Feedback from the Primary Care Talking Therapy Stakeholder Consultation

Talking Therapy Board

February 2012

Contents

1. Purpose

This report gives a summary of feedback from the talking therapy consultation exercise that took place between 18th October to 18th November 2011, and indicates how the new service has been developed in response to these comments.

2. Context

A decision to re-commission the various talking therapy services from August 2012, into one Lambeth-wide, integrated counselling and Improved Access to Psychological Therapy (IAPT) service was taken by the Lambeth Clinical Collaborative Commissioning Board (LCCCB) in June 2011.

As part of the re-commissioning process, The Lambeth Talking Therapy Board undertook a month long consultation phase during October and November 2011. The Board

- Sent the consultation document to interested stakeholders (Appendix 6.1).
- Made the document available on the intranet.
- Held a workshop within the LCCCB 'All GP practice Learning Event' on the 12th October 2011
- Hosted a stakeholder consultation event which was held on the 1st November 2011. Invitations were extended to users, existing providers, GPs, Lambeth Council staff, providers who expressed an interest in tendering for the service, and the general public. A follow up meeting for participants to discuss and develop outcomes of the consultation event was held on the 8th November 2011.
- Presented the proposals and document to a user and carer Vital Link meeting.
- Initiated a user survey which was initiated via the Improved Access to Psychological Therapies Service.

Feedback was invited on specific aspects of the proposed service including:

- The vision
- Outcomes of the new service
- Employment support services: should the existing employment services embedded in IAPT be maintained
- What has worked well in the past 3 years which needs to continue?
- Ideas to ensure equality and equity
- Suggestions on how to access the service
- How the principles and values of the Lambeth Living Well Collaborative could be implemented in the new model

3. Responses

3.1: Summary

The numbers and cohorts of responses can be seen below

Table 1: Summary of respondents

Cohort	No of responses	Comments
Individual responses		
People who use services	34	The Lambeth IAPT service undertook a consultation exercise. Users who responded were therefore predominantly uses of the IAPT service, and some had used counselling services.
GPs	5	2 from the South West Locality, 2 from the North, 1 from the South East
Individual staff	2	Neighbourhood counselling staff: 1 each from Streatham and the Hills
Responses from organisations		
Current providers of talking therapies in Lambeth	5	Status Employment, South London & Maudsley Trust (SLaM): provider of Lambeth IAPT, Neighbourhood counselling services: Clapham & Brixton, the Hills, Streatham
Other organisations	2	St Mungo's, Terence Higgins Trust
Events and meetings		
Open Space event	60	Attended by service users, GPs, talking therapy provider staff, Lambeth Borough Lambeth Council (LBL) staff, voluntary sector provider staff
Open Space Follow Up Meeting.	12	Attended by some of the above participants and some people who could not attend the Open Space Event.
Vital Link Meeting	10	Attended by service users and carers.
All Practice Event	8	GPs, Practice Managers, LBL & PCT commissioners attended a mental health workshop as part of wider general practice learning event
Total responses	138	

3.2 The Open Space consultation event

This event was conducted as an Open Space in which those present set the agenda and identified and led the areas chosen for discussion. This methodology empowered participants to take responsibility and talk about what was important to them rather than to a fixed agenda.

Participants were at liberty to move between the different discussions to enable them to contribute to as many of the topics that interested them as they wanted. At the event, the participants collectively identified 22 areas of importance that they wished to discuss and these were streamlined into 6 themed discussions:

1. Referral process, triage, central referral and choice
2. Access
3. NICE compliance and contractual arrangements
4. What people should expect from therapy
5. Integration of health and social services
6. Employment support

After brief feedback from each group summarising their discussion, participants identified their top 5 priorities to be addressed by the new service.

The most popular priorities, in order, were:

(i) The need for a single point of access/assessment process,
(ii) The need for pre-therapy preparation so that users and referrers were clear about what the service could offer
(iii) The provision of language specific services and the support of people for whom English is not their preferred language particularly into employment,
(iv) Provision of a variety of therapies to respond to individual need and achieve integration without losing diversity,
(v) The need for a suitably skilled workforce to triage users.

Thirteen participants from the Open Space event attended the follow-up meeting one week later. The aim of this meeting was to synthesise the reports from the event into a single submission to the talking therapies consultation. Certain principles and themes were then agreed which should be considered by the commissioners when developing the specification for the service.

These were reported as follows:

- Outcomes and standards: It was felt that commissioners needed to specify the outcomes and standards (such as clinical guidelines and professional standards/competencies) that providers need to meet. The service specification however, should not be prescriptive about the model of service delivery.

- Access: Fair and equitable access needs to be clearly specified, particularly stressing the need for access to people who currently do not

access current services. This would have to include any legislative requirements.

- Information and data: The new provider must provide accurate service information for users and referrers which include information about other services that may be helpful. This should reduce inappropriate referrals and give the user an idea of what to expect.

  Data collection systems need to be efficient and sensitive to confidentiality needs of the users. The service specification should include details of mandatory data collection and reporting in relation to demonstrating equity of access to services and outcomes, and diagnosis to support care pathway development. There should be clear communication between providers, users, commissioners and other stakeholders on data collection and information sharing.

- Types of therapy: Participants asked for a variety of providers to offer a variety of therapies were available. All would, however, need to work in an integrated manner, and work closely with social inclusion agencies and mainstream services.

- Employment: A creative response is needed to provide a service for those in employment and those seeking employment. Participants did not wish to loose the partnerships already in place which facilitated collaborative working with mainstream employment support services.

- Non resolution of symptoms: When therapy is not working, users should be reassessed, by talking therapists and other agencies. This will avoid the common assumption that more or different talking therapy is needed, when it may be that medication or social support is necessary

- Utilisation of informal networks: The strength of informal networks as well as formal networks in Lambeth needs to be acknowledged such as the Wellbeing in Lambeth Network.

- Staff and good working relationships: The need for trust and confidence in staff was raised. It was felt important to acknowledge their learning and development needs and ensure these are addressed.

3.3: User feedback

3.3.1: User survey - The IAPT service collated the views of their users via a survey. The full consultation document was summarised to make it more accessible and digestible so as to engage more meaningfully with users and encourage responsiveness. The questions asked are found in Appendix 6.2.

Table 2: summary of user feedback

34 responses in total: 62% were satisfied with the vision stated in the proposed service specification 53% supported the proposed outcomes and had nothing further to add 68% wished to maintain the employment support function 71% were satisfied with the routes into the service 82% agreed that a single point of referral would improve access and reduce confusion 17% felt that more user feedback would be helpful information to support decision-making

There was overall agreement that self-referral was a beneficial aspect of the proposals allowing users to access the service in a way that is most suitable and timely for them. It was recognised that, in order to maximise the benefits of self-referral, the service needs to be publicised and marketed more widely so people are aware of the service before they think of approaching the GP. Increased use of internet and other technologies were seen as potentially useful ways of supporting both access and treatment.

There was support for more integration of psychological with physical health and employment support, with many users acknowledging the significance between these factors in enhancing overall well-being. However, there was a request that both assessment and triage and treatment appointments are available outside of regular working hours so that people can receive support without having to take time off work.

Users were concerned that waiting times should be minimal as waiting too long can cause people to disengage. Many users reported a positive experience of the existing assessment and triage process. They felt that the service often anticipated difficulties with communication if phone triage was difficult as this was highlighted on their referral form. . In particular, they commented on how quickly and efficiently, yet sensitively, they were dealt with. One user, however, reported a negative experience of the system citing unacceptable waiting times as the main problem.

3.3.2: Vital Link response: Users and carers were particularly concerned as to ensuring that there was adequate services in place to meet demand, and that long waiting lists did not develop.

Joint working relationships of agencies working with users also were highlighted, the need to ensure that good communication occurred between the various people involved in someone's care.

3.4: All Practice Event and GP feedback

3.4.1: All Practice Event feedback

10 people attended the LCCCB workshop, mostly GPs, practice managers and providers of the existing neighbourhood talking therapy services. There was overwhelming praise of the existing service, noting that GPs were now used to the referral system and received positive outcomes for users. There was questioning as to why the service, in this case, was being tendered as relationships had been built. There was a strong commitment to identify, retain and enhance what works well, and not to 'throw the baby out with the bath water'. There was particular preference for:

- Clear and achievable Key Performance Indicators that were achievable rather than aspirational
- Self referral as a key component of a new service. However, there will be a need to ensure appropriately trained triage staff. There was a fear that too junior staff members would be less effective in referring users to the correct intervention.
- Building care pathways as an essential requirement, for example with providers who may be in contact with mood and anxiety issues, such as providers working with people with long term conditions.
- The building of relationships, notably with isolated practices.

3.4.2: Individual GP feedback

Five responses were submitted by individual GPs and they all supported the introduction of a single point of access anticipating that it would reduce confusion and help users to navigate through the system better. They agreed with LCCCB workshop participants that a key concern was that initial assessment and triage must be performed by appropriately qualified staff.

In order to ensure fair access to the service and reduce discrimination, 3 GPs mentioned the need for interpretation services to be prompt and efficient.

3.5. Feedback from individual talking therapy staff

Two members of existing neighbourhood counselling staff responded individually. Both agreed that supporting users with employment issues was a useful aspect of the service and should be maintained. There was disagreement between them about the single point of access, with one supporting the principle, whilst the other felt that it was another hoop for clients to jump through to get the help they need.

They fed back issues around data, focusing on the use of CORE to measure outcomes, the importance of user feedback and developing locally based evidence.

Both therapists agreed that there should be an emphasis on early intervention to improve outcomes and promote appropriate use of healthcare services. One suggested that the service should extend to a greater crisis intervention role.

3.6: Feedback from organisations

Organisational responses were received from The Hills Counselling Service, Clapham and Brixton Counselling Teams, Streatham Counselling Team, Status Employment, Lambeth IAPT, the Terrence Higgins Trust and St Mungo's. The full responses can be seen in Appendix 6.3.

There was general agreement that the system at present was working well, and evaluation data showed a high level of satisfaction from both users and referrers.

Suggestions of modifying the specification to include longer treatment periods for certain users in primary care was suggested, which indicated that this may reduce the need for more expensive secondary care provision. Other organisations expressed concern that the service remained one for anxiety and depression, and did not offer longer term more complex therapy.

There was a concern that a new service would break the close counsellor/GP relationship, and hence a single point of entry would disrupt successful referral routes. There was also a suggestion of having a single process providing multiple entry points rather than a single point of access. This was cited as particularly assisting homeless people, or people with complex needs to access therapy.

Addressing the needs of different communities was suggested, notably people from African communities and gay men, particularly in relation to mainstreaming some of the HIV counselling.

Lack of comparable data across the existing services was seen as a disadvantage in recognising areas of good practice. Many responding organisations therefore stressed the need for a common database.

With regards to the service adopting the principles from the Living Well Collaborative, an asset based approach was welcomed, however it was felt that 'easy in and easy out' needed further clarification.

4. Summary of how the service specification was influenced by consultation responses.

It was evident that all stakeholders wished to build on what was working well, and there were many examples of good practice, and innovation carried out by skilled staff. The following table summarises how comments fed into the development of the service specification. Some particularly relate to more in-depth views expressed within organisational responses which can be seen in Appendix 6.3. Feedback follows the structure of the consultation document questions.

