



# **LINK Report: Treating Common Mental Health Problems in North Tyneside**



**June 2010**

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# 1. LINK Introduction

LINK members raised the provision of low-level mental health provision at our launch events early in 2009. Later that year, we commissioned Keith Metcalf from North Tyneside Carer's Centre to explore the issue further.

# 2. Author's Introduction

This report was commissioned at the end of 2009 to look at the availability and success of low level and preventative mental services in North Tyneside. The impetus to this work was the concerns that had been expressed by patients and carers at North Tyneside LINK events earlier that year. Patients and Carers reported long waiting times to receive help for common mental health problems like depression or anxiety.

At the same time the Primary Care Trust was just beginning to introduce a new mental health service called Improving Access to Psychological Therapies. The new service offered increased numbers of therapists and treatments for the type of conditions that people were waiting for. In this context the LINK decided to find out more about the current outlook and availability of low level mental health services. This report will look at waiting times, patient satisfaction, recovery rates, examples of unmet need and produce suggestions based on the findings that are made. We will begin by looking at:

- The level of demand for low level mental health services. This will help us to have some understanding of the level of need and to give us some bench mark by which we can compare the actual provision of services.
  
- Individual services that provide assistance for common mental health problems and see how successful they are in treating the large numbers of people in distress. They will be assessed by how long people wait for their service, the numbers that are treated, the recovery rates for the patients and how happy patients are with these services. These services are:
  - Improving Access to Psychological Therapies
  - Primary Care Counselling Service
  - Relate
  - Other Smaller Services
  - Services and Projects that promote good mental health

There are also Case Studies of interviews with people who have experienced common mental health problems in North Tyneside and have looked for help. We will draw upon interviews with patients, discussions with GPs and counsellors, NHS staff, local Government and voluntary sector workers as well as data collected by the relevant organisations and departments. This information was collected between October 2009 and June 2010.

Based on these findings, recommendations have been made as to how services can improve or maintain their good work in helping people in distress.

### 3. The Demand for Low Level Mental Health Services in North Tyneside

#### 3.1 Introduction and definition

In medical terminology, what is called ‘mild depression’ sounds like a minor hiccup yet it describes a condition of misery and hopelessness that no one would want to minimise. Definitions are useful however because health systems cannot cope with 60 million forms of unwellness and groups do emerge that benefit from similar treatments. That is why in this paper we are going to refer to low level mental health problems or common mental health disorders (CMDs). Both definitions point to people experiencing milder forms of depression, anxiety, phobias, obsessive compulsive disorder and panic disorder.<sup>i</sup> The use of the word milder does not mean that the symptoms the patient experiences are not serious but to separate them from other conditions that are not within the scope of this report.

CMDs can play havoc on people’s lives in numerous ways; they can lead to individuals leaving jobs or education, losing relationships, becoming isolated and physically unwell. They can also lead people to progress to more critical mental health problems. Tackling CMD’s is clearly an important priority. We are now going to look at the scale of CMDs in North Tyneside.

#### 3.2 Estimates of Demand

The 2007 Psychiatric Morbidity Survey estimated there are 25262 adults aged 16 to 64 in North Tyneside with a common mental health disorder. This comprises 19.7% of the adult population and it is above the national average of 17.4%.

##### Estimates of Common Mental Health Disorders in North Tyneside

Numbers by category	2009
Generalised anxiety disorder	7,498
Mixed anxiety/ depression	12,674
Depressive episode	4,933
Phobias	3,095
Obsessive Compulsive disorders	1,528
Panic disorders	1,411
<b>Any CMD</b>	<b>25,262</b>

Source: Planning4care estimates, 2009<sup>ii</sup>

Mixed anxiety/depression is the most common form of CMD with 12,674 people experiencing this condition. The alternative way of counting the number of people with CMD's is the psychiatric co-morbidity survey which tries to estimate the number of people with more than one mental health problem. This method is used because it is thought that having more than one mental health problem is a useful indicator of the severity of a person's difficulties and the type of services they will need. This method counts 13430 people who would benefit from primary care mental health services or psychological therapies and another 14000 people who would benefit from preventative or some other low level intervention. This is out of an adult working age population of 130,000.

### **3.3 Groups at Risk**

#### **3.3.1 Poverty and Mental Health in North Tyneside**

One of the key risk indicators for Common Mental Disorders is poverty. The 2007 Psychiatric Morbidity Survey states that people who are in the 20% of the population who are the most economically disadvantaged are 3 times more likely to have CMD's than people who are in the top 20% of incomes<sup>iii</sup>. This has direct relevance to the level of need for low level mental health services in North Tyneside. Although North Tyneside is relatively prosperous compared to its neighbours this disguises substantial areas of poverty; 6 wards in the Borough rank among the most deprived 10% of wards in England. These six wards are deprived with regards to the income, employment status and health of their inhabitants, they are:

- **Chirton**
- **Riverside**
- **Collingwood**
- **Longbenton**
- **Howdon**
- **Wallsend**

Two of these wards Chirton and Riverside are in the 5% most deprived wards in England; they have significant levels of deprivation in education, skills & training, housing and geographical access. Overall a quarter of the population live in areas that are in the top 10% wards for economic deprivation.<sup>iv</sup> An equitable provision of low level mental health services in the area would devote more resources to these areas of high need.

#### **3.3.2 Gender**

Women are particularly at risk of low level mental health problems. More women than men experienced CMD's and this was particularly acute in women aged 45 to 54 where some 25% of this group are thought to experience CMD's compared to a lower 14% of similar aged men. Young men are at particular risk of suicide with 14 men per hundred thousand

taking their own lives compared to 4 women per hundred thousand. Although low level mental health services do not work with people at risk of suicide they could play a valuable in preventing young men especially from becoming so unwell.<sup>v</sup>

### **3.3.3 Ethnicity**

North Tyneside has a smaller BME population than Newcastle and is lower than the national rate at 3% of the population. Ethnicity plays a role in the demand for mental health services because women from a south Asian background are particularly in need of help with low level mental health services with an estimate of 34% of women in this group thought to have CMD's.

### **3.4 Estimates of Unmet Demand**

Given the scale of the 25 to 27000 people estimated to have low level mental health problems in North Tyneside it's useful to see how many people are thought to be receiving treatment for these conditions. We will examine in more detail the number of people receiving help in North Tyneside in the following section but the national estimate is that 75 to 81% of people with CMD's are receiving no help whatsoever with their mental health problems. The estimate of people receiving the nationally endorsed treatment of counselling for CMD's was only 8 to 10%.<sup>vi</sup>

Another indicator of the overall demand was a survey that estimated that one in three visits to a GP were for psychosocial reasons. This situation is made more difficult to assess because the patients are often either not aware of their emotional problems or did not directly share their mental health problems with their GP. Also another issue was the lack of training of many GPs in mental health with only one third receiving training in mental health in the last 5 years. This could also contribute to many people with CMD's going unrecognised.

### **3.5 Future Demand**

The planning4Care report estimates that the number of people with low level mental health problems will increase by 4% over the next 20 years. Risk factors such as a growth in unemployment are to be expected as the recession hits public sector employment in the North East in the next few years.

Another consideration in judging likely demand is the growing awareness of mental health problems and the lessening of stigma in sharing these problems with a health professional. If as seems likely more people ask their GPs and others for help then local services will have to deal with referrals from the 75 to 80% of people with CMD's who are currently dealing with their problems away from services.

### **3.6 Treatments for CMD's**

The Government's independent medical advisory body NICE recommends guided self help, physical activity programme, group Cognitive Behavioural Therapy (CBT), computerised CBT and face to face CBT for mild and moderate depression and anxiety. It also cautiously recognises that counselling might have some role in treating depression but not anxiety.

Increasingly Talking Treatments have become acknowledged as the primary means of countering CMD's as they are seen to be more effective than medication alone and avoid any side effects. The downside is that they are expensive compared to medication. There is controversy surrounding the type of talking therapy that is best suited to resolving CMD's. Two camps have developed; those for CBT and those for counselling therapies. Those who favour Cognitive Behavioural Therapy say it has proof for its success in the scientific literature and has become the NICE endorsed form of therapy and subsequently that of the Government. This scientific background has led to the Government favouring CBT as the therapeutic vehicle for its IAPT programme.

The opposition to this has come from people who favour counselling methods that try to look at the root cause of the problems in a person's life. There are also those people who while acknowledging the merits of CBT feel a single form of therapy cannot help everyone and an effective low level mental health service should be able to employ more than one type of therapy. This approach has become more mainstream with NICE now adding a therapy called Interpersonal Therapy to CBT as a recommended therapy and the Government saying it is looking at extending the types of therapies on offer. NICE also recommends counselling or psychodynamic therapy for patients who refuse CBT. <sup>vii</sup>There is also the issue of choice for patients; should patients be able to choose between therapies or should that decision lie with therapists and the commissioners of services? It flies in the face of moves to a more individualised health service and the promotion of choice for patients to be only offered one therapy when there is a body of opinion saying CBT is not effective for everyone. Therefore in looking at the demand for services in North Tyneside we should look for evidence that services are able to give patients a choice between different talking therapies.

### **3.7 Waiting Lists**

As patients are more likely to go to a GP or other service for help with a CMD when they are in distress it becomes all the more important that waiting times are kept as short as possible. If patients spend prolonged periods on waiting lists then the risk of patients not attending appointments increase, the problems might resolve themselves by the time the appointment comes only to return later. There is also the risk that the problem might exacerbate and periods of unwellness might lead to the loss of relationships and jobs that cause even more long term mental health problems. In looking at services in North Tyneside a key criteria for the success of services will be their ability to deliver timely services.

## **4. Improving Access to Psychological Therapies Service**

### **4.1 Introduction: Background and Overview**

#### **4.1.1 National Overview**

In 2007 the Government announced the introduction of a new national mental health service called Improving Access to Psychological Therapies (IAPT). Its goal was to fill the historic gap in provision for low level mental health problems. Traditionally people seeking help for less complex mental health problems could spend months or even years waiting to see a therapist. It aims by 2011 to employ 3600 therapists and treat 900,000 patients with half of that number recovering following treatment.<sup>viii</sup>

The project uses a type of psychological therapy called Cognitive Behavioural Therapy (CBT) to treat common mental health disorders such as mild or moderate depression and anxiety, phobias and OCD. CBT has become the Department of Health's favoured form of therapy as the National Institute of Clinical Excellence recommends it as the therapy that has the most evidence in improving low level mental health problems<sup>ix</sup>. This reliance on a single form of therapy has been controversial with practitioners of other forms of therapy<sup>x</sup>. More recently the former Government has announced it has plans to expand the range of therapies on offer in 2010<sup>xi</sup>.

