how we build and nurture that relationship from the beginning will be of primary importance in effecting change. If the system is not providing the opportunity for clinical staff to respond to the clients' needs from the very beginning (and facilitate the building of trust between them and the service), then something is wrong with the system.

Attachment theorists inform us that our early attachment experiences play a crucial role in our ability as adults to self-regulate.[3] The latest developments in neuroscience have also made us pay attention not only to what happened to our clients in terms of their past significant relationships, but how their bodies, brains and minds have remembered these experiences.[4] It would therefore follow that how we attune or misattune to our clients during that initial point of contact holds the potential to begin the process of transforming their past experiences or re-activating them. Ruptures are an inevitable part of the ongoing process of therapy. We would hope, however, that when these happen, the relationship between client and therapist has had time to develop. As such, it is more secure, thus ensuring the client can better tolerate any ruptures.

The turning point

By late April, our waiting list had reached over 40. I had to report this information to other senior managers. I understood completely why senior managers expressed serious concern about this situation. There were students who would clearly never receive the one-to-one therapy that they had been assessed for. The critical point for me was the realisation that I had no confidence that this situation would alter – unless we made some significant changes to our service delivery model. It was evident that the service needed to be redesigned and I began looking into what was possible in terms of change. How could the existing processes and procedures be pared down to reduce the workload for counsellors and increase their availability for clients? How could we, as practitioners, incorporate our understanding of the importance of attending to a client's relational needs as well as their presenting issues from the first point of contact? How could we aim to soothe, calm and establish trust in the service at this crucial point? How could we eliminate the tyranny of waiting?

Lean methodology and the process of change

Because of my desire to challenge the structure of the service and to look at creative solutions, I was able to take up an offer to work with the university's Process Improvement Unit (PIU). This unit consists of a small team of specialist staff, whose role is to work with other departments to make improvements to processes and services. PIU uses Lean Methodology.[5] Lean was developed by Toyota as an approach to improving flow and eliminating waste. In the Health Service, Lean is used as a patient-first approach that puts the patient's needs and values at the forefront.[6]

Lean demands a primary focus on delivering value to those accessing a service and renders anything other than this to be a waste of resources.

Lean follows five main principles:

Principle 1. Understanding value

What does the client want from the service? This is about understanding the service from a client's perspective. Focusing on what the client wants ensures that anything that does not support the client journey is considered waste.

Principle 2. Identifying value streams

This is process mapping. In fine detail, identify all the steps that make up the client journey. We had a process map for all the different types of appointments.

Principle 3. Create flow

What are the obstacles and barriers that prevent the free flow of the client accessing and gaining what they have approached the service for? For example, one obstacle for us was the amount of forms clients had to fill in before they could request an appointment. We had different forms for different appointments.

Principle 4. Leverage and pull

Clients pull the demand rather than services leading it. Nothing is offered that is not requested, resulting in client demand becoming more stable as the client knows they can access the service when they need it.

Principal 5. Seek perfection

Aim to continually improve and change. Embarking on this process was not without nervousness on my part. I was leading my service into a process whereby we would be working with non-clinicians to analyse how we were delivering a therapeutic service. What would the fit be like between a Lean Methodology and our own working philosophy as psychotherapists? In spite of this, it was a good opportunity for the team to engage in a process of critical self-reflection. The process of change was set in motion.

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Working through the lean process

Stage 1 – establishing the focus

After having consulted our key stakeholders and provided an overview of the service via key statistics, we set up a small project team. This included myself, a member of my administrative team, one of our clinicians and our student welfare officer. The role of this team was to set the scene. This included outlining our current position, the key problems/weaknesses of this and which of these weaknesses we wanted to focus on. There was general agreement that the key issues within the service as it was then delivered were:

- The different types of client appointments with a number of different access routes.
- The waiting list, with its overly complicated procedures and processes for prioritising the treatment of clients. This in turn created a lack of transparency about what we were offering, which was confusing for students and referrers.
- The use of two distinct and unlinked IT systems: CORE net and Titanium Schedule, resulting in complex risk management procedures. In addition staff were also keeping paper-based files for all clinical work. Administration was taking up considerable staff time.
- Poor use of the physical space, with some rooms looking barren and unwelcoming.