Area	Responses	TT Board response
The vision	The suggestion of extending the vision to offer longer term therapy (16-20 sessions) which was seen in some cases as more cost efficient than referral to secondary care. Some agencies also reported that longer sessions are often requested by users themselves.	The service configuration is not recommended for long term individual support. However, the Provider will be expected to develop user-led support groups to provide long-term support in the community. The service specification mentions user involvement in the delivery of services as one of the relationships of the whole system The service is to deliver primary care talking therapy, and will interface with the Community Options Team to help users access long term support as needed. If longer term therapy is needed, referral can be made to secondary care talking therapy services (which offers 16-20 sessions).
	The suggestion that the service should offer crisis intervention and support.	The service is not primarily a crisis support service, but is committed to making sure people are seen by the right service at the right time. The provider must make good relationships with crisis services for referral purposes and ensure that the triage process has an adequate risk assessment. In the past it has been reported that the counselling service was supporting people in crisis due to difficulties in relationships with community mental health teams, and a difficulty in enabling people to access secondary care. Much work has been completed by the Living Well Collaborative in promoting an 'easy access' to secondary care. Commissioners will work with the successful provider in ensuring that users access the right support.
	The suggestion that the service should be	The service specification states; 'There may be exceptional circumstances when younger people are seen, such as within a

Area	Responses	TT Board response
	opened up to younger people and children if family intervention is needed.	family intervention or transitional arrangements for 16-18 year olds. In these circumstances, the Service shall liaise with the Children and Adolescent Mental Health Services (CAMHS) to ensure that younger people receive the most appropriate care. CAMHS, generally, will treat people under 18, but being younger than 18 is not a sufficient criterion to exclude someone from the Service. There is no upper age limit'. SLAM have also been successful in gaining CAMHS IAPT funding.
	Prison requirements should be specified.	At present the IAPT service outreaches into Brixton Prison. Counselling is provided already, hence the new provider is expected to work with existing services in the prison.
	Talking Therapy should be offered routinely as part of the hospital discharge process.	This is not thought to be beneficial. The service specification particularly relates to a primary care talking therapy service, and should not be used as a step down facility. The new service within the Living Well Collaborative, the Community Options Team is an available resource to assist people with their social recovery needs.
	Some reported that there was too much emphasis on CBT.	The specification is consistent with NICE Guidance. This includes details of needs where a CBT and non CBT approach would be beneficial. The provider is therefore required to offer varying modalities of intervention in order to meet this need. It is also worth noting the commissioner is aware that NICE Guidelines are expanding its range of interventions.
Outcomes	The service needs achievable and not aspirational KPIs. This needs to be backed up by robust integrated data collection**.**	Targets for the service are set by the Department of Health. Commissioners are requesting providers to determine how they can increase these within the existing financial envelope. KPI's will also remain in waiting time targets and an additional one added, that of ensuring that users, if needing the integrated talking therapy service are offered an appointment at the time of triage. It is hoped that this will promote optimum engagement. The provider is expected to establish a robust data collection process that will be used by all aspects of the integrated service.
	Users need to be reassessed when needed by appropriate agencies to achieve recovery outcomes This needs to be backed up by ensuring development needs of	This will be addressed within the specification, which shall also stress the need for collaborative partnerships to achieve this assessment. There is an obligation of ensuring continual development needs of staff are met and that supervision requirements are also in place. Organisational responses particularly highlighted the added advantage of in-house clinical supervision, which was a recommendation of the Talking Therapy Review (2008).

Area	Responses	TT Board response
	staff are met. Diagnosis also needs to be recorded.	This shall be fed back whenever possible.
	Other outcomes could include a reduction of onward referral, a reduction of revolving door or multiple onward referral.	This is welcomed, however only if the service maintains its remit in order to do so and does not diversity into longer term therapy, whereby it duplicates the remit of other services.
	If some services are being mainstreamed i.e. HIV services, workers would need specialist knowledge to achieve outcomes.	The services to be mainstreamed are those whereby mainstream services could meet needs. Areas where specialist knowledge is required will remain as separate. An HIV service review is currently taking place to make recommendations to this effect. There is however an obligation for the successful provider to ensure training is available, notably awareness and knowledge of HIV.
	The CORE Assessment was preferred by some as an outcome measure, rather than the GAD7 and PHQ9.	The PCT is currently focusing on these assessments due to government guidance. The successful provider however may also wish to adopt this measure, although this is not a requirement.
	Some agencies felt that a discharge plan for every user being sent to primary care was burdensome and unrealistic.	The PCT is particularly responding to GP concern that they wish to see a discharge summary so that they are aware of progress and need. It is recognised however that consent is needed, and there is an option for service users to not identify their GP.
Employment support.	This aspect of the service needing to be advertised more widely.	This will be a requirement of the new provider.
	There needs to be flexibility of support depending on the need of the user.	It is recognised that this function is likely to experience increased demand from August 2012 as counselling users of services will be eligible to be referred to the service. This may also be the result of the existing economic situation with more people being unemployed. This was also highlighted in responses.

Area	Responses	TT Board response
		The Provider will need to demonstrate smarter and innovative ways delivering the service. We are encouraging tenderers to think of how users can also be involved in this service delivery to offer more options of how people can be helped.
	This element of the service needs to be optional.	The service is completely voluntary and no-one will be made to use it if they do not wish to
	There is a need to work collaboratively.	The service specification stipulates that the service must have a joint working protocol with Job Centre Plus. The existing employment support service has working links with major employers in Lambeth. This element of the work is recognised as good practice and will continue.
	The need to ensure opportunities for training.	The employment support service also includes opportunities for training and preparing for the workplace, as well as voluntary work.
	The need to be able to access this service immediately.	Employment status is assessed at initial triage and support with employment issues is available as soon as somebody is in therapy. The person can choose when to access employment support depending when is most suitable/beneficial
What can be learnt from the last three years?	There was a suggestion that more data is needed about the performance of existing services to determine how the proposals will enhance what already works well	Regular contract monitoring is in place and an IAPT Board meets on a bi-monthly basis. Much information has been obtained via this process which has directly fed into the service specification. Some of the data across the services is difficult to compare i.e. between counselling and the IAPT service. This will be remedied within the new service as there will be one information recording system.
	Many of the relationships, notably with GPs have worked well. There was a fear that the tendering exercise will put this at risk.	The Talking Therapy Board wish to maintain aspects of the service which are working well. It is recognised that good working relationships with general practice is very important for the effective support of many individuals. General Practice is named as one of the main groups that the Provider will build collaborative relationships with, to provide education around referral protocols into the service as well as support primary care clinicians in the management of people with common mental health whether they are receiving therapy or not. Relationships with GPs is also reinforced in the description of care pathways in the service specification

Area	Responses	TT Board response
		Good practice by existing providers will be built upon such as routinely visiting practices and having locality focused staff
Ideas as to how the service could be offered to ensure equality and equity.	The need to continue language specific services, and access interpreters quickly. Interpreters were also seen by some as not effective in the therapeutic relationship – mother tongue being preferred.	This is a requirement of the specification to ensure that the language needs of users are met. It is recognised that it is not always possible to employ therapists with all languages requested. Regular contract monitoring will bring up any issues in this regard, and the provider will be expected to address these promptly.
	The need to outreach to specific communities must continue.	Fanon currently provides outreach to BME communities via their community development worker contract. This will continue. It is expected that providers will also have additional ideas as to outreach to different groups who currently do not access therapy. Commissioners have asked for an in-depth analysis of IAPT activity to further highlight specific communities and groups not accessing therapy to inform future service provision.
Access	The need to continue self referral The need to publicise the service appropriately to both facilitate access to BME communities, as well as promote early intervention and improved outcomes.	The TT Board plans to work with the new provider on a robust and creative communications and marketing plan to the local community and within other partner mental health and physical health services within Lambeth. This is stated in the service specification as a high level objective to facilitate 'easy in' access. The Provider is expected to complete and implement an Equality Equity Impact Assessment (EEIA) plan which will include the marketing and publicity of the service to under-represented groups within Lambeth. The provider will be required to identify actions as to how to address any inequality issue, and these shall be monitored within the contracting process. The service specification cites a main aim of the service as being to improve wellbeing, resilience and social inclusion and also includes a measure of social functioning as an outcome measure A Key Performance Indicator (KPI)around building community resilience will be developed with the Provider

Area	Responses	TT Board response
		The stepped care model provides lower level intensity interventions aimed at helping people at a lower level of need to develop and have confidence in their coping skills It is expected that the new provider would be able to market their services in an effective way, to ensure user understanding. This will include publicity in relevant languages etc.
	Rather than have a single point of entry, there should be a single assessment process and a number of ways of accessing the service. There was concern that this would exclude people, notably those who were homeless, or who had an initial bad experience of the triage process and therefore this would result in users not wishing to enter therapy at a later date. There was also concern that this would not promote choice.	The service specification states that there should be a single point of entry into the service. This is qualified as an integrated service within a single assessment process. It is up to potential providers as to how they wish to interpret this. The commissioner requires that there is consistency of approach and that users, irrespective of their community, age, race, religion, ethnicity, gender, social status and sexual orientation can access the service easily. The provider is also asked to promote choice. Learning from the implementation of the talking therapy review has shown the increased choice available to users in times of treatment, and choice of therapist. This will continue. Within the current IAPT service there is an opportunity for assertive follow up of users who may find the triage process difficult. Fanon are also commissioned to provide 'buddies' to support people, notably from black and ethnic minority communities who would benefit from additional support. Fanon will continue to be commissioned and the successful provider will have influence on how this service develops. The provider will also be encouraged to offer intervention in different locations, depending on need.
	The need to be seen quickly	Waiting times are specified by the KPIs within the service specification and will be developed with the Provider as part of the tendering process. The existing KPI for counselling services is 12 weeks from referral to treatment and it is expected that this will fall more in line with the current IAPT target of 28 days The proposed system of telephone triage and assessment aims to reduce the time that somebody waits for treatment. The service specification states that an appointment date for a first session should be arranged at the point of triage, once the person is accepted for treatment
	The need to clarify a	The service specification states the ability to benefit from the service as the main inclusion

Area	Responses	TT Board response
	referral criteria	criteria The service is aimed at people with mild to moderate/moderately severe anxiety/depression. The service specification requires the Provider to: a) Provide information and signposting to those, who after an initial assessment are thought not to benefit from the service b) urgently signpost people with immediate or high risk of self harm to more specialist mental health and other services
	The need for triage and therapy to be offered out of working hours to support people in the workplace	The hours of operation as cited in the service specification are 8.00 am to 8.00 pm Monday to Friday with the proviso that some appointments will be available at the weekend
	There was a fear that Self-referral will increase demand and waiting times will increase as a consequence	Self referral is reported by the National IAPT Board as an effective way of people accessing therapy who would not normally go via their GP. This needs to be coupled with effective triage and timely treatment appointments to ensure that those people who can benefit from services can access therapy. Analysis of national IAPT data also shows that those who self-refer achieve higher than average outcomes. Providers will need to demonstrate how they can manage any additional demand.
	The need for a skilled triage function, which is not only based on the telephone. This was felt to be daunting to some users. .	The service specification stipulates training and education requirements of the triage workforce. Over the last 2 years, expertise in telephone assessment and triage has been developed and there is more clarity around protocols and procedures, training and supervision. The TT Board will work with the new provider to ensure standards are maintained and built upon. Currently there is an option of assertive outreach to users who may find the telephone triage difficult. This can be highlighted by referrers on the referral form. Fanon also offer a 'buddy' system, whereby people who find it difficult to access the service, and attend therapy sessions, can have individual support.
	The need for good marketing material which explains the service pre-therapy.	It is planned to develop a package of pre-therapy resources with the Provider. Internet and on-line resources are currently being explored with the development of an IAPT website. There will be the potential to include samples of resources and tools used during therapy such as homework, diaries and short video of a sample therapy session etc. This will also provide