#### **4.1.2 Local Implementation**

The North East Strategic Health Authority chose North Tyneside to be one of two regional pilots for the IAPT service in September 2008 on the grounds that its primary care mental health services were sufficiently developed to incorporate IAPT. The SHA gave North Tyneside PCT the target for its new IAPT service to see 2500 people and help 70 people back to work in its first year<sup>xii</sup>. North of Tyne PCT added the new IAPT service into its new Integrated Psychological Therapies Service. This new service brought together all of its Primary Care mental health services under one roof and used the Step model approach to mental health. According to how complex or urgent a person's mental health needs are they can be referred to a particular service within the new integrated service. The IAPT service sits at step 2 and some of step 3 while Psychologists and Mental Health Practitioners occupy the higher steps.

#### **4.1.3 Low and High Intensity Services**

The service employs two types of worker, the low intensity therapists or CBT coaches who treat patients with more moderate conditions (in NHS parlance this level of unwellness is called step 2) and high intensity therapists who treat more complex cases of common mental health problems (step 3). As well as treating different severities of conditions they see people for different periods of time. Low level therapists will usually see people for 5 to 6 sessions and high intensity therapists will see people for as many as 22 sessions. The low intensity team or CBT coaches employs 7 fully trained staff and 5 trainees who are expected to have a caseload of 20 to 25 patients<sup>xiii</sup>, although this will increase as the coaches work start to work with people in groups and through self help computer software. The High

Intensity workers have a caseload of 17 patients each on average.

### The IAPT model of stepped care

Step 3 High Intensity Service	Depression Mild, Moderate and Severe	CBT , IPT behavioural activation
	Depression Mild-Moderate	Counselling , couples therapy
	Panic Disorder	CBT
	Generalised anxiety disorder ( GAD) mild- moderate	CBT
	Social Phobia	CBT ,
	Post Traumatic Stress Disorder ( PTSD)	CBT , eye movement desensitisation and reprocessing (EMDR)
	Obsessive Compulsive Disorder (OCD)	CBT
Step 2 : Low Intensity Service	Depression Mild-Moderate	cCBT , guided self-help , behavioural activation , exercise
	Panic Disorder Mild -Moderate	cCBT , guided self-help , pure self help ,
	Generalised anxiety disorder ( GAD) mild- moderate	cCBT , guided self-help , pure self help , psychoeducation groups
	OCD mild - moderate	Guided Self-Help
Step 1 : Primary Care/ IAPT Service	Recognition of Problem	Assessment / Watchful Waiting

## 4.2 Type of Treatment

- **Cognitive Behavioural Therapy**

The psychological approach used by the IAPT service focuses on the problems the person is currently experiencing and offers various targeted techniques for overcoming them. CBT tries to help people understand how their styles of thinking and behaviour can create mood states such as depression or anxiety and learn alternative ways to think and act. For both IAPT services there will be an initial meeting or assessment where the worker will discuss with the patient what they see as the problem and what they want to achieve from their treatment. The worker will then put in place a structured programme that will attempt to do this with CBT techniques.

- **Controversy over CBT in IAPT**

The prominence given to CBT in the IAPT programme has been very controversial with supporters of counselling criticising both CBT as a therapy and its virtual monopoly as a

treatment in IAPT. Detractors of CBT argue its focus on short term problem solving ignores the historical and relational nature of many mental health problems. It is likely that many individuals will feel uncomfortable with the innovations that CBT introduces. Being helped via the telephone, through a computer or in a group might feel impersonal and deter some people from seeking help. In other parts of the country IAPT services have used telephone therapy to reduce the amount of time they talk to people from the standard 45 or 50 minutes to 23 minutes per session. Supporters of counselling argue that many mental health problems are more effectively treated with person centred counselling with its more traditional face to face hour long appointments.

Most of the criticisms of CBT in IAPT have come about because it dominates the programme. The department of Health has sanctioned IAPT to use only NICE recommended treatments in its programme. NICE has advocated CBT because of the amount of research evidence in its favour and the lack of evidence for other psychotherapies. The supporters of counselling say this is because of lack of research rather than a sign of counselling's ineffectiveness. NICE appears to acknowledge this and now plans to commission research on counselling's efficacy. NICE extended the number of therapies on offer in IAPT to include interpersonal therapy and was considering widening the therapies it would support.

The IAPT service in North Tyneside has no plans to extend the types of therapy offered by their service. People who are uncomfortable with CBT or who find it ineffective are not offered any alternative within the IAPT service.

However, North Tyne Primary care Trust has responded that "the integrated psychological therapies service offers a range of therapies including Interpersonal Therapy to clients based on need." "Primary care counselling uses a range of interventions largely based on but not exclusively person centred approaches. The appropriateness of counselling was recognised by NICE and is available in all practices across North Tyneside for conditions that are appropriate and amenable for that intervention."

- **High Intensity Treatment**

The high intensity service will see people face to face over an average of 18 to 22 weeks, the worker seeking to help the patient restructure the thinking and behavioural patterns that are causing them distress. In contrast to the low intensity service they help people with more complex versions of common mental health problems like depression, anxiety, OCD and panic disorders. They can also work with more difficult conditions such as phobias and Post Traumatic Stress Disorder. As their work is more complex they will expect to see fewer patients over longer periods.

- **Low Intensity Treatment**

The low intensity worker will normally see someone from between 1 to 10 sessions<sup>xiv</sup>. The national IAPT programme promotes a variety of ways the low intensity service can help people such as face to face sessions, over the telephone, through a computer programme or in a group. With face to face sessions in North Tyneside the worker will use an established CBT self help guide on depression or stress that the patient will complete week to week, carrying out its tasks as 'homework' and discussing the results with the worker<sup>xv</sup>.

- **New IAPT Treatments**

As well as seeing people face to face the low intensity service has recently begun developing some of the other IAPT recommended treatments. These less intensive ways of helping people aim to help people with less complex types of depression and anxiety. As they are cheaper and treat larger numbers of people than the traditional face to face practice they should result in larger numbers of people being seen. In North Tyneside these high volume low intensity treatments are only beginning to be rolled out despite the service being operational since the end of 2008 and their potential in tackling the service's long waiting lists.

North Tyneside Primary Care Trust has responded that "the timescale from receipt of funding in September 2008 and the recruitment of staff, followed by mandated university training commencing in January 2009" needs to be considered when interpreting this information, as well as "the fact that part of the training staff are restricted in the caseload size and complexity. Waiting lists are for patients with more complex needs that are not amenable to low intensity IAPT input and are outside of the skills of the staff employed in this area of work."

- **Group CBT**

Since February this year the CBT coaches' team has begun organising groups. The first group of 12-13 people met at the Green for a 3 week course on lifestyle and stress. The group was led by two CBT coaches who acted as facilitators. Participants didn't have to be referred by a GP but could come from any source including self referral. Promotion for the group included posters at GP surgeries.

- **Initial Telephone Assessments and Ongoing Sessions**

Telephone Therapy is an alternative to the therapist or worker seeing the patient face to face in an office. In other parts of the country low intensity workers assist patients with guided self help over the telephone. NICE have recommended telephone therapy as an effective form of help since 2004 and it allows the NHS to help more people at a cheaper cost. Telephone Therapy can be a benefit to people who are housebound for whatever reason whether that is disability or poor weather. In theory it should be an attractive option for North Tyneside PCT given their difficulties in finding accommodation for the IAPT service. However the service has only begun to use the telephone since the New Year for initial assessments and for a limited number of treatments<sup>xvi</sup>.

- **Telephone Therapy and Choice**

In other areas telephone therapy begins after the client has been given a choice between face to face sessions or telephone therapy. It is likely some people will feel uncomfortable talking over the phone and some people will not be able to because of privacy issues in their home. Therefore any new rollout of telephone therapy in North Tyneside would be more successful if it was accompanied by a commitment to give the patient the choice to decline telephone therapy in favour of face to face sessions.

North Tyneside PCT has responded that this mode of treatment is available and is not driven by cost as they believe savings would be marginable. Inclusion in the approach is dependent upon the patient's needs. Training is required for staff as this is not covered in the IAPT curriculum.

- **Computerised CBT**

There are various computer software packages that enable the patient to interact with a programme and become familiar with CBT techniques for tackling anxiety and depression. The advantage of this method is that it is recommended by NICE with evidence it is effective in tackling depression and anxiety<sup>xvii</sup>. CCBT allows large numbers of people to be treated at a low cost. The low IAPT service has plans to use the computerised CBT programs 'Beating the Blues' for depression and 'Fear Fighters' for anxiety.

The IAPT service is still to decide whether to offer the programmes online in people's homes or at public locations like libraries where there might be privacy issues<sup>xviii</sup>. Again the question of choice would be a crucial consideration in the rollout of this therapy with some people feeling uncomfortable with computers and preferring to talk to a human being. This approach is not planned for people who need the high IAPT service. As with the other innovative low intensity treatments there have been delays in introducing these developments in North Tyneside with the service still not being used introduced as of April 2010.

North Tyneside Primary Care Trust has stated that the decision depends on the client's condition and choice. Computerised CBT needs to be monitored by a therapist and it is not appropriate for high intensity intervention, so it is not being planned for people with high intensity needs. Computerised CBT in the form of FearFighter and Beating the Blues will be available in North Tyneside from September 2010. It is part of the range of step two interventions delivered by low intensity workers (CBT coaches). Like all new approaches training for staff on use of the programmes is required as there is still a clinical risk for patients, which needs to be addressed. Protocols will determine what action will be taken if a patient shows risk via their scores.