Stage 2 – the action points

Once we had established our focus, a wider project team was set up. This included members of the small project team and the rest of my staff. We met over a period of four days to map and review current systems/processes and to consider what improvements could be made. We decided to implement the following changes:

- The only access route into the service would be via our online registration, with students being able to complete a simple process in no more than two minutes. We would take only basic contact details, GP contact details and details of any access issues the client might have. This also meant that we would now only accept self referrals.
- Within 10 days of registering, students would be invited to attend a face-to-face triage session.
- Our physical space would be redesigned to provide an environment that was welcoming, warm and friendly. We also wanted to create a space for staff to meet, relax and be with each other, and therefore agreed to develop a staff room.
- We would operate a single IT system, Titanium Schedule, consequently replacing the use of Client Outcome Routine Evaluation (CORE) as a clinical measure with Counselling Centre Assessment of Psychological Symptoms (CCAPS), which can be accessed through Titanium Schedule. This would simplify administrative procedures for both clinical and admin staff, as well as ensuring more coherent and consistent risk management procedures.

The triage model

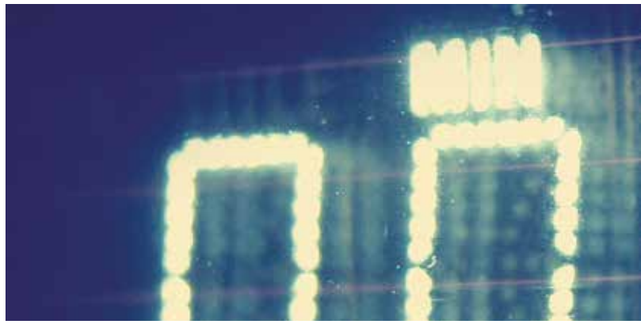
The concept of triage was developed during World War 1 as the number of casualties reached epidemic levels. Soldiers were triaged as a sorting procedure, using a patient's severity of injury to gauge and categorise casualties, as well as beginning to prioritise for treatment.[7] The terms *triage* and *assessment* are often used interchangeably. It was therefore important for us to be clear about the difference. Previously, our assessments involved taking a detailed client history, as part of a clinical process. This led to problem formulation and a treatment plan. In contrast, the emphases of our triage sessions are to:

- Make sure that clients are seen face to face with the least delay.
- Consider the range of options that are available, in order to decide with the client the best way forward. These options may include one-to-one sessions, workshop sessions, therapeutic groups, access to self-help, and referrals to secondary mental health services.
- Enable us to adopt a relational stance with clients at the first point of contact so clients feel responded to, attuned to and contained. This relational stance supports trust in a system designed to prioritise clients and that creates the foundation for the therapeutic relationship.

The fact the clients are seen quickly (and if required, can return to the service and be seen quickly again), means that if the option decided upon is not the best one then clients have the chance to reconsider. They know they can gain fast access to our service.

Reflexivity – developing and refining our service

The triage model means that we, as individual counsellors, are constantly engaged in making clinical decisions. We must consider which treatment option is preferable and appropriate for a particular client with a particular set of presenting issues at a particular point in time. In order to remain responsive, we need to be open to refining and developing how we work. There are times when we do not get it right, and we have to be open to challenging our assumptions, beliefs, values and biases which may be negatively influencing our decision making. Adopting a reflexive approach is central to formulating informed clinical decisions and as a team we need to ensure that our interpretive lenses are clear.[8] Reflexivity acknowledges, however, that this can only be aimed at and never fully



achieved. However, we endeavour to have some process by which we can remain as interested in ourselves as we are in the clients we see.