Area	Responses	TT Board response
		opportunity to publicise and market the service?
How can the service adopt principles of the Living Well Collaborative?	Collaboration between services - the need for therapy to be seen as a care package with physical health.	As stated, the provider will be expected to make the necessary relationships to ensure that users receive holistic and integrated care. In the description of the service model within the service specification, the Provider is expected to work closely with Lambeth's Early Intervention Health Promotion Service (offering weight management, exercise, stop smoking etc) to enable an holistic, wellbeing approach for people with common mental health issues
	The need to ensure continual user feedback.	The service specification dictates KPIs that require the Provider to consult with users (as well as referrers and staff) and to demonstrate how their views are incorporated into the service annual development plan
	The service needs to ensure utilisation of informal networks	The provider will be expected to comply with all aspects of collaborative thinking. The Collaborative will soon launch its website which shall map users' ideas as to the informal resources available in Lambeth. The provider will be expected to link with this website and adopt an asset based approach whereby users will identify strengths from their own networks.
	There is a need to specify 'easy in and easy out'.	Commissioners will request providers to identify how they will maximise prompt access to the service and how they will ensure effective discharge which will include working with the user to identify a contingency plan in further help is needed. The Service specification also states the following targets: • 1 to 3 working days from referral to registration on the electronic case management system. Once registered, clients will be asked to "opt-in" to the Service. For more vulnerable clients, there will be assertive outreach to ensure that people with more complex needs are able to access assistance. The provider will identify how best to implement this requirement. • 1 to 10 working days from opt-in to triage assessment; • 100% of users will be offered an assessment/treatment appointment if needed at the end of their triage interview; • no more than 2 weeks from triage to assessment/first therapy session at Step 2; and • no more than 12 weeks from Triage to assessment/first therapy session at Step 3.
	There are opportunities to increase service user delivery.	This is encouraged within the specification. Peer support has been shown to both assist the person acting as a peer, and to the person being supported. Additional benefits of this approach lead to an increase in the capacity of the service.

5. Conclusion and next steps

This paper has highlighted how the consultation exercise has influenced development of the service specification.

Providers who have been shortlisted via the Expression of Interest stage are currently completing their tender documentation. Interviews will take place in March 2012. Tenders will be evaluated not only by GP commissioners and commissioners from NHS Lambeth, but also an independent clinical expert and a user who has direct experience of talking therapy and employment support.

The successful provider will be in place from August 2012.

If you have any questions you wish to raise or any clarification please do not hesitate to contact Joiss Soumahoro at joiss.soumahoro@lambethpct.nhs.uk (new email here).

The Talking Therapy Board wish to thank all those who have responded to the consultation as this has greatly assisted in the development of the new service.

6 Appendices

Appendix 6.1: Distribution list of interested stakeholders

- Lambeth Link
- Local Medical Committee (LMC)
- Lambeth Clinical Commissioning Collaborative Board (LCCCB). The full consultation document was posted on the LCCCB website
- All Lambeth GPs
- SEL sector
- Telefona de la Esperanza UK
- Existing talking therapy providers (neighbourhood counselling, IAPT services, Awareness Centre, Centre 70, Waterloo Community Counselling)
- IAPT Board
- LLWC: COT and PCSS, all members
- Vocational matrix
- Vital link
- SLaM services: CMHTs, Psychotherapy services, commissioning
- Status Employment
- GSTT
- London IAPT commissioners
- A&E (liaison)
- Substance misuse
- Health and Wellbeing groups

Appendix 6. 2: Questions posed to people who use services

1. What do you think of the vision for Lambeth?

- Does it leave anything out?
- Does it include something that shouldn't be in?
- Do you have any comments about how Lambeth Talking Therapy Board can ensure this vision can become a reality?

2. What do you think of the proposed outcomes of the new service?

Should other things being included? If so what do you suggest?

3. Lambeth Primary Care Psychological Therapies Service (Lambeth IAPT) currently provides employment support alongside its clinical services. Employment support helps people with issues pertaining to retaining existing employment as well as finding a new job. Do you think this function should be maintained in the integrated service? If so, what are your ideas around how it should be offered?

4a. The proposed route into the service includes:

- Referrals via a single point of entry
- an initial assessment at triage
- strongly encourage people to be able to refer themselves, without having to see a GP first
- active liaison with and sign posting to other services

Have you any comments on proposed routes into the service?

4b. Lambeth Primary Care Psychological Therapies Service (Lambeth IAPT) and North Lambeth Talking Therapies Service currently have one central single point of entry to their services , where clients may be referred by their GP/ practice staff, other mental or physical health services, or by self referral.
Lambeth IAPT then offer a brief telephone assessment to determine the most appropriate service and type of intervention and establish treatment preferences. Face to face assessments can be made if necessary. Clients are then booked into their treatment appointments. Referrals to other services are made, as appropriate, following this triage assessment
What is your experience of this?
What are your comments about this central point of entry and telephone triage system?

5. Do you think more information is needed to help decision making about future service arrangements?
If yes, what is this information and where might it be obtained?

7. Do you have any other comments or questions?

Appendix 6. 3: Organisational responses

Hills counselling team, Lambeth

We would like to begin saying that we welcome this consultation paper and the opportunity to offer our thoughts on this significant change in the services in Lambeth. We have heard that referrers and clients are requesting a simpler service to provide treatments, one that is easy to access for all the population and offers as many treatment choices as possible.

This response has developed from a team meeting attended by all counsellors and trainees (including team leader, Carolyn Emanuel) and the final version has been accepted by all members.

We are aware of the interest from provider organisations from outside Lambeth. For those in particular, a more detailed description of the current service would be paramount to the planning of a new and better service for all.

We would like to make the following points (in no particular order). These points are all on the basis that, as a team, we think there is too little information on the current Lambeth counselling service and its positive results in terms of quality and efficiencies. Although we are only able to provide data from the Hills it would be proposed that information about the whole counselling service in Lambeth (Clapham SPMS, North and Streatham) is included. We would also like to point out the ways the existing teams can be integrated to incorporate the proposals.

1. The HIlls neighbourhood counselling service offers excellent value for money at a high standard; it is an efficiently organised brief focused counselling service offered to residents of South East Lambeth at a comparative value to other services. The budget for 6 months is £107,535.00, a cost of £14.97 per clinical session. (We are unable to actually compare costs as the data has not been made available to us to date). Between April 2010 and September 2011, we offered 7181 clinical sessions (average of 1197 per quarter). 1857 clients were referred (average of 309 per quarter) of which 68.8% were assessed and 56.1% completed treatment. Of those that completed treatment, 76% moved at least one band down (having made progress) on a PHQ9 &/or GAD 7 score. The average number of those that attended booked sessions was 89.84% (92 and 91% in last 2 quarters).
2. Clients using the counselling service are asked to evaluate their service upon completion. Responses from the satisfaction surveys show a satisfaction rate of 97% average in this period (95-100%) with an average return rate of 70%.
3. Vision section 5 The vision is far reaching and will require a collaborative approach where all providers are regarded as specialists in their areas. The support and development of talent and expertise in existing teams is recognised and valued. We agree that services must be provided in light of NICE guidelines; however these guidelines are to be seen as guidelines and as part of the picture only. We offer a range of highly effective modalities. We are experienced practitioners working in accordance with the talking therapy service specification (2008) and accredited by professional. We are experienced outcome oriented therapists offering depth and choice for our clients with good post therapy results assessed by PHQ9 and GAD7 scores. It would therefore be advisable for further training of existing experienced staff in required modalities including NICE suggested modalities.
4. Proposed outcomes An omission here is in section 2, point 2 ‘the service is easy to access by all who need it including people: who work between 9-5 on weekdays.
5. What worked really well?
    - Outcome oriented service: With pre and post treatment assessments, brief, focused

treatment models, providing choice for clients, working in teams enabling practitioners learning and developing from each other.

- Links and good relationships with GP surgeries and primary healthcare staff: These relationships have been invaluable for clients' engagements and success. Referrers and clients like in house counselling.
- 2 way relationship between IAPT services and counselling services. Smooth and efficient referral procedures have been created between the 2 services that are currently provided alongside each other.
- Offering a wide variety of treatment models to people close to their homes and in a familiar environment high levels of engagement with impressive results at comparable costs.

6. <u>What has not worked well</u>
    - The experience levels of practitioners undertaking triage assessments in IAPT is not sufficient in areas of complex need and risk and needs to be seriously reconsidered.
    - Some relationships between counsellors and the surgeries they work in have somewhat weakened since the counsellors are no longer employed by surgeries. This relationship benefits the client and encourages holistic treatment approaches. This needs to be balanced against the increased relationship between counsellors strengthening professional support and development and increased choice and access for clients.
7. <u>Further ideas</u>
    - We would suggest that, on occasions counselling could be provided for more than 6 (or 12) sessions as a cost effective way of providing a more in depth service for those that would formally be referred for long term psychotherapy via the specialist outpatient panel.
    - All triage/ assessment procedures are reviewed; high quality, efficiency for the client and clinicians and best value for money are prioritised.
8. <u>Equality of access for all</u> Managers and Practitioners need to receive ongoing feedback from their monitoring in order to make decisions about who they are seeing and what needs to be done to increase access to unrepresented groups. A more eclectic service offering choice may be more attractive to different groups accepting referrals and/or making self referrals. A thorough knowledge and understanding of all the services (models of treatment and psychological development) by those making assessments will be required.
9. <u>Single point of entry</u> This can be seen as a creative opportunity to help referrers and clients enter primary care talking therapies efficiently and quickly. However, with the existing history of established relationships between referrers and counsellors, an option for direct in house referral could also be considered. The success will be in the investments of using experienced staff to assess, using all staff to be part of the team and creating systems where clients are engaged to the right service as quickly as possible. We would be willing to be part of the single point of entry process which we would consider an integrated team and not to be regarded as owned or run by any single provider.

<u>The Hills counsellors: Julie Bennett, Gale Burns, Julie Carroll, Carolyn Emanuel, Tony Gough, Anthony Graham, Paul Gurney, Sandra Paul, Angela Rochester-Daley, Kalyco Stobart (trainee), Graham Thomas, Lorraine Varley (trainee)</u>
<u>November 2011</u>

Clapham & Brixton counselling teams, Lambeth

1. What do you think of the vision as set out in **section 5**?

The vision of a 'talking therapy service in Lambeth *[that]* will… optimise the health and wellbeing of Lambeth's population by providing high quality, easy to access, equitable (fair) services to people according to need *[and]* promoting recovery and social inclusion of all service users…focussing on: wellbeing, *[and]* people being able to fulfil their role in family, work and society; and by addressing the wider influences on mental health as well as illness; emphasising choice…integrating physical and mental health treatment and care…, reducing duplication and gaps in a user-focused way…working collaboratively with other organisations…encouraging and supporting skills development in other mental health services…*[and]* challenging the stigma surrounding mental health and the discrimination experienced by people with a mental health history in Lambeth, by promoting inclusion and a positive approach to diversity...' is a vision of an ideal service which Clapham SPMS and its counselling team share and aspire to – and are proud of having already made a significant contribution to establishing and implementing in the primary care counselling/talking therapy services it has developed and delivers in the south of Lambeth.