## **4.3 Referral**

### **4.3.1 Eligibility for IAPT**

The IAPT service is open to all adults in North Tyneside who meet the referral criteria and have been referred by their GP. It does not normally work with people with severe and enduring mental health problems or drug and alcohol problems. In contrast to the Primary Care Counselling service where access is determined by the practise a patient belongs to, patients from anywhere in the borough are able to access the IAPT service. Referrals are sent to the Green in Wallsend where referrals are assessed according to need.

### **4.3.2 How patients are referred**

Patients are referred through their GP into either, the low or high intensity IAPT service. The referral is then picked up at IAPT's offices at the Green in Wallsend, where IAPT workers will judge whether the referral is appropriate. If they think it is, they will put the person onto

the waiting list to be assessed. If the patient's needs are deemed to be urgent they can be designated a priority and seen by a step 3 or 4 worker such as a Mental Health Practitioner or a Psychologist<sup>xix</sup>. The person will either be assessed at an initial meeting or by a telephone assessment. If the worker thinks the service can help that person they will make an appointment to begin that person's treatment. If they feel the service is inappropriate they can be transferred or "stepped" up or down to a more suitable branch of the Integrated Psychological Therapies service. If the worker thinks the service will not be able to help the patient at all they will be referred back to the GP.

North of Tyne PCT have subsequently informed us that referrals should be into the integrated service and consequently GPs can request input from either, the low or high intensity IAPT service, primary mental health practitioners and psychologists. Additionally the service provides access to employment advisors.

### **4.3.3 Problems with the Referral Process**

The above description appears straight forward but its success relies on a number of factors, not least the skills of the GP, the clarity of the referral criteria and the relationship between the GP and the IAPT service. It appears the referral process has experienced some long standing problems as witnessed by its long waiting lists and fears expressed by GPs and staff that people are being referred incorrectly. North of Tyne PCT says as of June 2010 people are waiting for 30 weeks for the High Intensity Service and 9 weeks for the low intensity service. GP's have reported to us that some people have been waiting as long as 9 months. The numbers referred to the service also speak of confusion over the referral criteria with 255 people referred to the High Intensity Service and only 39 people waiting to see the supposedly high volume Low Intensity service.

North Tyneside PCT has since told us that they believe that the longest waiting times are associated with psychology. They have sent referral criteria to all practices and the numbers referred to the low intensity service reflects the complexity of other referrals.

### **4.3.4 Inappropriate Referrals**

#### **Disparity between referrals to the low and high services**

In its Service update the Integrated Psychological Therapies Service reported that as of January 2010, 255 people were waiting to use the High Intensity Service and only 39 people were waiting to use the supposedly high volume Low Intensity service. The caseload of each service was 222 for High Intensity and 165 for the Low Intensity. What is surprising about these figures is that although the High Intensity service has marginally more capacity with 13 full time workers compared to the low intensity's 8 workers plus 5 students, it is designed to operate a smaller caseload than the lower intensity service. The High Intensity service aims to see a smaller number of more complex cases over a longer period of time. In contrast the Low Intensity Service was designed by the Department of Health to treat high volumes of people over shorter periods of time using innovations such as group therapy or CCBT to boost numbers. The response by the Integrated Psychological Therapies Service to this unusual pattern was:

“As there are more High Intensity Staff it is to be expected that they will carry a higher aggregated workload.<sup>xx</sup>”

Although the Low Intensity Team’s recruitment problems will account for some of this disparity it cannot account for all of it. There appears to be a pattern of GPs over referring to the High Intensity Service and under referring to the Low Intensity Service. The IPTS went onto suggest this lack of referrals for the LI service was because it, “reflects the lack of simple low level need.<sup>xxi</sup>”

North Tyneside PCT have since told us that the service overall is experiencing high numbers of referrals and the number of simple low level referrals is very low. A significant number have 10 year durations. Linked to this there are waiting list problems with IAPT reported across the country, so much so that a waiting list project has been implemented. North Tyneside is part of this project, as well as conducting its own waiting list initiative.

## **REFERRAL PATTERNS ELSEWHERE**

Nationally IAPT services have been receiving large numbers of referrals and some IAPT areas have more Low Intensity workers than High Intensity workers.<sup>xxii</sup>. Last Year in Barnsley low intensity workers saw twice as many patients as their higher counterparts. Community Care magazine interviewed a low intensity worker with a caseload of 80 patients<sup>xxiii</sup>. It is unlikely that North Tyneside differs greatly from the rest of the country and has less need of a low level service. What is more likely is that GPs are referring inappropriately.

### **• GPs Referral Preferences**

This was the case made by a GP we interviewed who said that GP’s are referring in a risk averse way and opting to refer people to the higher end rather than take a risk sending them to a service that might not be able to manage their needs if they prove to be of a more serious nature. The GP argued that the PCT had not made an effort to increase the referring skills of GP’s and inform them of the value of Low Intensity services. In its Service report the IPT Service acknowledged that in the past GPs were told to manage to manage low level cases within their practices and that GPs needed further education on discerning which patients are suitable for the low intensity service.

There is also the question of whether correctly referring patients is the whole responsibility of GPs. One GP said it was IAPT’s job to sort out “rubbish referrals”; they were the specialists and GPs the generalists. Given the weight of inappropriate referrals it would be valuable to know if IAPT can step down some of these referrals from the High Intensity to the Low Intensity Service.

North Tyneside PCT has responded that they “are concerned that the comments only reflect the views of one GP who was interviewed for the purpose of this report. His/her opinions are not echoed elsewhere and we feel that as it is only one person, this GP’s views should not be presented as representative of all GPs in North Tyneside.”

- **Over Referring by GPs**

It is difficult to say with absolute certainty GPs are over referring patients to the IAPT service as there is little information available on IAPT referrals. The overall psychology service has had a significant increase in referrals with the average monthly referral prior to January 2009 being 130 increasing to 266 in October 2009. The introduction and publicity surrounding the new IAPT service must have played a part in increasing referrals from GPs. Unfortunately the IAPT service's first year was beset by challenges over the amount of training the new workers had to carry out (2 days a week) and issues over recruitment of the new workers. This led to the service being unable to meet the expectations it had created with GPs. A senior member at the PCT said one of the problems with IAPT was that GPs were told there was a new service available with a substantial workforce but they were not fully informed about the delays there would be in the service because of training the new workers. The pathways were not explained in great detail and this led to the big increase in referrals and waiting lists. One of the GPs we interviewed echoed this observation, that GPs had been told there was a new service in place and had referred people indiscriminately. He said the IAPT service had not informed GPs how to refer appropriately to the new service.

North Tynside PCT has told us that, "all practices were informed how to refer to the service and a referral form with advice on how to complete the form and the choice they had over where to refer in the pathway was presented."

- **GPs Lack of Knowledge of Waiting Lists and Referral Rates**

In a similar vein both of the GP interviewees and 3 of the GPs we surveyed said they were not aware of waiting lists or referral rates for the IAPT service. If GPs have not been informed about the increase in waiting lists or appropriate referral rates then it is not surprising there have been difficulties.

These problems were discussed in the April Service Update where as part of its Action Plan the IPT Service states it has contacted practices about high referring and to inform them about referring to commissioned levels. The IPT service also committed itself to informing practices of its tightened inclusion and exclusion criteria for its services. Both of these measures can be interpreted as an acknowledgement that GPs need more and better information from the IPT service.

#### **4.3.5 People being referred who should be seen by other services**

IPT report they are seeing patients who should be seen by secondary services, similarly patients we interviewed said that although they wanted to be seen by a psychotherapist or other worker they were actually being seen by a counsellor. If this practise of services dealing with patients who would ideally be treated by more complex services is common then it's likely that some of the people the High Intensity workers are seeing should ideally be seen by another service but they are carrying this role out as there is no one else to help that patient. It is a likely factor in the high waiting list for the High IAPT service.

### **4.3.6 Communication between IAPT and GPs**

The issue of communications between the IAPT service and GPs is worth examining as it is likely an important factor in the delays patients have experienced. The communication difficulties appear to take three forms, one is the lack of appropriate information about the capacity of the IAPT service to enable GPs to decide whether to refer someone, the second is the lack of information or training in understanding the role of the IAPT service, especially the merits of a high volume, low intensity service. The final issue is the lack of contact between GPs and IAPT workers.

### **4.3.7 GPs not given enough information about capacity of IAPT**

The IAPT service reports that at the commencement of IAPT they circulated information about the new service. Two of the workers we interviewed, one a GP, one a senior member of staff at the PCT raised the issue that IAPT had created expectations about its ability to deliver treatments to patients without informing GPs about the degree to which training and recruiting the new workers would reduce IAPT's capacity. The result was, according to the interviewees a pattern of indiscriminate or inappropriate referring by GPs that led to the high waiting lists. Whether it was possible for IAPT to have foreseen the issues with training and recruitment is something to be considered.

North Tyneside PCT has told us that, "there is now a GP IAPT lead in place to assist with this process. The service has produced information which we have been advised by the GP that primary care can only handle in small amounts. It has been agreed with commissioners that the service will lead on communication with GPs. To this end a number of practices have been visited with further visits planned. This is in addition to written communication being sent to practices."

## **4.4 Ongoing waiting list/referral rate issues**

Two of our GP interviewees and four of the eleven GPs who replied to our survey said they were not being informed about waiting lists and referral rates. This is important because if the system is overwhelmed then GPs need that information so they can alter their referring so as not to add to an already very large list. GPs can also make choices about referring to counselling or to a voluntary organisation or seeing the patient within practise

### **4.4.1 GPs not given enough information about merits of low intensity service**

Low Intensity IAPT is a radical new move in treating low level problems and it does have evidence for its effectiveness in mild and moderate depression and anxiety. That does not seem to have reached all of the GPs in the area with only 39 patients waiting to use the service compared to 255 for the High service. 11 out of the 160 permanent GPs have not referred any patients at all to either of the IAPT services. One GP interviewee said the lack of referrals to the low IAPT service was because GPs were not referring according to a stepped model. Many GPs he said were referring according to a stratified care model that is a more risk adverse approach. The outcome of this is that the High Intensity service is receiving more referrals than it should be and the low intensity service are experiencing

smaller caseloads than reported elsewhere in the country. This is likely to improve if the IPT service carries out training to GPs it has indicated it is planning.