Operating a service without a waiting list requires discipline and an ongoing commitment to continue doing so. The whole team has to maintain trust that the system will cope. That what we offer is sufficient, even when the number of registrations exceeds our plans, or when clients present with complex needs. At times it would have seemed easier to place certain clients, who we deemed to have less desperate needs, on a waiting list, thus undermining our system. Students know that they will be seen within 10 days regardless of how they present. This has improved the relational dynamic we have with them. We are now a service that is worth approaching. As one service staff member commented, 'Getting rid of the waiting list felt like opening the shutters and windows of an old and very stuffy building. The new system offers a very clear, straightforward route for clients to access our service. It's one that both staff and clients can understand. It's a breath of fresh air… [it's] more honest not having a waiting list. For me, waiting lists are just a way of rationing services without anyone taking responsibility for that. Now responsibility for allocating resources rests where it should: with each individual clinician'.

Does the model work?

Is the student population, and in particular, those facing acute anxiety, stress and depression being serviced by the counselling service? Are we getting the outcomes for our clients? It is too early for us to fully answer all of our questions and too early to have any strong evidence about client outcomes. But what we do know is:

- We have reduced the wait for the first face-to-face contact, now called triage, from 11.5 to five days, a reduction of over 50 per cent.
- We have seen a reduction in wait from triage to the first ongoing appointment from 20 days to 9.8 days, again a reduction of over 50 per cent.
- We have seen a 43.5 per cent increase in initial

contacts for our service, all of which we have been able to absorb without a waiting list.
- We have seen a 2.4 per cent decrease in rate of missed appointments.
- Although it is early days from which to draw long-term conclusions, we have not seen any significant reduction in the total number of face-to-face counselling sessions received per client.

Conclusion

The process of change has meant that we now deliver a service that makes more sense to me as a psychotherapist in terms of my underlying philosophy. It also fulfils my aim as a manager running an efficient and effective service which places the service user at the centre. We now offer a straightforward, accessible, receptive process from a service that can easily be accessed and reaccessed. This seems to cultivate, from both clients and therapists, a sense of trust and hope in the service. This results in both parties being more willing to engage in helpful and meaningful dialogue. Our services have to be responsive to students' needs. Students are, in the main, only at university during term time; therefore, we have to deliver our services in a timely manner. We have also held onto the Lean principles and in particular principle five, that is, aiming for perfection. As a team we have been looking at how we can make more changes, how we can work more creatively. As a result of this change process, we are now in the process of redefining and reshaping how, and to whom, we offer workshops and groups. We are looking at ensuring our groups and workshops better reflect client need, so again, the pull is from the client.

THE LEAN PROCESS DEMANDS A PRIMARY FOCUS ON DELIVERING VALUE TO THOSE ACCESSING A SERVICE

I have led a process of significant change and believe that this change has laid the ground for my team to be able to work from a different starting place. We will continue to stay open to the changing needs of the student population and be willing to adapt to these when necessary. We will also endeavour to be aware of new developments in our professional field which may better inform our thinking and decision making in the future. But for now, we have been successful in liberating our service from the tyranny of the waiting list.

ABOUT THE AUTHOR

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REFERENCES

01. Duncan BL. The heart and soul of change: delivering what works in therapy. American Psychological Association; 2009.

02. Norcross JC (ed). Psychotherapy relationships that work. Therapist contributions and responsiveness to patients. New York: Oxford University Press; 2002.

03. Schore AN. Affect regulation and the repair of the self (Norton series on interpersonal neurobiology). New York: WW Norton and Company; 2003.

04. Bessel van der Kolk MD. The body keeps the score: brain, mind and body in the healing of trauma. New York: Penguin Group; 2014.

05. Balzer WK. Lean higher education; increasing the value and performance of university processes. New York: CRC Press; 2010.

06. http://www.institute.nhs.uk/option,com_quality_and_service_improvement_tools/Itemid,5015.html (accessed 24 January 2015).

07. Walton CJ, Grenyer BFS. Prioritizing access to psychotherapy services: the client priority rating scale: Clinical Psychology and Psychotherapy 2002; 9: 418–429.

08. Johnstone L, Dallos R (eds). Formulations in psychology and psychotherapy: making sense of people's problems. London: Routledge; 2006.