'The provision of language and culturally specific/translation services, an 'easy in/easy out' approach, enabling people to get the help they need when they need it with timely and appropriate access into, and exit out of, treatment, emphasis on self-referral… *[and]* locations across the borough in both primary and community settings, both in the statutory and voluntary sector…' are, in our opinion, all essentials in order to deliver the service envisaged.

- Does it leave anything out?

Yes. It does not include provision for younger people, which is essential in order to achieve the vision. The foundations for mental and physical health are laid down early and built on through time and experience. Early intervention is essential to prevention.
There should be provision for children through services open to families, and with their parents/carers/guardians; and referral routes, and services, based in and/or linked to appropriate locations and organisations in their environments.
(Clapham SPMS currently offers a limited service to families, and existing services are open to over 16's individually, and under 16's accompanied by a responsible adult. Referrals are accepted from schools, social services, probation and other sources via GP based clinicians)

In terms of being **'creative in managing demand…'** the examples of provision of groups, self supporting groups, the use of peer support, budding are all useful; however it leaves out other creative demand management fundamentals such as requiring self referral, opt-in, and a 'partnership commitment' (therapeutic contract). Up-front, accessible information detailing the commitment and practical and emotional investment required, also helps prevent casual, uninformed, service 'sign up'.

- Does it include something that shouldn't be in?

Yes, as follow, (a) – (d):
(a) 'every user who has been triaged to receive a follow up assessment/treatment appointment on the day of their triage' would be a poor use of limited and valuable resources. It would create a high rate of cancellations and unattended appointments. People often approach talking therapy services in moments of high anxiety, crisis, stress and distress; clinicians/professionals often refer due to their own anxiety and concern for (and sometimes frustration with) patients/clients, rather than their clients/patients desire for talking therapy. It contradicts the ethos of self-referral informed

choice/consent, which requires time to reflect rather than make snap choices/commitments at moments of heightened emotion.

(b) '100% of users who receive therapy to have a discharge plan which will be sent to their GP' would be administratively burdensome, a poor use of resources, and would raise all kinds of issues and concerns around informed consent and confidentiality; it is also clinically unnecessary and therefore unsound.

(c) In order to achieve the vision of being easily accessible by all who need it, and the vision of challenging stigma and discrimination, the service availability (5.3) either needs to be widened or needs to be kept general as specified in the first two points (although we would make the age eligibility for 1:1 counselling/therapy 16+):

- all adults of 18 years and over willing to engage in the service;
- adults living in Lambeth or registered with a Lambeth GP;

The lists given (see below) have the potential to be used to exclude and discriminate against many of the most vulnerable and needy people, including drug and alcohol dependent users, people with severe and enduring mental ill health diagnoses. People in Brixton Prison are referred to in 5.4: 'The current IAPT service currently provides services within HMP Brixton and it is expected that this component will continue and will be developed' but it is not clear whether counselling/talking therapy services are to be extended to them as they are not included in the lists:

- people experiencing mental distress due to anxiety and/or depression, whether related to a physical health condition, including HIV, or life circumstances e.g. unemployment, family breakdown, or for any other reason; and
- people with a drug or alcohol problem, who are sober at the time of their treatment and willing to change.

Counselling/talking therapies should be open and accessible across the spectrum of people and presenting issues in primary care [as indeed they already are in the services delivered by Clapham SPMS]

(d) 5.5 'All referrals will be made via a single point of entry.' This is prescriptive, restrictive and excluding – there are many people who will not access counselling/therapy if there is only one entry point (only one telephone number is also being suggested!) Different people need different ways in. As has been suggested, a single (umbrella?) organisation is not the same as a single entry point and it is a **single process** with multiple entry points that is needed. This is also important if the service is not to be overwhelmed, and in order to avoid 'bottlenecking.

'Service Users referred will receive an initial assessment at triage': Again this is prescriptive and restrictive. It assumes there is no other method than triage whereas in fact, there are other clinical options, which are also less costly as well as more clinically appropriate and efficacious. Triage is discriminatory per se: it apportions treatment – it is only necessary in the circumstances where there is not enough equal treatment to go around – that is the very essence of it. In terms of primary care counselling/talking therapies in Lambeth, there are still many efficiency savings and more effective distribution to be made before restricting choice and access through the proposed triage model. [Clapham SPMS has greatly improved uptake and distribution and massively reduced waiting times with no increase in resources, and there is still creative potential to make services even more administratively efficient and clinically effective before having to restrict access. Where assessment is part of the treatment process and contiguous with it (i.e. no gap between them),

there is greater uptake and adherence and higher satisfaction ratings (see PCT/contract monitoring data and SPMS data)

- Do you have any comments about how we can ensure this vision becomes a reality?

Yes: by retaining a diversity of service provision, building on the great improvements that have already been made, using **practice-based evidence** to inform clinical and commissioning decisions, striving for continuing professional improvement; recognising and respecting the different professional disciplines and modalities that exist in current services and redressing the lack of awareness of different clinical remits and applicability so that clinical potential can be optimised.

Principally though, by having a truly accessible, open, non-excluding and wide-ranging service provided by well qualified experienced competent professionals. Barriers (such as lengthy referral procedures, restrictions and exclusion criteria and their application; numerous steps and lengthy pathways with sign-posts in only one or few languages) are more costly to impose and maintain than open and accessible services that do not have special requirements to get into them.

What do you think of the proposed outcomes of the new service as set out in **6.1**?

The proposed outcomes are great, except for the list of people for whom 'the service is easy to access by all who need it including…' This list itself risks becoming discriminatory because it is not – and cannot be – exhaustive: for example, and notably, people with mental health problems are not on the list! If the service is open to all, there is no need for lists. We suggest that the only exclusions should be: anyone who doesn't want counselling/psychotherapy, anyone who poses an actual/active threat of violence to anyone they come into contact with in accessing the service (and possibly, anyone for whom the limitations of the service would be detrimental)

- Should we include other things? If so what do you suggest?

Reduction in onward referrals, revolving door referrals; multiple referrals. Reduction in use of other clinical resources.

IAPT currently provides an employment support alongside its clinical services. Employment support helps people with issues pertaining to retaining existing employment as well as finding a new job. Do you think this function should be maintained in the integrated service? If so, what are your ideas around how it should be offered?

We think this aspect of IAPT services could be usefully retained and probably expanded. IAPT has the potential to provide invaluable general social and psychological care and support. The clinical role/time currently taken up by IAPT practitioners who have limited training and experience, who frequently (appropriately) refer on to the much more widely experienced, professionally trained, accredited/registered counsellors/ psychotherapists in the counselling services, could be re-invested in order to support rather than duplicate 'talking therapy' time.

What do you think are the most important things that have been learnt in the last 3 years within current service provision?

- High standards of recruitment and equal opportunities processes have resulted in representative, professionally trained, qualified, experienced, BACP/UKCP accredited/reg. counsellors/ psychotherapists; increased patient satisfaction; reduced revolving door referrals, and onward referrals, including reduced specialist referrals.
- High frequency supervision and on-call consultation are essential to working safely with patients at risk, managing challenging caseloads, preventing staff burnout, keeping waiting lists low, and

patient satisfaction and clinical outcomes high.
- A framework of procedures and protocols are important in a needs-responsive, flexible service.

- What's really worked well?
  In-house clinical training programme/ Inter-Practice Referral scheme/ Out-of-work-hours appts/ risk assessment/ Urgent, fast-track and routine appt system/ Flexible,
  paper-light, self-referral opt in/ Weekly supervision/ On-call clinical consultancy.

- What has not worked well?
  Non-clinical senior management of services/ Unclear IAPT publicity and info has generated confusion and led to duplication and to-ing & fro-ing of referrals / Lack of comparative data for inputs/outputs, performance, cost, outcomes measuring etc with which to monitor evaluate and improve services/ Assessment & 'triage' within IAPT services carried out by staff with inadequate, limited clinical training and experience.

- What ideas do you have for making sure any mistakes are not repeated?
  Clear accessible joined-up services and information, improved links and communication, removing competition and promoting collaboration in order to promote and develop service delivery, common data set and comparative evaluation, assessment to be carried out by well qualified and experienced clinicians in the appropriate field, introduction of patient experience measures

  All public organisations such as health and social care are required to offer services that are fair so people with equal need get equal services and equal chance to benefit from that service. This doesn't always happen, for instance older or younger people, men or women, people of different ethnic background or disabled people can be left out.

  We want to ensure the service is fair to and suits. What do you think we should do to ensure the new talking therapy service is fair for everyone and does not discriminate against people?
  - Remove exclusion criteria and barriers to entry (see No.1, p1-2) including age and diagnostic barriers, inappropriate steps, single entry & standardised, manualised assessments and measures that require a rigid one-size fits all approach and interfere with clinicians' abilities to treat patients/clients according to their professional judgement and patients/clients needs and wishes.
  - Ensure a variety of referral routes and entry points (see (c), p2-3)

Have you any comments on proposed routes into the service (paragraph 5.5)?
Yes. See (d), p 3-4

7. How could the concepts of the Living Well Collaborative be applied within the service?
Maximising accessibility applies the concepts of the Living Well Collaborative. Ongoing contact/ liaison with Community Options and Primary Care Mental Health Teams, peer support network, timebank participation and joined-up linking with and between services, will enable patient-centred need-appropriate (not manualized) responses so that patients/clients can engage in and benefit from counselling/talking therapies.

8. Do you think we need more information to help us in our decision about future service arrangements? Yes

If yes, what is this information and where might we obtain it from?