#### **4.4.2 Contacts between IAPT workers and GPs**

One of the merits of the Primary Care Counselling service is that counsellors are attached to particular surgeries. With IAPT the link is less strong as workers are not always seeing patients in a GPs own surgery. This means there has been less opportunity for workers and GPs to forge working relationships and for GPs to learn more about the service. It also means there is a lack of informal channels where workers and GPs can quickly discuss a patient's needs, which is the case with the Primary Care/Relate counsellors. The IPT Service has said they will assign IAPT workers who will link with particular surgeries. This is a positive move but its success will depend on how it is implemented and how much time the worker spends communicating with their allocated practise.

North Tyneside PCT has told us that they feel, "the report does not acknowledge that all the primary care psychological interventions can be delivered in primary care. However, space in GP practices is a major problem. The service has worked with the Estates Department to access extra space."

#### **4.4.3 Lack of self referrals**

Although it is national IAPT policy to encourage self referrals and Northumberland IAPT service has successfully introduced it, self referral has not been introduced in North Tyneside and there appear to be no plans to implement it. In our interviews with patients the issue was raised of a patient wanting a talking therapy and communicating this request and the GP not referring them. Also during IAPT information event in October a counsellor who was present said there was a reluctance among some GPs to refer patients and said a GP at the practise she worked had only referred someone once in 6 years. Some 11 permanent GPs have not referred anyone to IAPT service despite the service being over 18 months old. The patients of these GPs have no access to IAPT if their GP chooses not to refer them. There are also arguments around groups in society who can have difficulties accessing Primary care such as BME groups. Self referral would be of benefit to these groups. The fear that puts some people off self referral would be a wave of inappropriate referrals but as the low LI workers are now operating a telephone triage system this would likely filter out inappropriate referrals. Also in a written reply the IPT service said only 5% of referrals in the areas where it had been introduced were from self referral, so it is unlikely the service will be overwhelmed.

North Tyneside PCT has responded that, "by comparing Northumberland IAPT, the author is not comparing like with like, as the Northumberland service is not part of an integrated model. Patient groups have been in place since February and are self referral. Further to the group delivery, adult education classes will be available to all North Tyneside adults registered with a North Tyneside GP from September. Details of these classes have been sent to all homes in North Tyneside as part of the adult education curriculum."

However, we feel that comparisons with Northumberland are valid because they serve people with the same conditions with similar treatments, workers and funding. If the Northumberland IAPT service can offer more flexibility by not being part of an integrated

model then perhaps this makes a case for North Tyneside to follow the Northumberland example.

## 4.5 Outcomes

Seeking information on how successful IAPT has been in tackling the demand for help with common mental health problems in North Tyneside has proved very challenging. The three most valuable sources of information about the outcomes of the service are from patients, staff and from the data collected by the Primary Care Trust.

Efforts to retrieve information from the Primary Care Trust were not completely successful in that the computer system the IAPT service used to collect data on their service has been unable to work with the requirements of the new IAPT service. The IAPT service say they are now going to address this problem by installing a new computer system called IAPTus that will take 5 months to set up. This deficit in knowledge means the PCT have been unable to provide us with detailed information relating to:

- Waiting Times for the two IAPT services
- Numbers referred since its start up
- Numbers who have commenced treatment
- Patient satisfaction results
- Detailed Patient Recovery data
- Numbers of people who have dropped out of treatment
- Total number of Contacts for each service

The information we have received on outcomes for the IAPT service relates to the Key Performance Indicators they send to the Department of Health each quarter:

Data for Quarter	KPI5 The number of people who have completed treatment (for any reason including completed, dropped out, signposted on) (during the reporting quarter)	KPI6 The number of people who are "moving to recovery" (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not) (during the reporting quarter)	KPI6b The number of people who have completed treatment not at clinical caseness at treatment commencement	KPI7 The number of people moving off sick pay and benefits (during the reporting quarter)
Q4 08/09	12	2	4	9
Q1 09/10	44	5	18	0
Q2 09/10	108	23	31	
Q3 09/10	148	16	55	9
<b>Total</b>	<b>312</b>	<b>46</b>	<b>108</b>	<b>18</b>

The KPI data says some 312 people have completed their treatment with the service in 2009. The growth of the service can be seen in the increase from 12 completed in the spring to 148 in the last three months of 2009. Of that 312, 46 are counted as 'moving to recovery'. This means at the beginning of their treatment with IAPT they will have answered questions relating to their mental health and considered to have a mild or moderate depression or anxiety or another common mental health disorder. At the end of their treatment they will have completed a similar set of questions and if their score has improved so they are no longer within the threshold of depression or anxiety they will be considered as 'moving to recovery'.

Column 6b refers to people who did not score a high enough mark on the initial form to be have a diagnosis of depression or anxiety but who must have been experiencing a level of distress. At the end of their treatment some 108 of these people were still below the threshold of a diagnosis. Unfortunately we cannot tell from these figures whether the IAPT service actually helped these patients. All it tells us is that they did not become seriously unwell while being treated. The last column refers to 18 people who left benefits while seeing the service, the target figure for the first year was for 70 people to have been taken off benefits<sup>xxiv</sup>

#### 4.6 IAPT Caseloads

The other figures we have from the PCT relating to outcomes are that as of January 2010, 222 patients were seeing the High IAPT service and 165 patients were seeing the Low IAPT

service. That works out as a caseload of 17 for the High service and around 20 for the low service if you do not include the students and 12 if you do. The PCT have also disclosed that 214 GPs in North Tyneside have referred to the service with only 11 permanent GPs not referring anyone to the service. Other data exists that shows waiting list times, satisfaction levels and contact numbers for the overall Integrated Psychological Therapies Service but IAPT only forms a part of this umbrella service that includes treatment of more complex cases than common mental health disorders.

## **4.7 Patient perspectives on IAPT**

Attempts to recruit members of the public to be interviewed on their experience of IAPT were unsuccessful despite a variety of promotional efforts, included placing articles in the Evening Chronicle and News Guardian inviting interviewees and payments of £15 in recognition of their time. There are a number of reasons why people are reluctant to be interviewed; one explanation is that people with low level problems might still be affected by the stigma that surrounds mental health. Other explanations are that the service is still in its early days and the pool of people might be too small to effectively survey. Other considerations are the confusion members of the public experience in understanding the different mental health professional roles and services. It was common for the people I interviewed to use the words counsellor, nurse and psychologist interchangeably when it was clear from the other details they gave me they had seen a counsellor.

## **4.8 Staff and GP Views on IAPT Outcomes**

### **GP Survey**

In May 2010, 50 randomly selected permanent GPs were sent survey forms asking them to anonymously answer questions about their views of the IAPT and counselling services. Out of that number 11 responded and filled in the forms. This is too small a number to be representative but does give a valuable insight into some GPs experience of the service. They were asked, "In your opinion how successful has the IAPT service been in treating your patients? Five options were offered: Poor, Below Expectations, Average, Fair and Very Successful. The results were mixed with:

- 1 blank
- 4 below expectations
- 2 average
- 2 fair
- 2 very successful

GP's were also invited to leave comments about how they chose to refer patients, how long their patients waited before they were treated by IAPT and any other comments they wanted to make about IAPT. The other comments are as follows:

*“Very useful and more organised approach to patient demand. Very approachable and helpful”*

*“No major experience of service as yet-few patients that have tried it have found it beneficial”*

*“Many patients end up DNA as they have waited too long. Far too long waiting lists for assessment need to be able to respond within 2 weeks”*

*“Been very expensive service for very little people seen. Idea is good in practise not delivered-should be better now as more low intensity IAPT functioning now”*

*“We had hoped it would improve at start of 2010 with new workers/counsellors. Waiting times have been awful and I am not yet aware that they have improved. Get rid of the referral form!”*

*“I spend far too long with depressed patients because there is nowhere to send them. How can we offer CBT before medication if the wait is months?”*

*“Difficult to say as early days for service. No clear feedback mechanism.”*

Most of the comments seem to be addressed at the waiting times their patients experience rather than the quality of the service. There is clearly a level of dissatisfaction among some GPs at the waiting times to see the IAPT service. There is more encouraging news for the IAPT service in GPs assessment of how successful the IAPT has been in treating their patients. Although 4 GPs said the service was below expectations, 2 said average, 2 said fair and 2 said very successful. All 4 of the GPs who made the below expectations remarks also made the strongest criticisms of the waiting times. This suggests their views on IAPT might improve if waiting times got better.

## **GP Interviews**

In March 2010, two GPs were interviewed for between 30 and 45 minutes on their experiences as a GP on low level mental health services in North Tyneside. Both were critical of the waiting lists for the IAPT service and the lack of information GPs had received about the service. Their criticisms seemed to be more aimed at how the service was managed than of the IAPT idea or the use of CBT which were not mentioned. Both seemed

to believe that improvements could be made to how IAPT is delivered. Both suggested more information about waiting lists, one said GPs should receive more training on referring, one suggested greater use could be made of the Low Intensity side of the service and the other suggested North Tyneside could emulate other providers such as Northumberland.

The comments below reflect their concerns:

*“The PCT has achieved a rare feat they had been given 24 new workers and had delivered a worse service”.*

*“There’s a lot of money been put into IAPT and it hasn’t got better, it’s got worse”.*

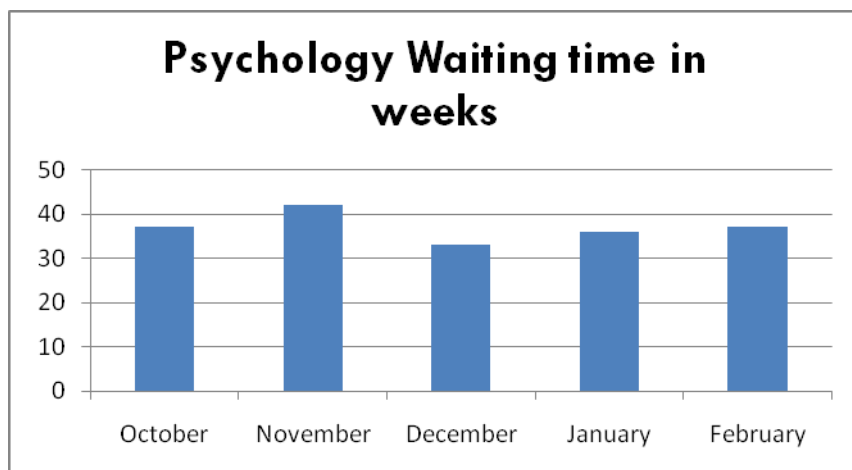
## **4.9 Waiting Lists**

The IPT service has said that because of problems with their established computer system they were unable to provide statistics on waiting lists for the IAPT service. However in early June the PCT was able to give the current waiting lists for the service:

- Low Intensity IAPT 9 weeks
- High Intensity IAPT 30 weeks

We have not been given any older information about waiting lists so we cannot tell if the situation is getting better or worse. Therefore to judge the waiting lists for this service we will have extrapolate from other figures that are available. Waiting times are available for the IPT service as a whole and show the longest times a patient has waited to use the service as consistently over 30 weeks, rising to 42 weeks in November before falling down to 37 weeks in February<sup>xxv</sup>.