Consultation with a representative sample of service users
Comparative service data: clinical, cost and administrative
Establishing a common data set in order to make comparative evaluations and establish practice-based evidence (as has been being requested since the last Talking Therapies Review and was recently turned down by IAPT and some Talking Therapy providers)

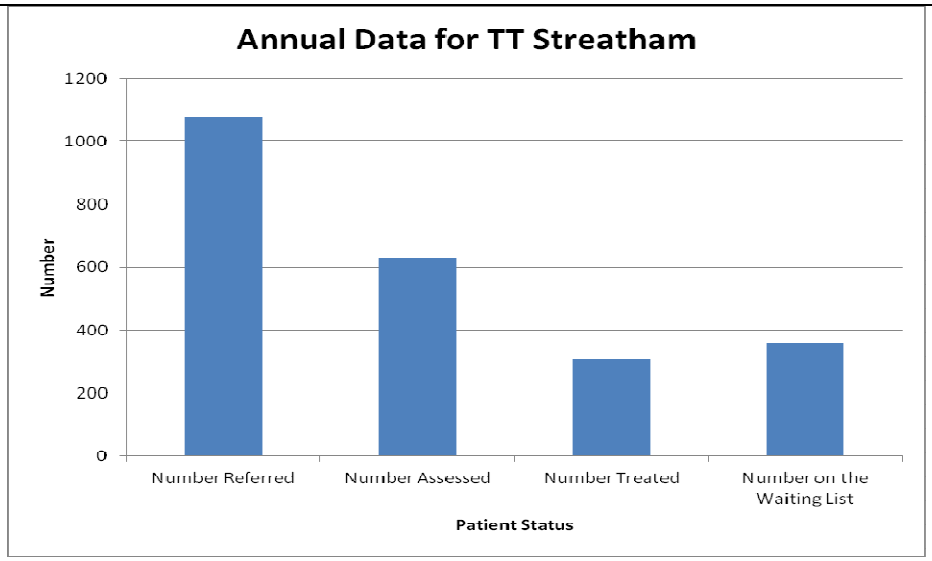
Do you have any other comments or questions?
The last review also threatened to homogenise service standards to a lower common denominator in the pursuit of equivalence: thankfully, commitment to quality and equality, diversity and choice prevailed. In the last 3 years, a significant proportion of Lambeth's Primary Care Counselling/Talking Therapies Services have gone from strength to strength and now offer more patients/clients from more backgrounds, ages, ethnicities, socio-economic circumstances and experiences, of more varied and wide-ranging physical and mental health needs, conditions and diagnoses, more modalities of therapy with more diverse clinicians. Waiting times for assessment and treatment have gone down (from 3m+ to a year and closed in some surgeries in 2007/8) to less than 12 weeks maximum and an average of 3–4 weeks for routine referrals in the south of the borough). The number of patients seen and treated has gone up, as has patient satisfaction, which is 100% of returned evaluations (40-50% of patients completing treatment). Black and ethnic minority service use is around 30-40% of total service user population, with patient satisfaction ratings of very good to excellent from over 95% of BME service users, who return over 50% of the total number of evaluations.

The vision then of a high quality, easy to access, equitable talking therapy service is already a viable and active work in progress in Lambeth, and only needs ongoing commitment and the resources to sustain it in order to continue to thrive and develop.

These achievements should not be ignored. Yet again, the plea, as a service provider said at the consultation, is not to throw the baby out with the bath water, as in fact, the Lambeth Talking Therapy baby is currently meeting all its developmental milestones.

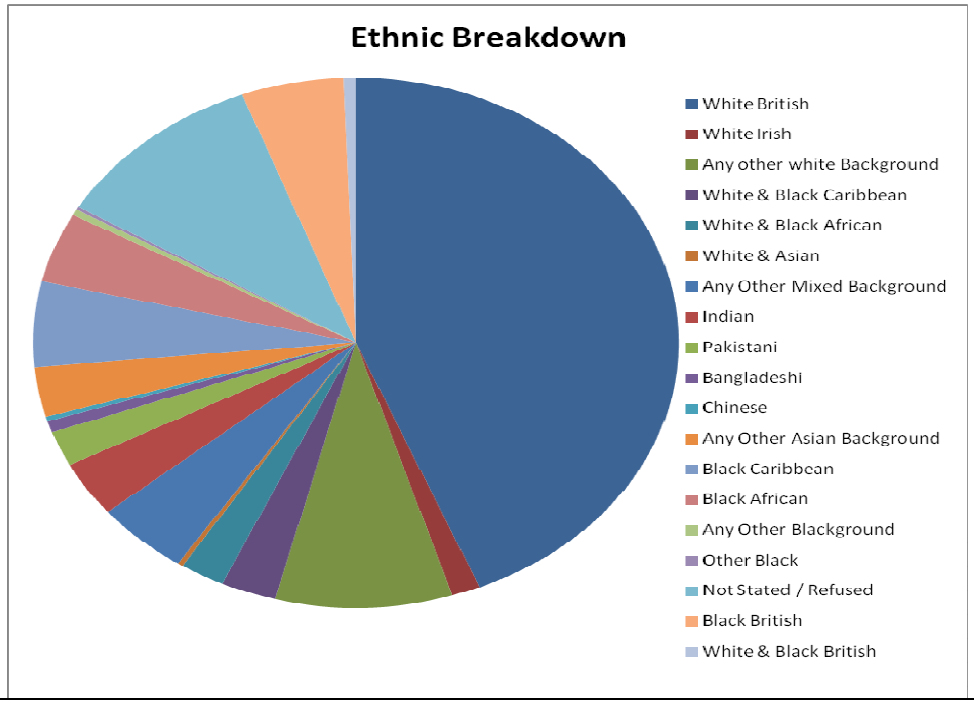
Streatham counselling team, Lambeth

I have completed and included figures based on last year returns to illustrate that the counselling service is already fulfilling the criteria included in the proposed service specification. I have disseminated the proposed document to the team who have contributed to and read this STT Service response, to the information sought in the latter part of the proposal document. We have responded to this in the sections set out 1-9 in the second part of this document. **Please note: referrals have increased considerably since last year.**



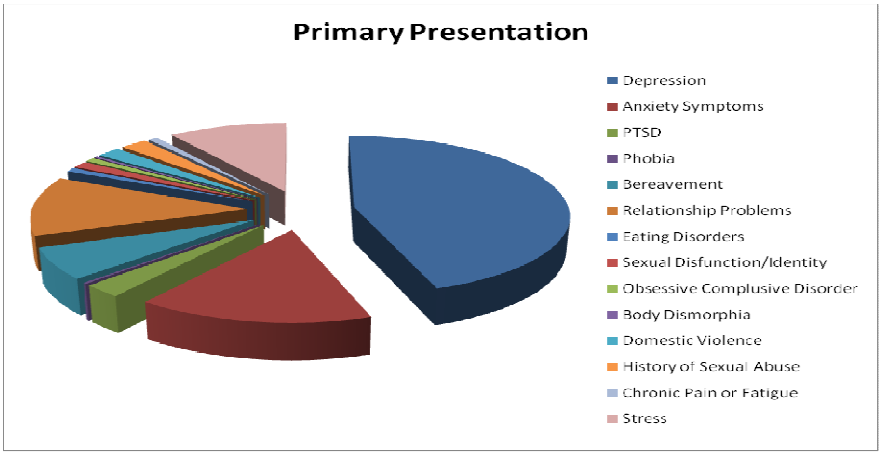
Annual Data for the STTS April 2010- March2011

The above figures are the annual referral figures for the Streatham Talking Therapy service the final figure relating to the number on the waiting list on March 31st 2011. The substantial difference between the number referred and the number assessed. The majority of clients 97% are offered an appointment within 12 weeks of the referral, over 50% within 4 weeks, difficulties being if the patient is restricted by work/home commitments, we have however increased the availability of early morning and evening appointments and now provide a Saturday Service where possible to accommodate these patients. The substantial drop between the number referred and the number assessed also indicates a level of inappropriate referral, this figure is approximately 33% in most services but is 10% higher within this service. This may be accounted for by a misunderstanding of what counselling consists of, cultural or linguistic misunderstanding and/or a level of GP compliance. Over 54% of patients once assessed complete treatment which is above the national average of approximately 34% this indicates a good level of therapeutic engagement within the service.



Ethnic Breakdown

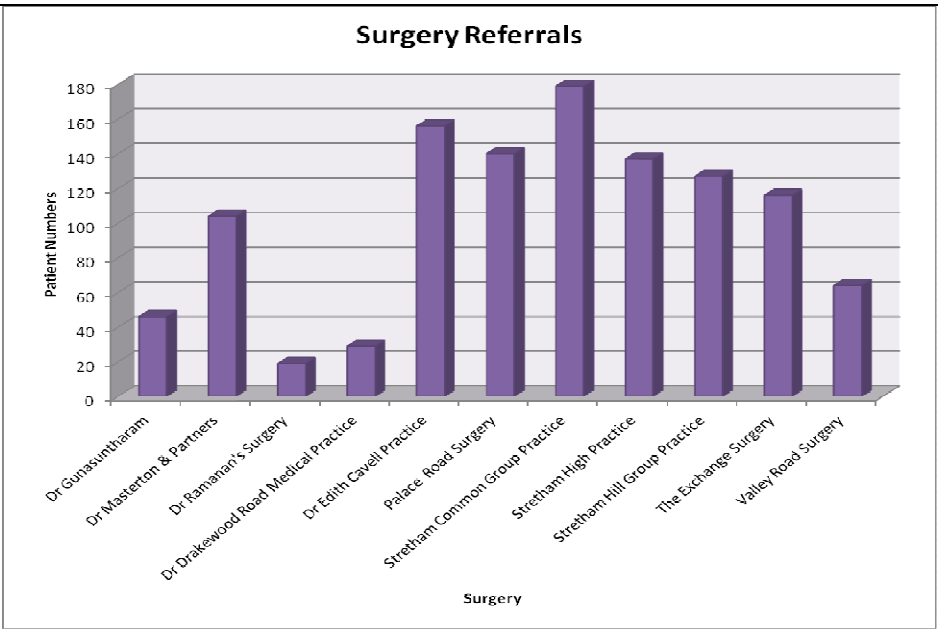
The above pie chart illustrates the ethnic breakdown of the patients seen by Streatham TT Services. The population of approximately 270,000 comprised 38% ethnic minorities which is the 7th highest figure amongst the London boroughs. There are 150 languages spoken in the borough, after English the next most popular languages are Portuguese, Yoruba, French and Spanish. A number of our counsellors speak languages other than English and we refer internally between surgeries to ensure that if possible we can facilitate an appropriate linguistic match. The Index of Multiple Deprivation rates Lambeth as the 5th most deprived borough in London and there are a number of issues that arise in the therapeutic work that stem from this statistic, and the difficulties that arise as a result of this demographic..



Primary Presentation

The patient is initially assessed as being appropriate for the Streatham TT Service through the use of the PHQ9 and GAD7 which measure depression and anxiety respectively. A score of between 5-9 indicates minimal symptoms and require s support and education, 10-14 is minor depression which requires support and watchful waiting, or Dysthmia which requires antidepressants or psychotherapy, or (mild) major depression which requires antidepressants or psychotherapy. 15-19 is major depression (moderately severe) requires antidepressants or psychotherapy, 20+ major depression (severe) requiring antidepressants and psychotherapy . GAD7 has a maximum score of 21, scores 5, 10, and 15 are the threshold points for mild, moderate and severe anxiety respectively.

The above pie chart illustrates the primary diagnosis with depression being the dominant presentation closely followed by anxiety, stress and relationship problems this is in line with the NICE guidelines. It also reflects the areas of expertise within the team which has particular skills in sexual dysfunction, couples, systemic work and relationship problems. The team is developing an expertise in EMDR Eye Movement Desensitization and Reprocessing, this technique is recommended within the NICE guidelines as the preferred treatment for PTSD but an increasing evidence base supports this technique for trauma, early childhood sexual abuse, phobia , depression and other presentations etc.



Surgery Referrals

The Streatham Talking Therapy Service also employs a pooled referral system to manage waiting times efficiently. Referrals will be relocated if a preference for times or days is expressed by the patient and we now offer 13 appointments on a Saturday. Referrals will also be passed within the service if a specialised approach to the therapeutic work is required, couple counselling, family therapy psychosexual therapy, substance misuse or certain European or South East Asian languages. The team is also developing an expertise in PTSD treatment with EMDR.

We have responded to this Document by Section

1

The vision as proposed in section 5 aims to promote an equitable service provision for Lambeth and that is to be commended. Equality of access and provision is what we strive for currently and STTS aim to promote inclusion and diversity (see previous information).

- Promoting Choice and personalization--- The team presumes this would be to include in addition to choice of therapist, choice of therapeutic approach and to include one of the range of therapies currently being provided by TT ie not CBT. Research indicates that a one size fits all approach to mental health is not appropriate for the individual and that different therapeutic approaches in addition to different therapists elicit different levels of recovery with patients. NICE guidelines is constantly expanding it's list of different "evidence based " approaches and RCT's are not the only evidence base for an effective intervention. UKCP, the governing body for psychotherapist's commissioned a telling critique of the NICE guidelines from the research unit at Roehampton University www.psychotherapy.org.uk/niceunderscrutiny . This report has led to a robust challenge to the way that the NICE guidelines are produced and particularly its reliance on Random Controlled Trials (R.C.T.'s)

5.2

- Aim for culturally specific services as the nuances of language and meaning are difficult to grasp with a third party acting as a translator this interferes with the

therapeutic alliance.

- Easy in /easy out requires good interagency and multi disciplinary working and this will require education and good , clear referral pathways and perhaps even further extension of therapeutic availability.
- Self referral question of confidentiality and GP involvement. If the client does not want the GP informed and has self referred there cannot be 100% discharge plans sent to GP's. This is a rare occurrence in practice but has potential for difficulty arising (levels of consent?).

5.3

There is an emphasis in 3.4 of this document in "mainstreaming" therapy, this relates specifically to HIV, physical health conditions and substance misuse all more obvious examples of service provision which require a more specific knowledge base. In the case of substance misuse a more intensive and longer term interaction as dual diagnosis is normally evident as is complex and challenging behavior . Issues in relation to more complex clients and co-morbidity do not appear to be explored and there is very little provision for longer term therapeutic engagement currently which is not discussed in this proposal.

6.1

Again the principles of this section are sound however:

- IAPT's inception related closely to employment outcomes this is hard to reconcile in the current economic climate where there are few job prospects and uncertainty and concern for those in employment .
- Again if we are discussing choice of therapist we need to be examining choice of approach (see above) and the provision of art therapy, body therapy, groups, and drama therapy, in addition to an integrated therapeutic approach.
- What constitutes a successful outcome and how is it measured? PHQ 9's and GAD 7's and the 3 other IAPT measures are extremely simplistic SCREENING tools. Our feedback forms which are a good indication of satisfaction with the service have an average 98% satisfaction with the service over the course of the year. An average of 80% plus register an improvement in their mental health through a reduction in banding as measured by PHQ 9 and GAD 7.
- The commonest complaint we have on our otherwise extremely satisfactory feedback forms at STTS is that the patient feels that they have had insufficient sessions, if we wish to include service user choice this is an important consideration and how will this be catered for in service provision.
- Very little option for longer term therapy for the more complex or co-morbid client, difficult to access psychotherapy, the panel rejects patients that are patently not suitable for short term counselling or CBT. Possibly the counsellors could be offering some longer term work 16-20 sessions, they are trained to provide this.

3

We feel that retaining work and obtaining employment is vital for supporting mental health. I think that it is important to retain employment assistance but in a supportive non punitive manner. Unfortunately the country's circumstances have changed since the inception of IAPT and the global recession has made employment and the retention of it more

problematic. A number of our current clients present with concerns and anxiety in relation to employment issues. We think that IAPT service should provide this assistance but it should not be incorporated in the counsellor's remit.

4. **Works Well**

- We feel that the residents of Lambeth have benefited from improved investment in mental health and a subsequent decrease in the stigma attached to a referral into psychological therapies.
- We think that the helpful and co-operative attitude of the current IAPT service management has assisted a collaborative approach to mental health within the borough.
- We have experienced IAPT practitioners as helpful and co-operative and the relationship is working well
- Evidence based short term therapy providing choices for clients re therapist, ethnicity, gender and location. Working a pooled team response to ensure patients are seen asap if they are prepared to be flexible re. location.
- Relationship between counsellors, GP's and the clinical team within the surgery, this assists communication, engagement and treatment.
- The continuation and promotion of good multi disciplinary and inter agency working, the promotion of other therapeutic services, educational meetings with professionals and promotion of services should continue to ensure good working alliances. It is also important that therapeutic interventions are measured in an identical manner to IAPT to ensure service parity.

Not so well

- We think that the promotion of CBT based therapy to the detriment of other therapeutic approaches has not been helpful, counselling / psychotherapy in spite of employing highly qualified, experienced, professionals has been denigrated as a lesser service because of the RCT evidence base promoted as "gold standard" by the NICE guidelines, other research and evidence bases have been completely ignored as one therapeutic intervention has been promoted. **See UKCP research discussed above**
- PWP's have had insufficient experience and training to assess clients with complex and challenging presentations which is what they are increasingly required to do.
- Provision for longer term work is reduced and the counseling teams could provide this.
- Multiple referrals by the GP who in some instances refers simultaneously into counselling and IAPT, counselling commences and then the confused patient obtains an IAPT referral this is not helpful with regards to treatment.

5

Equality of access seems to be a target STTS is already achieving, an analysis of the STTS figures appears to relate correctly to the demographics of the borough in relation to ethnic split, age, gender etc. I do however think that we need to be constantly vigilant in exploring ways to engage hard to reach groups, young males older people, ethnic groups etc. This needs to be done through service promotion, in appropriate languages, in places where these groups meet , through the website, face book, twitter etc where younger people engage. We need to be proactive and creative in our thinking in relation to service

engagement. Services also need to be further promoted in practices and with clinical teams.

6.
Re 5.5 I appreciate that a single point of entry simplifies the provision of services and that a telephone triage by a PTP provides the client with an instant response and also provides evidence of easy access and a lack of waiting times which has been the problem for traditional counselling provision where there have notoriously been long waiting times for assessment and subsequent treatment. It is to be hoped that the telephone triage signposts the patient to the appropriate service asap.
My concerns relate to the level of experience of PWP's who often do not have the knowledge of therapeutic work or the level of professionalism and experience to recognize certain mental health presentations or to contain them . GP's have commented on this to counsellors and have had concerns in relation to some triage assessments where they feel their judgment was being questioned or challenged. This however is improving and with further multi agency liaison could improve further still.
The single point of entry will however be detrimental to the existing referral arrangements with practice counsellors and the clinical team within the surgery, where their is local and personal knowledge.

7
The concepts of the Lambeth Living Well Collaborative and improved care pathways, multi agency approaches and interdisciplinary thinking could be incorporated within the service through greater liaison between services. Education through team meetings, workshops and information dissemination and perhaps the appointment within teams of an individual to monitor clinical options and best practice liaising regularly with a service user forum. There should be greater encouragement for service users to set up self help groups and a way of monitoring and facilitating this. Educating service users in relation to taking some responsibility for their mental health and with regards to appropriate treatments and interventions.

8
Unfortunately the service user synopsis was prepared too late for there to be much of a response prior to the 11/11 deadline, an analysis of feedback forms from TT and IAPT could assist with this. The most common complaint in what is otherwise extremely appreciative feedback at STTS (98% positive) is the desire for longer term therapy.

9
The NICE guidelines have moved slightly from the original position that CBT was the therapy of choice and the most effective. This position occurred because of the more obvious RCT based evidence for this approach. NICE choose to ignore the research using CORE in PHC counselling and the CORE data base which provided plenty of evidence that it was the affectivity of the clinician that was more important than the approach. Increasingly a different range of existing approaches are acquiring an evidence base within the terms of the NICE guidelines. The existing TT teams have had substantial training in these approaches and have a level of professionalism, qualifications and experience which is currently not being fully appreciated, recognized and rewarded why not utilize this level of expertise? All the counsellors working in STTS are BACP accredited or UKCP registered and most hold post graduate qualifications and considerable expertise in a range of fields.

PHQ 9's and Gad 7's are screening tools and are often an inaccurate measure of clients distress. Recently a client with severe psychological distress scored 1 on both forms, this is where clinical judgment and experience count because this was not an accurate reflection of the presentation.

Status Employment

Employment support should be maintained in the integrated service.

Why:

Excellent outcomes 2010/2011

Target of 69 off benefits or sick pay. Actual =173

Saves money

Dedicated employment support service can generate £2.79 in benefits for every £1 spent. See:

http://base-uk.org/sites/base-uk.org/files/[user-raw]/11-06/wfw_esw_economic_impact_report_final_v09.pdf

Supports therapists

With training for knowledge gaps and supports therapeutic process allowing them to concentrate on therapy

Early Intervention

Steers patients away from dependency on Work Programme, Secondary Mental Health, GP consultation, Medication use etc

Economic environment

In light of a contracting labour market and increased competition for jobs demand for employment support will rise

Meeting proposed outcomes

As outlined above there are two outcomes that necessitate an employment support function

- *Meeting national KPI standards within IAPT* – KPI7
- *Increasing Health & Wellbeing outcomes –"*improved employment, benefit and social inclusion status".

Offer:

Should continue to be offered in current form and capacity at least.

3 x Staff, Group Workshops, Peer Support, Sporting Activity

If higher numbers of referrals i.e. through counselling are expected to be seen a commensurate increase in resource would be required to facilitate support.

Lambeth IAPT

This is an exciting vision that encompasses the need to maintain and improve quality with a better, integrated care pathway system and a more actively outward focussed service. We support the entirety of this vision. Within it, we have some specific emphases to highlight below.

5.1 Highlights a crucial and often overlooked point; the need for high quality services, in line with evidence, especially NICE guidance. There is minimal gain for services to be accessed by anyone if they are not effective. So the rest of the document is to some extent predicated on 5.1 happening in practice. This point, and the DoH 'must do's' of NICE guidance and IAPT implementation, can be taken for granted and overlooked in public consultations in favour of the perhaps more exciting new developments. This is importantly restated in this section.

5.2 Can there be clarity in the section - 'easy in, easy out…..'every service user who has been triaged to receive etc'. So for example it would be relevant to specify that that 80% of service users are to be triaged within 24 working hours of their opt-in call. The other 20% represents people where there is a need to get hold of previous reports, which brings a delay, but are needed for a meaningful triage.

5.3 These are good aims. It would be helpful for the commissioners to be a bit more specific (accepting that this is difficult in practice) about these additional services such as to people with LTC, HIV and drug and alcohol problems and what level of work they require. For example, we assume they are talking about a primary care level of generic intervention, not a specialist level one. So, for people with LTC, and those with HIV, it may be about helping them once they have had their medical diagnosis agreed and this is a stable diagnosis, and had initial information about their condition and services from the medical team, and while they are now being primarily managed in primary care. The talking therapy support may be helpful if they are still struggling with the consequences of their health issue, to adjust to their new diagnosis and provide a supportive space to help them manage their consequent feelings, and depression or anxiety. For drug and alcohol, it is to specify that this is for a group whose main problem is a mental health one of anxiety or depression, who also use / abuse drug and alcohol to alleviate these symptoms of depression or anxiety, and who are able to use a psychological intervention.

There are distinct advantages to the service user having one worker following even more of a case management approach than is currently carried out; but this needs to be weighed against the time it will take from the therapist deploying their main area of clinical expertise. It may reduce the amount of intervention available to people with CMH problems that are effectively treatable (as our current service record of over 50% recovery demonstrates).