Last September a Health Insurance magazine made a Freedom of Information request to PCT’s across the country asking for waiting times for somebody referred for CBT, North Tyneside PCT replied the longest time somebody had waited for CBT was 34 weeks<sup>xxvi</sup>. This was one of the longest waits in the whole country. There are no figures available as to whether there is a difference in waiting times for the low intensity service as opposed to the high intensity service but it’s probable the waiting list for the high intensity service is much longer as the number of people waiting to use this service was 255 in January compared to only 39 people referred to the low intensity service.



Numbers sourced from Newcastle and North Tyneside Community Health Board Performance Updates

#### 4.9.1 Other Waiting List Sources

Of the eleven GPs who responded to our question in early to mid May 2010 on how long their patients were waiting to see IAPT, five didn't know how long the waiting list was and made comments such as "many weeks," "absolutely ages," "2months", "not sure" and "n/k no figures received". Two said it was four weeks, two said it was three months; one said it was nine months and one GP said his patients waited on average one year. It's not established whether the GPs received these figures from the PCT or from observation of their own patients' waiting times. The survey didn't ask for waiting times for each of the IAPT services but given the difference in referring numbers its more likely the nine months and one year referred to the High Intensity service. Eight out of the eleven GPs made negative comments about the waiting times for the IAPT service. Examples include,

*"Waiting lists far too long. We would like a service where people are seen within 2 weeks."*

*"We had hoped it would improve at start of 2010 with new workers/counsellors. Waiting times have been awful and I am not yet aware they have improved"*

*"Far too long waiting lists for assessment need to be able to respond within 2 weeks. Many patients end up DNA as they have waited too long."*

*"Waiting times unacceptable... [IAPT] bounce things round so bounced someone for 9 months."*

On a more positive note a GP whose patients had only waited 4 weeks to see the IAPT service said:

*“Very useful and more organised approach to patient demand.”*

One of the GPs we interviewed made the following remark about the IAPT waiting lists: *“Our patients are doing rubbish.”*

#### **4.9.2 Reasons for the Waiting Lists**

In April the IPT service presented a report to Newcastle and North Tyneside Community Health Board to explain why its waiting times were so high. A number of explanations were given that were pertinent to the IAPT service. These were:

- **Recruitment**

The IPT service say they have experienced great difficulties recruiting 5 low intensity IAPT workers and they only succeeded in recruiting the workers in November 2009 having failed to recruit these workers on two previous occasions.

- **Large increase in Referral Numbers**

Referrals to the overall IPT service had grown from 130 a month prior to January 2009 to 266 in October 2009, latest numbers were 190 in January.

- **GPs not referring according to commissioned levels**

That GPs needed to be “realistic about the number and type of referrals”. The report said that “Practices must play an active role in ensuring the appropriateness of referrals and support those patients who are not at “caseness” for this service”.

- **As a consequence of the reduction in access to secondary care services**

The reported said there was a decrease in the numbers of people seen by Northumberland and Tyne and Wear Mental Health Trust and these patients were now being seen by the IPT.

- **Training**

All trainee IAPT workers had to spend 2 days a week at Newcastle University plus two hours a week being supervised. As most of the workers are trainees this has had a big impact on service provision.

- **Accommodation**

The IPT service says they have experienced great challenges in accommodating the introduction of the new service. There is a shortage of room space in GP surgeries as more

services are offered at a local level and not enough room at the Green in Wallsend where IAPT is based. It says this problem will worsen as more trainees become full time workers.

#### **4.9.3 Additional Contributors to Waiting Lists**

Other reasons that could be taken into consideration are the lack of training and information GPs received at the beginning of IAPT, according to two of the people we interviewed, this resulted in indiscriminate referring by GPs that led especially to the Higher end of IAPT being overwhelmed. Other issues highlighted have been the lack of ongoing communication between IAPT and GPs so the latter were not fully informed as to the existence of an already lengthy waiting list and referred to IAPT. If they had been given more information they could in theory have referred differently. Years of unmet demand for low level mental health services are likely to have played a role in the increase. Another cause might lie in the recession leading to a rise in distress among the population who sought help from their GPs who then correctly referred their patients onto the appropriate service.

#### **4.9.4 Future prospects for waiting lists**

There is encouraging news for waiting lists as the IPT report said the IAPT trainees will soon be able to work full time and increase the capacity of the service by 570 clinical hours per week. This however was dependent on accommodation becoming available to house the new workers. The report also said that the referral criteria for the service had been tightened. This might be a negative step if people who were previously entitled to the service are now deemed not suitable not because they were wrongly referred but because the level of unwellness was increased. It also stated that some high referring GP surgeries had been contacted to adjust their referral rates. Again, this might reduce the waiting list but it might not reduce the number of people who need the service but who would instead be managed within practise.

The welcome introduction this year of alternatives to face to face sessions by the IAPT service may also play a part in reducing the waiting lists. Telephone, Group therapy and CCBT all offer methods by which large numbers of people might be taken off the waiting list.

If the IAPT service does increase its education of GPs on the value of low intensity treatments there might be an altering of GPs behaviour away from referring to High Intensity service to referring to the Low Intensity service instead. This would reduce the waiting list to the High service and send more people to the CBT coaches who can see more people in a shorter period of time. There is also the question of whether more referrals could be stepped down at the assessment stage by the IAPT service.

### **4.10 Future of IAPT Service**

The IAPT service is likely to experience a productive period as the service settles down and the new trainees become full time workers. Its data systems should begin to work and the service become more open to scrutiny. The substantial expansion in clinical hours available will be dependent on the IPT service finding accommodation to house these workers. In its April report the service says it has 3 months to resolve this problem. If this is resolved then the number of people helped should increase and the waiting lists decrease.

Other factors in the reduction in the waiting list will be GPs responding to IPT's new stricter referral criteria for the service and advice to reduce their rate of referral. These changes to how people are referred may reduce the waiting list but they will not reduce the number of people going to a GP with mental health problems seeking help. Any tightening of access to the service could see people being managed within practise as has traditionally been the case and resolving this issue was the *raison d'être* for IAPT. A more positive step would be made if GPs discovered the merits of the low intensity service and altered their referrals to that newly enlarged service. Alongside growth in the use of group, telephone and CCBT this would see the service expanding to help many of the people who are currently seeking help.

Financially and politically the IAPT service is better protected than other services with its high profile and support by national politicians. The PCT's present contract with Newcastle and North Tyneside runs to 2013, at face value this appears to protect the service until then from looming cuts facing the NHS.

## **5. Primary Care Counselling Service**

### **5.1 Introduction-Background and aims of Service**

North Tyneside PCT funds Newcastle and North Tyneside Community Health to provide the Primary Care Counselling Service in North Tyneside. The other half of the service is contracted out to the charity Relate. The service is located within the Integrated Psychological Therapies service who also oversees the Relate contract. Its six Counsellors<sup>xxvii</sup> are attached to GP surgeries from which they receive their referrals. In addition to paid qualified workers, the service oversees 8 to 10 counselling students from Tyne Metropolitan College who are working towards their counselling degree. The service is not distributed equally across North Tyneside and some surgeries have more access to counselling. It offers short term counselling over an average of six sessions using person-centred therapy and other types of counselling therapies. At the present time the PCT has not supplied us with our request for the referral criteria for this service. However the service is termed a Generic Counselling service and that usually means treating people who are experiencing difficult life circumstances such as bereavement, work stress, divorce or other types of emotional distress that are not complex enough to warrant referral to another mental health service.

North Tyneside PCT has responded that they agree that, "provision across the area does vary as there is not the same level of provision based on weighted practice population or other proxy of deprivation. Referral criteria are known to practices and this is evidenced by appropriate use in primary care. Many of these clients do not require referral onward and this is the appropriate mode of treatment."

### **5.2 Type of Treatment**

The type of treatment used by counsellors is usually a branch of psychotherapy called person-centred therapy. This focuses on encouraging patients to find their own answers with the support of the counsellor. Patients are invited to look at their past and their feelings

face to face with the counsellor over 6 to 8 sessions. This contrasts with the Cognitive Behavioural Therapy approach of the IAPT service that focuses on the negative symptoms happening in the present. The IAPT worker will seek to challenge the established thinking patterns of the patient. The person-centred and other types of counselling are regarded as having less scientific authority by supporters of CBT and the IAPT approach.

### **5.2.1 The Case for Counselling**

The reliance by IAPT on CBT has led to fears that the person centred therapies used in counselling are becoming marginalised. In particular the preference by the Government's medical advisory body NICE for CBT has made counselling appear less relevant to dealing with low level mental health problems. This tide seems to have turned recently with some research papers favouring counselling being published while Government and NICE seem to be acknowledging that counselling does have a contribution.

Counsellors who attended the October IAPT event made the case that not everybody can be helped by a single type of therapy. This argument was accepted by the previous Government who said they were going to look at adding therapies other than CBT to the IAPT service.<sup>xxviii</sup> The National Institute of Clinical Excellence does now recommend counselling as a treatment for depression for those who decline CBT<sup>xxix</sup>. There has been concern about the lack of evidence for any of the talking treatments for mild depression and this issue has also been raised by NICE who have stated that the effectiveness of CBT on low level depression is not conclusive and they plan research on the effectiveness of counselling.

“Low-intensity cognitive behavioural interventions have the best evidence base for efficacy but the evidence is limited and longer-term outcomes are uncertain, as are the outcomes for counselling.”<sup>xxx</sup>

These developments might turn out to be too late for counselling as PCT's seek to make cuts and the creation of the IAPT service as an excuse to cut their counselling service as has happened in PCT'S like Buckingham.

### **5.3 Counselling Environment**

All of the counselling sessions take place in rooms at GP surgeries. At present they all take place from 9 to 5 and on week days with no plans to extend the service to evenings or weekends. A working time only service is a serious challenge for people who are employed or in training and have no choice but to decline the service unable to take time off work. Sessions are 45 to 50 minutes long and counsellors will aim to spend 6 sessions with the patient although some individuals may receive a small number of extra sessions if that is needed. The patient will see the counsellor either weekly or fortnightly following an initial meeting. The counsellor will assess whether the service will benefit the patient and discuss what the patient wants to achieve through their meetings.

### **5.4 Access to Counselling**

The service has evolved over a number of years beginning with GP surgeries initially hiring independent counsellors through GP fund holding in the 1990's. More recently a contract

was signed with the charity Relate to provide half of the counselling services. At some of the larger surgeries like Shiremoor there is a PCT counsellor and a Relate counsellor. When trust holding was replaced the PCT appears to have chosen to have kept the existing counselling arrangements in place for what they say are “historical” reasons<sup>xxxvi</sup>. The result is that the provision of these services is not distributed equally across North Tyneside according to either population size or need.

Some GP surgeries appear to have disproportionately more access to the service and receive more Counselling sessions than other surgeries. It is common to hear of people complaining of a post code lottery in health services between PCT areas, in North Tyneside we have a post code lottery within the PCT area for people who need counselling. The PCT have stated that they are looking at making the provision of Counselling more equitable but it is not clear yet by what set of guidelines these changes will be made, when the changes will happen or how the public will be involved.

North Tyneside PCT has responded that they feel, “the report does not reflect that two services are in essence providing the same service albeit via different agencies. Reference to proposed changes to practice allocation would be based on deprivation indicators including weighted practice populations.”

LINK would be interested to know if there are plans to change practice allocation and if so to have more detail on these.

## **5.5 Referral Criteria**

### **5.5.1 The Role of GPs**

Referral to this service is through a G P who will decide whether the patient will benefit from seeing a Primary Care Counsellor. The options available to the GP for somebody who appears to have a low level mental health problem at this point are

- “watchful waiting” - asking the patient to return at a future point to assess their health,
- Low Intensity IAPT worker
- A voluntary sector organisation like MIND
- Primary Care/Relate Counsellor

*(GPs can still use refer patients to self help books at libraries but the Books on Prescription service no longer has any dedicated workers from the PCT )*

Although medication is not supposed to be a front line method for dealing with low level mental health problems, some counsellors report that some GPs have established patterns of prescribing anti-depressants to this group<sup>xxxvii</sup>. In our GP survey one GP commented he was unsure how he was expected to avoid prescribing medication when the waiting lists for talking treatments were so long.<sup>xxxviii</sup> One of the patients we interviewed said she felt her GP offered her medication too readily and she had to ask for a talking therapy.

## 5.5.2 Informal Referring via Counsellors

Although the GP is supposed to have the central role in choosing if someone should see a counsellor or the IAPT service it has been reported that not all GPs directly refer patients with low level mental health problems but instead hand this role over to the counsellors attached to the surgery.<sup>xxxiv</sup> The counsellor then has the role of assessing whether the patient is suitable for the Primary Care Counselling service or to refer that patient onto the IAPT service.

## 5.5.3 Confusion over Referral Criteria

### Counselling Vs IAPT

North of Tyne PCT is unable at this time to tell us what the referral criteria for the Primary Care Counselling service is. They were able to give this description of contrasts between the two services,

“IAPT is designed to treat people with milder forms of depression and anxiety as well as people with mild to moderate depression. Counselling as a profession would deal with a range of conditions not necessarily depression. These could include bereavement reactions, poor self esteem, psychological and emotional distress.”

The feedback I have received from GPs and Counsellors is that GPs tend to refer patients to counsellors who are experiencing stressful life events and who would benefit from talking through their problems. This description means it is difficult to differentiate the client group who would benefit from counselling as opposed to IAPT. One Counsellor from Relate commented, “Nobody knows the answer to that” when I asked her what the difference was. A GP echoed this answer in the GP survey, “Very difficult to decide.”

To differentiate whether a patient is in distress because of a life event or because they are vulnerable to depression or anxiety must present a challenge to GPs. This might not be a significant issue if both services are equally efficacious for all low level mental health problems or had similar waiting lists. The worry would be if people were being referred to the wrong service or a particular service was being under-referred. Ultimately GPs will refer depending on their skills and training in dealing with mental health issues and experience of whether a patient will benefit from a service. They will also refer according to the relationship they have established with the Primary Care Counsellor at their surgery and the counsellor’s particular skills.

North Tyneside PCT has responded that, “the description given in the report clarifies this distinction, it is necessarily something which is defined by clinical judgement which would explain the comments that the author quotes from the counsellor and the GP.”

## 5.5.4 GP Mental Health skills and relationships with patients

The question of how well GPs relate to mental health problems in general is pertinent. There are long standing concerns about the training of GPs in mental health. Mind has reported on a survey that found that only one third of GPs had received training on mental health in the last 5 years<sup>xxxv</sup>. There are no obligations on GPs to keep informed on mental

health once they have they finished their initial training<sup>xxxvi</sup>. As well as concerns about GPs being able to recognise mental health problems there is also the issue of the relationship with the patient. One of the patients we interviewed felt uncomfortable raising her mental health needs with her GP<sup>xxxvii</sup> and others we talked to were dissatisfied with the help they received from their GP for various reasons<sup>xxxviii</sup>. At the LINK counselling event in October 2009 (the report from the event can be downloaded from LINK's website), one of the counsellors present said a GP at the surgery she worked had only referred one patient to the Counselling service in 6 years.

### **5.5.5 Patient Choice**

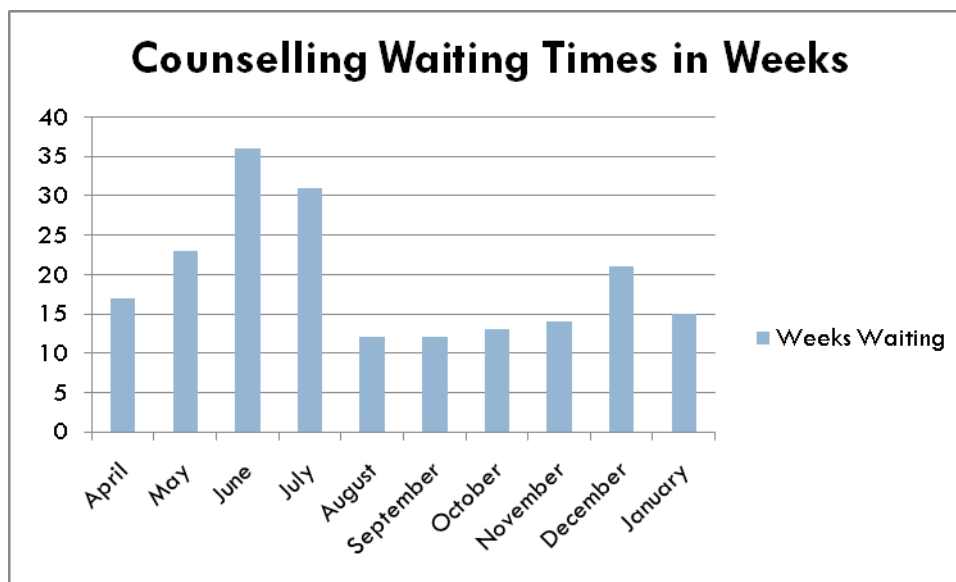
As the GP is the only official portal for receiving low level help, these issues meant the patients either received no help or help they felt was inappropriate. It should be noted here that other patients we interviewed praised their GPs and the commitment to the welfare of their patients amongst the GPs we contacted was obvious This does not take away the abiding concern that placing all the referral eggs in one basket as happens in North Tyneside will lead to poor patient outcomes that could be avoided by sharing referral responsibilities between different professionals or introducing self referral.

At present there does not appear to be a mechanism for patients to decide between seeing a counsellor or an IAPT worker. Any element of choice would lie with the GP and their willingness to present the patient with a choice and act upon it. North of Tyne PCT has not shared any plans to open up this service to self referral or tell GPs to give suitable patients a choice between counselling and IAPT.

Given the slim evidence base for the merits of one type of therapy perhaps the most pertinent referral issues here are not whether confusion exists over the type of service to refer to or if counselling is superior to CBT but rather ones of capacity, equality of access and plurality of access.

## **5.6 Waiting Lists**

The most recent waiting time for counselling North Tyneside is 15 weeks as of January 2010, with the longest time somebody has waited over the past year being 36 weeks.



As the service isn't centrally organised each surgery operates separate waiting lists with waiting times varying depending on the counselling resources available and the number of referrals made by GPs. This means if a counsellor has time off for sickness the waiting list will quickly lengthen. North of Tyne PCT have not been able to tell us whether these waiting times include both the Primary Care and Relate counsellors but I will work on the assumption that the figures do include both services. As the above demonstrates the length of the waiting list is consistently high while the length of time patients wait seems to change dramatically from month to month. It peaks at 36 weeks in June then falls to 12 weeks before rising again to 21 weeks in December.

The response of the IPT service to the high waiting lists was first to suggest there was a problem with the way the numbers were being recorded<sup>xxxix</sup> before concluding the length of time was due to a rapid escalation in the numbers of GPs referring patients to the counselling service<sup>xi</sup>. It has not been established why referrals have increased. One explanation is that the increase was due to GPs believing the introduction of IAPT would reduce demand for counselling and so led them to refer people who needed the service but who they had previously tried to manage themselves.

All GPs contacted during the research made plain their unhappiness with the length of time their patients were waiting to see a counsellor, with many of them saying the length of time should be 2 weeks. One of the counsellors reported that by the time some patients started their sessions they had difficulty remembering the issues that led them to seeking help. This was also reported by one of the patients we interviewed who said she found it difficult to recall the feelings that had upset her 5 months earlier.