In saying this, we are highlighting the previously unmet needs of people with CMH problems, in particular for access to evidence based effective psychological treatments. People with CMH problems are a group who often have less of a voice at public consultations. Ironically this reflects the success of the existing easy in (including self referral) / easy out model and high recovery rate, so that service users do not stay with the service so long and so are less invested in its development. There is therefore a real danger that their voice is heard less than that of service users attending consultations who have had more contact with secondary care services, and have more complex difficulties or serious mental illness, and understandably would want a service more focussed on their needs. Similarly SUs with CMH problems may appear less of a pressing problem to referrers and commissioners as they are so successfully and briefly treated. Hence we thought it

essential to represent their voice about the success of the current service specification and capture their feedback. We participated in an independent report by Rethink about London IAPT services, and following this, commissioned an evaluation by Rethink of our own service. The Rethink report stated:

'Impact of Service

"It has provided much needed support in my traumatic journey. It is the direct reason I have a job today which has done WONDERS for my mental health." (L106)

"Identifying how to work with my condition and being constructive about it helps me to be self-supportive." (L29)

"The therapies have explained and opened my understanding to my experiences." (L60)

"I feel I am ready to move on with positivity" (L9)

"I have social phobia all my life and I did not know that I have it until I spoke to my therapist. It is a relief for me to know what my problem is" (L64)

Conclusions

Our findings show very high levels of satisfaction with Lambeth IAPT service.
Most participants were very happy with the therapy and their therapist and were able to point to a direct, positive impact of the service on their day-to-day lives.
Overall, satisfaction with the service was very high.'
Any service specification will need consider how service developments are complimentary to the continuing success of the service provided to people with CMH problems.

1. What do you think of the proposed outcomes of the new service as set out in **6.1**?
    - Should we include other things? If so what do you suggest?

These are a comprehensive range of appropriate outcomes.

The first point, that service users achieve what they seek from the service, requires that good information is available so that service users know what the service offers and do not have expectations that cannot be met.

Access needs to also include that a service encourages recognition and treatment of the wide range of common mental health problems and their diagnoses, as some, e.g. PTSD, have traditionally been missed in psychological therapy services. This also reflects that the demographic profile of a well accessed service is not the same as that of the whole borough, as it will have a greater weighting towards women, for example, who in census data record greater levels of anxiety and depression.

6.3 IAPT now has a high level of mandatory data. This means that demographic information including ethnicity, gender, sexual orientation, faith, disability and long term health conditions are recorded and can be monitored. In addition, in line with DoH evidence based practice, it specifies routine outcome monitoring so that this is transparent. We support very much that 'the IAPT standards should apply to the service', and that this applies to the whole integrated service. This is

so that modern levels of data collection and outcome monitoring can benefit the treatment of everyone, including those receiving counselling. It allows transparent reporting, as specified in the outcomes.

2. IAPT currently provides an employment support alongside its clinical services. Employment support helps people with issues pertaining to retaining existing employment as well as finding a new job. Do you think this function should be maintained in the integrated service? If so, what are your ideas around how it should be offered?

Employment support is a key part of social inclusion that the whole integrated service, both IAPT and counselling can benefit from. It would work well to stay integrated in the service.

3. What do you think are the most important things that have been learnt in the last 3 years within current service provision?

    - What's really worked well?
    - What has not worked well?
    - What ideas do you have for making sure any mistakes are not repeated?

The current IAPT service has proved itself to be of high quality; it is the best IAPT service in London across the range of Key Performance Indicators. As part of this, the single point of entry at a central point has enabled a body of expertise to be built up around liaising with local services, and around the triage process. Self referral has been well received and enabled access for people who would not otherwise have presented. Triage has enabled the application of NICE guidance and service user choice, so that the right people are seen by the right service at the right time. It also allows a very early risk assessment at point of entry to the service and consequent prioritisation. A service specification needs to specify that these outcomes need to be achieved.

There are high service user and GP satisfaction levels with the IAPT service and triage.

We have strived to enable our service users to contribute to this consultation. Two aspects to bear in mind when considering this feedback are that there has been a recent, intermittent, issue around the telephone system which has led to problems accessing triage. Once this was brought to our attention we brought in a temporary solution, so this problem is not now happening, and we are implementing a longer term solution.

Recently we have had staff who joined the service at its beginning leaving to go onto further clinical training etc.. This is, to be expected after two years of the service, and the staff have been replaced. However, there is an inherent delay in going through normal recruitment processes and this has meant that the recent cohort of service users have, in some cases, had difficulties getting through and then had to wait longer than usual.

We highlight these issues as both have been resolved, there is no longer delay in getting through and the new staff are in post, but it may colour the service user feedback.

We are currently piloting one point of access in the North of the borough. This has been successful so far. It has highlighted the benefits of both IAPT and counselling being in the same data system. This system and triage is being thoroughly evaluated with feedback from service users and GPs and this will be shared with commissioners.

Monitoring the time between contact, triage and commencement of treatment along with outcomes and levels of satisfaction, as we do now, will go a long way to ensuring the continued delivery of a high quality, effective service.

What has not worked well has been a lack of data and of comparable data for all of the different talking therapy services. This has prevented greater scrutiny of effectiveness, and being able to identify areas of good practice that can be shared among all the services. Having all the services on one data system will allow these benefits.

What has also worked less well is that separate services sometimes see service users who, by reason of NICE guidance or service user choice, would be better seen with a different treatment in a different service. The proposal of one service provider contract will reduce the incentive to do this. This is because the success of a service will depend on the success of the whole service partnership, not just their one part. Similarly an integrated service with an integrated care path, will enable NICE and SU choice at an early stage, reducing the risk of the service user having a less appropriate treatment or having to have multiple reassessments.

4. All public organisations such as health and social care are required to offer services that are fair so people with equal need get equal services and equal chance to benefit from that service. This doesn't always happen, for instance older or younger people, men or women, people of different ethnic background or disabled people can be left out.

   We want to ensure the service is fair to and suits. What do you think we should do to ensure the new talking therapy service is fair for everyone and does not discriminate against people?

There needs to be continued emphasis on the service being able to deliver talking therapies in a variety of settings, at suitable times, by a range of therapists and in different languages (or access to translators where this is not possible).

Service users will need accessible information about what the service can offer and support in making informed decisions about which therapy would best suit their needs.

The service needs to continue to develop active outreach to the groups of people who traditionally find it difficult to access services. To do this the service will need to further develop its links with other local services and organisations as well as being imaginative about how and where the service is advertised.

5. Have you any comments on proposed routes into the service (paragraph 5.5)?

An integrated care path will bring benefits to service users, service providers, and commissioners, as described earlier.

We support the proposal as a single point of entry, with an effective assessment process (triage), ensures that entry into treatment is timely, smooth and that there are minimal gaps into which service users can fall.

Equally, effective triage can help to ensure that service users do not waste their time in the 'wrong' service by actively signposting them to the service more suited to their needs.

7. How could the concepts of the Living Well Collaborative be applied within the service?

In part, the principle of working collaboratively and transparently with other organisations, especially GPs, is already there in the current service. Nonetheless, further work can only improve these collaborative relationships especially in the area if interactive communication.

What does require further work, in particular, is the involvement of service users in the delivery and the development of the service. Focus groups have been held and these need to be built upon and extended to involve a wider range service users. Indeed, we are already working on the valuable feedback from the survey undertaken by Rethink on behalf of Commissioning Support for London on the London IAPT services from a service users point of view. LIAPT was one of the three IAPT service that participated.

Other areas under development are relationships with housing providers, organisations that deliver services to elders and healthcare colleagues working with people with long term conditions.

The Time Banking initiative, to which Lambeth IAPT have signed up to and thoroughly support, will provide opportunities to extend and develop more and better relationships with both the statutory and voluntary sectors. Furthermore, by encouraging our service users to become involved opportunities for their own empowerment will increase.

8. Do you think we need more information to help us in our decision about future service arrangements?
If yes, what is this information and where might we obtain it from?

No. If the commissioners are to receive further clinical guidance it would be helpful if this is from someone who is clinically expert in IAPT.

9. Do you have any other comments or questions?

Thank you for the opportunity to feedback in different fora.

Terence Higgins Trust

In general we welcome the vision as set out in Section 5, to provide a talking therapy service in Lambeth that will provide high quality and equitable services to people according to need. We are pleased that there is an emphasis on self-referral into the service, and on choice, and that the vision for the service is that it is well-communicated. We are also pleased that there is an emphasis on providing provision for creativity in terms of managing demand, for example, by the provision of groups, self support groups and the use of peer support and buddying.

Terrence Higgins Trust is currently funded in the borough of Lambeth, through the South London HIV Partnership, to provide talking therapies to people with HIV. We are aware of another public consultation that has just been released, the Lambeth, Southwark and Lewisham review of HIV health and social care. This consultation has been released this week, and has a three month period of consultation, and affects our service arrangements also. In this consultation, which clearly overlaps with the recommendations of NHS Lambeth, it is proposed that our HIV counselling service is transitioned into mainstream provision of talking therapies, and that we work with mainstream providers to ensure that an element of HIV specialism and expertise can be incorporated into more mainstream provision.

The huge burden of stigma and discrimination that those living with HIV face still around their condition is of primary concern for us in an era where services are being mainstreamed. Many people with HIV in Lambeth are still fearful of disclosing their HIV status to mainstream providers – and still experience a high level of discrimination from mainstream providers (e.g. problems with disclosure in mainstream (non-GUM) hospital services, GPs practices, and other settings). We would recommend that in order to ensure that the needs of people living with HIV are met that it is vital that an element of HIV specialism is maintained within any mainstream service.

6. What do you think of the proposed outcomes of the new service as set out in **6.1**?
    - Should we include other things? If so what do you suggest?

We are pleased that there is an emphasis on supporting people to access a safe, accessible and equitable service. Our primary service users are gay men, and people from African communities. Given the cultural issues involved in accessing counselling services for these groups, we can foresee that more specialist support might be needed to ensure that these groups feel that the service is approachable to them. The historic relationship between people with diverse sexual orientations and the psychological services they receive is well documented, and many gay men in particular fear that they will be pathologised by mainstream providers, not only around being gay, but also around their acquiring HIV. We would hope that any service would include provision of appropriate and sensitive services that recognise the problems and stigma associated with a long term illness like HIV, and issues around sexual health and sexual practice that go with this unique illness.

In terms of issues for the other main group of service users we have, the Black African community, we have traditionally seen very low uptake from this user group around talking therapies, and traditionally very low uptake around Black African heterosexual men. We currently provide an African Emotional Support Service in Lambeth, which helps people talk to a counsellor of African descent, and provides short term structured help and support in order to meet mental health goals and help people to help themselves. We would suggest that a specialist support service like this has been very good at gaining trust within the African communities and we would advocate that specialist support around emotional and talking therapies for members of the Black African community living with HIV is built into any mainstream service. At the very least we would advocate good African representation on consultation boards or user groups for the new services.

7. IAPT currently provides an employment support alongside its clinical services. Employment support helps people with issues pertaining to retaining existing employment as well as finding a new job. Do you think this function should be maintained in the integrated service? If so, what are your ideas around how it should be offered?

8. What do you think are the most important things that have been learnt in the last 3 years within current service provision?

    - What's really worked well?
    - What has not worked well?
    - What ideas do you have for making sure any mistakes are not repeated?

9. All public organisations such as health and social care are required to offer services that are fair so people with equal need get equal services and equal chance to benefit from that

service. This doesn't always happen, for instance older or younger people, men or women, people of different ethnic background or disabled people can be left out.

We want to ensure the service is fair to and suits. What do you think we should do to ensure the new talking therapy service is fair for everyone and does not discriminate against people?

We believe that showing people with HIV and others from marginalised groups that your service is friendly towards them is often related to the quality of awareness of the organisation and culture within which people work within the new integrated service. We would advocate HIV awareness training for all staff (including for example, front line reception staff, and back house managerial functions). We would advocate training in issues pertinent to marginalised groups such as diversity and awareness training, particularly in Lambeth around people that experience stigma and discrimination in society (women, older people, LGBT, people from Black and Ethnic Minority background, impact of disability – seen and unseen disability, HIV etc.)

People living with HIV often face particular barriers when accessing talking therapies, as outlined previously. In order to ensure that services are accessible to this group we would suggest that it is vital that a degree of HIV specialism is built into mainstream services. This will help to ensure that services are sensitive to the specific needs of this client group, both in how they access service and in ensuring that once they have made contact with services their needs are met appropriately.

It is vital that the user's voice is heard in all this, and we would recommend having a steering group for the project, that not only recognises users' voices, but also has input from specialist agencies such as Terrence Higgins Trust, who have a long history of working on issues such as HIV, race and equality, and LGBT issues.

10. Have you any comments on proposed routes into the service (paragraph 5.5)?
We would add that close links to voluntary sector providers such as ourselves need to added in here, so that we can encourage our own clients to access more mainstream provision and that we can support our clients to feel confident to either self refer into the services, or that we can set up a formal referral pathway between the voluntary sector and statutory provision.

7. How could the concepts of the Living Well Collaborative be applied within the service?

8. Do you think we need more information to help us in our decision about future service arrangements?
If yes, what is this information and where might we obtain it from?
We think it would be good if everyone involved in the Lambeth Talking Therapies consultation were made aware of the Lambeth, Southwark and Lewisham current review of HIV Health and Social Care issued this week. This document can be sought from the Lambeth HIV/Sexual Health Commissioner Jess Peck or Ali Young. Jess.peck@lambethpct.nhs.uk or ali.young@lambethpct.nhs.uk

St Mungo's

Background

St Mungo's has worked in the Borough of Lambeth for over twenty years, providing innovative services to rough sleepers and other vulnerable and excluded adults who are homeless or at risk of homelessness.

In Lambeth, we currently provide a range of first and second stage accommodation for rough sleepers and homeless people, an accommodation pathway for female sex workers with substance dependencies, a mobile street-facing substance use service, and an intermediate care service for homeless people with severe physical health problems. We were the first to introduce psychologically informed environments in the borough, and have championed the recovery approach as our guiding ethos for over five years. For the last four years we have also provided a psychotherapy service for chronically excluded adults in Lambeth.

The reasons that we introduced a psychotherapy service are twofold:

1. High levels of need in our client population – around 60% meet the criteria for diagnosis of personality disorder, high levels of attempted suicide (up to 40%), high levels of psychosis and psychotic episodes (>35%), high levels of substance dependency (c60%), high levels of polymorbidity (around 40%) (Maguire et al, 2009; Cockersell, 2011).

2. Lack of treatment options, particularly access to psychological therapy - despite these high levels of psychiatric, psychological and emotional disorders, peer research evidences low levels of treatment (around 11%) with the majority of respondents saying that they had tried to get help from mental health services unsuccessfully (Happiness Matters, 2009). Access to psychological therapies through the NHS is almost non-existent as the majority of services either are not qualified/designed to work with complex disorders (e.g. IAPT) or are hard to reach either because of long waiting lists (e.g. StThomas's) or because of restrictive referral criteria and long waiting lists (e.g the Maudsley).

In effect, the chronically excluded are further excluded from access to psychological therapies, This is particularly unfair as our psychotherapy service shows that, with the right provision, the chronically excluded and those with complex needs do very well in therapy, with high attendances (>70%) and high levels of positive outcomes (>75% improved wellbeing, >40% in employment/training by end of therapy, etc) (Cockersell, 2011).

We are therefore grateful for this opportunity to comment on Lambeth's plans for the future of Talking Therapy services, and hope they will be a step towards commissioning inclusive, rather than excluding, services.

Response to the Consultation Questions

1. What do you think of the vision set out in S5?

We are delighted that the vision talks of inclusive services, being fair to all, being anti-discriminatory; we would very much welcome greater access to psychological therapy for our client groups. We also welcome the commitment to delivering and developing services in line with recovery values.

However, the status quo excludes most of our clients and we feel that several parts of the proposal simply reinforce this or risk making it even less fair.

We are concerned with 5.3.3 and 5.3.4: primary care psychological therapy needs to be able to work with the presenting issues of those who come to primary care, not just a sub-section. These

clauses are unnecessary, and could serve to exclude many of our clients. We believe that primary care talking therapy should be available to all those living in Lambeth, without discrimination by presenting issue: the only two clauses needed are 5.3.1 and 5.3.2 – that would mean the service being available to all adults living in Lambeth or registered with a Lambeth GP. That is inclusive.
We are also deeply concerned about 5.5: our experience is that systems with a single point of entry and then onward referral discriminate against the most vulnerable and against those with challenging presentations, and those least able to advocate for themselves or navigate complex systems. Our experience of delivering talking therapies to socially excluded adults in Lambeth evidences that having a range of points of access increases accessibility, and take-up.

2. What do you think of the proposed outcomes of the new service as set out in S6.1?

In general we feel the proposed inputs and outcomes in S6 are laudable: however we feel that there needs to be a specific mention of not discriminating against those with mental health problems. It would be ironic for a primary care mental wellbeing service to turn away people because they have mental health problems. Our clients tell us that around 80% of them have tried to access help for their mental health, but only 11% are actually in treatment (St Mungo's, 2009): this redesign of talking therapy services is an opportunity to redress this.
There are sound economic, as well as clinical, reasons for providing early treatment: exclusion leads to increasingly poor mental health which ultimately costs more as people progress to needing acute and long term services. In the spirit of QIPP, the remit of the talking therapies service needs to be able to accommodate all those presenting in mental distress.
We would also like to see a specific commitment to providing talking therapies to people who are substance dependent: the majority of our clients tell us that mental health problems lie behind their dependency, and that is the experience of our own psychotherapy service. Co-morbid substance use remains a source of exclusion for many of our clients.

3. IAPT/employment support

We welcome the association of employment support and talking therapies as we recognise the importance of socially valued activity for recovery. We believe there is a good case to make that for many people it is a combination of social support and talking therapy that enables them to move on to greater independence and self-fulfilment, in line with recovery objectives.
We suggest that mental health graduates, rather than being deployed as undertrained assessment workers, could find a useful role in providing a floating social support service, alongside user organisations.
We would like to see more user-led support around employment and social integration, in the form of eg peer mentoring services etc.

4. What do you think are the most important things that have been learnt in the last 3 years within current provision?

Our experience of current provision by NHS Lambeth is that it provides very little that our clients can access. What we have learnt from our own provision in Lambeth is that accessible psychotherapy has a profound and positive effect with socially excluded adults, high attendance rates and good positive outcomes (Cockersell, 2011). We have also become aware that it fills a service gap, with around 30% of the referrals to the service coming from statutory mental health services who could not access suitable talking therapy elsewhere.
What we have also learned is that IAPT London does not provide a service to our client groups, and

is not willing to engage in a dialogue on how such services could be provided.
We welcome this opportunity for Lambeth to create a ground-breaking, innovative and truly inclusive service.

5. What do you think we should do to ensure the new talking therapy service is fair for everyone and does not discriminate against people?

The first discrimination is being refused treatment because you are experiencing the wrong kind of distress in the wrong way: there are a huge range of psycho-emotional conditions amenable to talking therapy beyond anxiety/depression, and even anxiety/depression often (usually in longterm cases) have their roots in other areas such as relationship difficulties or unresolved trauma. Most of our clients have disorders relating to compound, chronic and/or complex trauma, which they express through a combination of mental health, substance use and social problems, including homelessness itself. So firstly, there should be no exclusion criteria for presenting problem. The talking therapy service should be able to work with the full range of common disorders, including personality disorders, PTSD, and substance dependency.

Secondly, it has to be accessible. To ensure that the new talking therapy service does not discriminate against people, then access routes have to be as wide and varied as possible (for some people, for example, going to a clinic or hospital is very difficult; for some negotiating a series of referrals is impossible; etc).

6. Have you any comments on proposed routes into the service (paragraph 5.5)?

We feel that this is unnecessary and likely to be deeply excluding. As above, our experience is that there needs to be a wide range of potential routes into the service, at as many different locations as possible, to make it accessible to the socially excluded or to those who do not usually get access to psychological therapies.
What happens to someone who has a negative experience, as some inevitably will? If there is a single point of access, then that person's opportunity for talking therapies is closed down.
Similarly, what about choice? A single point of access is by definition a restriction of choice, and it is well-evidenced that choice enables greater take-up and more positive patient experience.
We are also concerned that if there is a single point of access: there will need to be very experienced clinicians staffing it, so that they can deal with any presenting problem from across the whole borough – which seems unlikely as it would be very expensive; there will need to be onward referral, and we know from experience that many clients will drop out if they are assessed but receive no treatment; there will be re-traumatisation, as clients expose their vulnerabilities to someone who is not equipped to offer them appropriate therapy.
We therefore suggest that the single point of access be re-thought, with wide service user consultation. Is the single point of access best for a homeless person with personality disorders and substance dependencies, a mixed race youth with a sense of disaffected identity, and a pensioner who has just lost her spouse of 40 years? Are these people all going to be comfortable together?

7. How could the concepts of the Living Well Collaborative be applied within the service?

We think that linking talking therapy to social support and to recovery models is excellent. We would like to see talking therapy offered as part of the support package to people discharged from psychiatric hospitals on a routine basis, Our own therapy work in Lambeth Hospital suggests that this would be an effective way of managing the transition from ward to community in a way that

empowers and enables, and creates sustained resettlement.

8. Do you think we need more information to help us in our decision/what is it and where might we find it?

We have considerable information on the impact of talking therapies for people with complex needs, and how to make them accessible; our clients have considerable research on exclusion, how to make things inclusive, and on the value of talking therapy to their wellbeing.
We think that the information that Lambeth needs is not so much who is using their services now, but who is excluded, and how could Lambeth make their talking therapy services more inclusive and more effective for the whole community for the same resource level.

9. Do you have any other comments or questions?

We think that the emphasis on IAPT provision is dangerous because IAPT provides a specific set of interventions for a limited range of conditions, mainly depression (and its efficiency in doing this is debatable on the current evidence, with prescriptions of anti-depressants increasing by 10% last year, and ambivalent findings from national studies).
Talking therapies can be an efficient way of helping a broad range of people with a very wide range of conditions, if used effectively. We urge Lambeth to look for the most inclusive ways of providing the service, not the most exclusive ways of 'managing demand'.
We believe that this is a great opportunity for Lambeth to take the lead in developing a cutting-edge talking therapy service that meets the needs of Lambeth's diverse population in all their complexity, and which would produce QIPP savings and longterm mental wellbeing and health positives.
We urge the commissioners to think broadly and boldly for clinical, moral (anti-discriminatory) and economic reasons, and we would be delighted to be a part of taking an inclusive and effective talking therapy service provision forward.

Peter Cockersell, Director of Health & Recovery, St Mungo's
November 2011

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