## 5.7 Numbers Referred

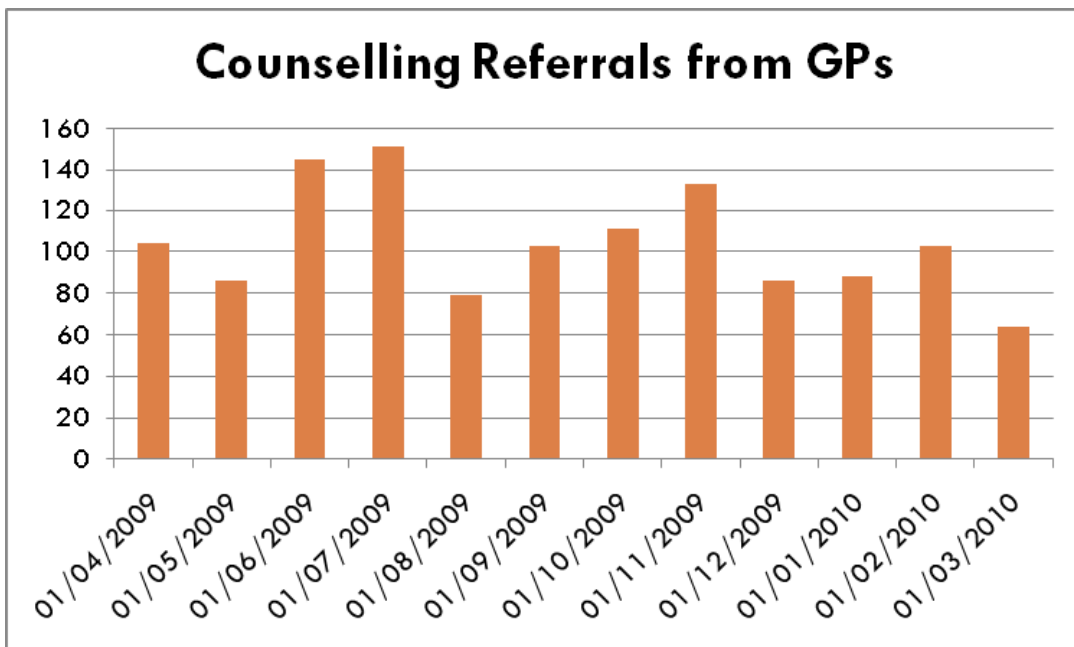
The number of people referred to the Counselling service from April 2008 to March 2009 was 226<sup>xii</sup>. There does appear to have been a significant increase in the number of referrals to this service with the numbers referred in the first quarter of the financial year of 2010 reaching 106 compared to 226 for the whole of the previous year. In early June, North of Tyne PCT gave us the numbers in the table below for referrals to the Primary Care Counselling Service. They show the number of referrals peaking at 145 a month in July before falling to less than half of that in March this year<sup>xiii</sup>. These figures adding up to 1261 represent a fivefold increase on the 226 number given for 2008/2009 by the Community Health Board.

We have asked the PCT to clarify these numbers and they have responded that, "This relates to an increase in demand in primary care and changes to the service level agreement activity."

## 5.8 Primary Care Counselling Outcomes

North of Tyne PCT has said they do not collect information on patient satisfaction for the counselling service. It is also not clear whether they collect information on recovery rates for the Primary Care Service as Relate Northumberland and Tyneside does do this. There is also the issue of confusion between data for the Primary Care Counselling service and for Relate. In our GP survey we asked GPs how successful the Primary Care Counselling Service had been (PCT and Relate Counsellors) and gave them 5 options, Poor, Below Expectations, Average, Fair and Very Successful. They replied:

- 2 - Average
- 5 - Fair
- 4 - Very Successful



This was a better response than the IAPT service had received from the same GPs with more positive scores and no 'Below

Expectations being chosen. In the patients we interviewed the response was similarly positive.

## **5.9 After Counselling**

At the end of the sessions patients who are still experiencing distress will be told to inform their G P of their continuing problems. It is then the G P's role to decide whether to refer the patient to another service. If their condition is deemed to be more serious they can be referred to a Primary Care psychologist or a service for more complex problems. If the situation is the same the G P could theoretically refer someone to the IAPT service as there is some overlap in the type of conditions they treat. However it is unclear whether it is common for G P's to refer someone to IAPT following referring them to another Counselling service. Or whether following referring to IAPT, patients are being referred to the Primary Care Counselling service. This would have the advantage to the patient of offering an alternative method of therapy if the CBT or Person centred therapy was unsuccessful. If the G P chooses to re-refer the patient to the Primary Care Counsellor they will have to return to the beginning of the waiting list.

## **5.10 Future of Counselling in North Tyneside**

Although the counselling service is widely respected and its waiting lists have reduced it might be facing some challenges in the next year. Any review of the counselling service to try to resolve the issues with inequality of access and lack of a central referring pool will coincide with the PCT looking to make cuts with mental health services. There is the concern that the PCT will be tempted to use these changes to introduce cuts to the counselling service. As IAPT has a high political profile and the contract with IAPT lasts another three years it is a possibility that the PCT will look for some of the £3.7 million pounds of cuts it is due to make in mental health from the counselling service. Other areas that have needed to make cuts such as Buckingham PCT have taken the path of ending their counselling services. This is a concern given the already high waiting lists for common mental health disorders and because the IAPT service only uses the CBT model of therapy. The Counselling services offer a choice of therapies and have a good reputation and play an important role in meeting the mental health needs of the area. It should be made clear the PCT have not announced any changes to the Counselling service apart from their intention to look at making access to the service more equal.

## **6. Relate**

### **6.1 Introduction**

#### **6.1.2 Background and Aims of Service**

Relate Northumberland and Tyneside (here after referred to as Relate) is funded by the Primary Care Trust to provide half of the generic counselling services in North Tyneside, the other half being provided by North Tyneside PCT's own Primary Care Counsellors. Both counselling services share similar approaches to treating low level mental health problems and have a similar referral system. Relate's contract is renewed on a yearly basis and it obliges them to provide 2661 counselling hours a year in various surgeries in the borough.

The service is only available to patients who use one of 17 particular surgeries in North Tyneside and are referred by GPs from these surgeries. Their service is aimed at people experiencing low level mental health problems, especially those that are connected to life events and relationships. Relate’s counsellors use a mixture of therapies called Integrative Counselling including psychodynamic and systemic counselling, although individual Counsellors may be able to use different therapies.

### **6.1.3 Type of Treatment**

Relate say their counsellors use an “Integrative way of working depending on the needs of the client”. This means they will use a combination of therapies, especially Psychodynamic and Systemic counselling to match the particular circumstances and personality of the patient. These types of therapies focus on the historical roots of problems and the role of relationships. From discussions with Relate counsellors it appears they have some flexibility in the approaches they can use and will use other therapies like CBT if needed.

The average face to face session lasts about an hour although this might be reduced to 40 minutes if there is an issue with waiting lists. A patient will usually see a counsellor for up to six to eight sessions, with some variability allowing for patients with complex issues to see the counsellor for longer periods although this appears to be rare.

The three main types of therapy they use are

- The psychodynamic approach to therapy that focuses on exploring and understanding unconscious drives and past events that impact on current situations.
- A behavioural approach where a person’s actions and responses are explored to elicit understanding and potential change.
- The systemic approach, where wider systems such as familial and cultural contexts are taken into account to enable understanding and change.<sup>xliii</sup>

Relate say all their counsellors are trained in the above therapies and receive regular ongoing training.

### **6.1.4 Appropriateness of Therapies**

As with the Primary Care Counselling service, Relate use counselling therapies that have less evidence than CBT<sup>xliiv</sup> although their counsellors can use CBT if they think it will be useful to the patient. In the previous sections on the IAPT service and the Primary Care Counselling Service we addressed the debate over the merits of counselling versus CBT. In the case of Relate their “Integrative” approach that seeks to use a combination of therapies including CBT according to individual circumstances appears very attractive. This policy of flexibility should be applauded and might go some way to explain the popularity of the service with patients and GPs. The downside is that this flexibility depends on the skills of the individual therapist whereas a CBT programme that uses a script and structured treatments might not be so dependent on the skills of any therapist.

## **6.2 Access to Relate**

### **6.2.1 Location**

In order to access the Relate service you must be a member of the following surgeries:

Bewicke, Forest Hall, Garden Park, Killingworth, Lane End, 45a Marine Avenue, 64 Marine Avenue, Monkseaton, Nelson, Park Parade, Portugal Place, Shiremoor, Wellspring, West Farm, White Swan, Whitley Road and Woodlands park.

It is not clear on what basis the PCT has decided to allocate counsellors to different surgeries but it appears to be the case that access to counselling is not distributed equally between the surgeries. The difference in waiting lists between different surgeries suggests it has not been distributed according to population size or need. For instance the waiting list for the Relate service in Shiremoor was eight months in February while the list in Killingworth was only six weeks. This picture of inequity of access was also alluded to in correspondence from the Integrated Psychological Therapies service:

*“Allocation has been on an historical allocation and so there is variance in relation to the number of sessions. This situation has arisen over the years as a result of GP fund holding and the locality priorities that came about under that regime.”*

### **6.2.2 Hours**

Relate have said that they currently only provide this contracted counselling service during normal working hours. They said this was because they had been commissioned by the PCT to provide a 9 to 5 weekday service. They would be happy they added, to provide an out of hours service if the PCT commissioned them to do so. They are able to provide an out of hours service for clients who can fund this themselves. Providing a service only during working hours means that anybody who works who is referred to the service would have to explain their situation with their employer and ask for the time off. Even if they were not uncomfortable asking, many people are resistant especially at a time of recession to take time off work. Unless the service opens up the hours of this service to evening and weekends it effectively deters a substantial number of people.

Sessions are often two weeks apart. This length of time can become an issue for clients when the counsellor has a holiday or is unwell. This means it can be common for there to be as long as a month between sessions. This happened to one of the people we interviewed who has had a month's interval because of a counsellor's holiday.

## **6.3 Referral**

### **6.3.1 Eligibility for Relate**

To be eligible for this service you must be on the GP list of one of 17 surgeries that are connected to the service. As with Primary Care Counselling Service the distribution of this service means the amount of counselling available differs from surgery to surgery. As the Relate contract came after the GP fund holding counsellors it would make more sense if the Relate service had been distributed by the PCT in a more logical manner according to

population or need. Unfortunately the Integrated Psychological Therapies Service was unable to tell us how the service had been structured.

If you are a member of a participating surgery then the next step is for your GP to decide to refer you. Referral depends almost completely on the skills and knowledge of the GP. As the GP directly refers patients to a counsellor working out of a room in his or her own practise with a minimum of involvement of third parties, access to the service sits completely with the GP.

### **6.3.2 Referral Criteria**

The referral criteria by which the GP refers is unclear.

The only reference to referral criteria we were given by the Integrated Psychological Therapies service was:

*“Counselling as a profession would deal with a range of conditions not necessarily depression. These could include bereavement reactions, poor self esteem, psychological and emotional distress”<sup>xlv</sup>*

### **GPs Perspective**

The GPs we talked to differed in their comprehension of the referral criteria. Of the eleven GPs who replied to our survey or interviews:

- 2 said they were very unclear about the referral criteria
- 1 left the question unanswered
- 2 seemed to use the same criteria for referring someone to either counselling or the IAPT service.
- 3 were confident in their referral decision making citing clinical and mentioned broad criteria such as patient need, waiting lists, patient choice and clinical need.
- 3 GPs specifically mentioned issues such as stressful life events, crisis situations or bereavement

### **Relate Workers' Perspective**

Of the 3 Relate workers we talked to 1 said there was confusion over the referral criteria, “Nobody knows the answer to that”. Another worker said most referrals were appropriate but she would find it useful to have more information regarding the referral criteria. She also said, “The majority of referrals I receive are for anxiety/depression, frequently with a relationship issue either specifically mentioned in the referral letter or emerging initial consultation so are certainly appropriate”. The other worker said that at the practise he worked at all the potential referrals were sent to him by the GP and he would decide if the referral was appropriate or whether it should be sent to the IAPT service or back to the GP.

As the Relate service has been working alongside GPs in their surgeries for a number of years, its likely GPs have come to an understanding of which type of patient or condition would be suitable. It is possible that locum GPs, new counsellors or confusions over the referral criteria of the IAPT service will produce inappropriate referrals. One Relate worker commented, "It is sometimes difficult to tell prior to the initial assessment interview which is the most appropriate mental health practitioners to refer to."

### **6.3.3 Self Referral**

As this service can only be accessed by a referral from a GP at a participating surgery patients are dependent on their GP. As has been discussed in the previous IAPT and Primary Care Counselling sections the absence of self referral reduces the ability of some people to use the service. Not only are people whose surgeries have little or no access to access to Relate affected. It also means people who for whatever reason find it difficult to their GP are denied the service. One of the people we interviewed gave up asking for help from an unsympathetic GP and went to a private counsellor instead.

### **6.3.4 Numbers of People Referred**

Relate report that in the year April 2008 to April 2009 they saw 550 people with 550 initial consultations and 1750 ongoing appointments. This adds up to 2300 contacts with patients in that year. In that year they were able to provide a service of 2661 counselling hours with the difference probably accounted for by DNA's and staff sickness.

## **6.4 Waiting Lists**

The period of time somebody has to wait for the service is very mixed with considerable differences between surgeries. As of January 2010 the waiting list for Shiremoor surgery was 8 months but at the White Swan Centre surgery in Killingworth the waiting list was 4 to 6 weeks for an initial assessment. The average wait according to Relate is closer to 10 weeks. The most recent news of the waiting list is 20 weeks at the Forest Hall surgery. Both Relate and GPs we talked to said that priority cases can be seen earlier but this is still within the context of the constraints of individual surgeries with potentially long waiting lists.

The previous table in section 5.7 is from North Tyneside PCT waiting list data for the combined Primary Care Counselling Service/Relate service. In the table you will notice these joint figures underestimate the waiting lists at the individual surgeries Relate works out of.

### **6.4.1 Reasons for Waiting List**

#### **General Problems**

The reasons behind the length of the waiting lists are identical to that of the Primary Care Counselling service with GPs increasing the numbers of referrals to the service over the last year. According to the IPT service referrals from GPs have increased due to greater patient demand and difficulties with other mental health services.

However the impact of current economic climate and the consequent impact on peoples' mental health results in greater number of referrals. Additionally problems with primary care accessing secondary services are resulting in greater use of primary care services<sup>xlvi</sup>.

Another contributory reason is likely to be the expectations by GPs that the new IAPT service would release additional capacity for the counselling service. As referenced in the IAPT section, GPs appear to have thought the introduction of the IAPT service would create more support for low level cases than was actually the case.

## **Local Surgery Issues**

These problems have been exacerbated by the service being based in individual practices leading to very high waiting lists in overburdened surgeries like Shiremoor. As the service is not distributed strictly according to population size or need, some surgeries have more capacity than others. Depending on one or two counsellors in a surgery for a service can lead to very high waiting lists when a worker is off sick and the whole service can grind to a halt. Any replacement counsellor would have to clear the backlog that has arisen. Unless this is reformed these inequalities in waiting times for the service will continue. A more centralised way of working would allow the waiting list to be organised on more equitable principles. It would also enable people who are waiting to be assessed to be immediately passed on to another worker and any backlogs to be shared.

## **6.5 Outcomes**

In line with the other low level mental health services in North Tyneside there are gaps in how this service records its own outcomes on patients. Although it does use a system called CORE that uses a questionnaire on a patient before and after treatment it does not collate them but sends them elsewhere. Despite repeated requests Relate were unable to pass this information on. One individual counsellor was able to pass on the averaged out result of his work with clients, they benefitted from an improvement in their mental health as measured by the CORE questionnaire of 45.1% at the end of their treatment compared to their score before they had received treatment.

## **6.6 Patient Perspective**

Of the patients we interviewed only 2 were able to identify themselves as having used the Relate service. The feedback on Relate we received was very positive with both said saying they had benefitted from seeing their counsellor. The patient whose sessions have now ended was the most complimentary she described her counselling sessions as excellent and said she would recommend it to her friends.

## **6.7 GP Perspective**

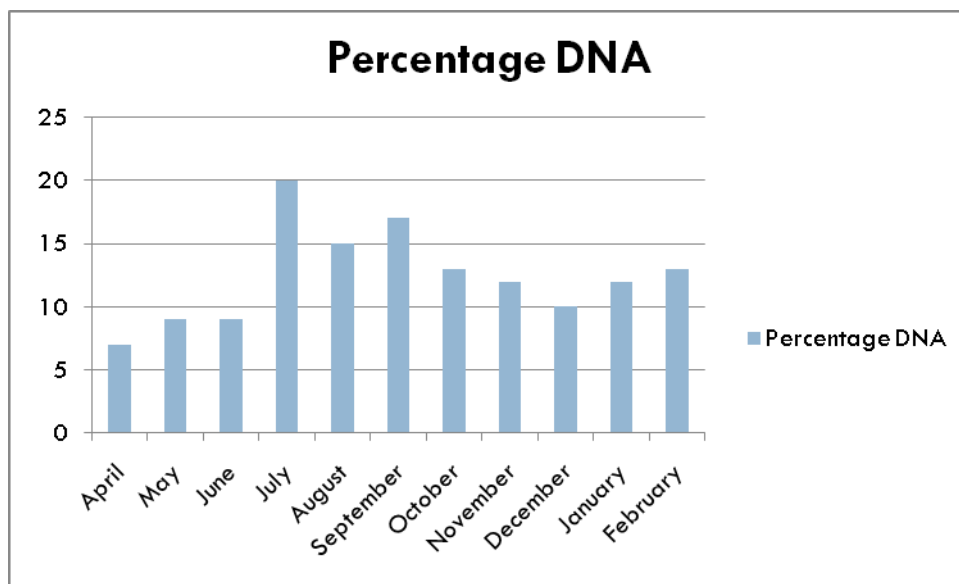
We asked the GPs we surveyed what their overall impression was of the joint Primary Care Counselling/Relate service. We gave them five choices: poor, below expectations, average, fair and very successful. They answered:

- 2 - average
- 5 - fair
- 4 - very successful

This was a stronger score than for the IAPT service by the same GPs which was one blank, four below expectations, two average, two fair and two very successful. Comments on the joint counselling service by the GPs were also favourable with GPs making broad remarks such as “works very well” and “excellent”. These were accompanied by comments about the waiting times and patients not attending appointments which seemed to exercise the GPs, “lots of wasted appointments though”, “Waiting lists simply too long! – puts a lot of patients off even considering as a viable option” and “Long waiting times sometimes defeat the object as symptoms resolved by the time patient is seen and result in further DNA and blocking of system.”

### 6.8 Do Not Attends

One way to measure a service is to record the number of appointments that are wasted due to patients not turning up. Here are the PCT’s numbers for the joint counselling service in graph form:



The number of people not attending the joint counselling service is consistently high with one in five appointments in July being wasted. Normally high DNA rates are an indication of long waiting lists as patients move and change address or their condition changes<sup>xlvii</sup>. One of the patients we talked to said he had almost not gone to his first appointment because of the length of time since he had originally seen his GP. He said as he was feeling better he was finding it difficult to remember the difficulties he had been experiencing<sup>xlviii</sup>.

North Tyneside PCT has responded that 'Do Not Attend' rates "are in line with national averages, which is 15%. DNA rates can be influenced by a number of issues including client compliance."

## **6.9 Future of Relate Service**

Relate received a positive response from patients and GPs and was open and helpful in providing information about its work. It's therefore concerning that Relate is likely to face a number of challenges in the future. Like the Primary Care Counselling service, Relate faces an examination of its service at a time of financial scarcity. The PCT has said it intends to look at the allocation and equitable spread of counselling resources<sup>xlix</sup>. This examination is welcome given the issues that have been raised about the inequitable provision of counselling services and the very high waiting lists in some surgeries. There is a worry that any discussion over the provision of the counselling service coincides with the North of Tyne PCT's plan to cut mental health services by £3.7 million pounds<sup>l</sup>. As the Relate service exists on a yearly contract it could be vulnerable to calls for the service to be "reconfigured". With the demand for counselling increasing as the growth in the waiting lists demonstrates any cuts in overall provision would lead to more issues with waiting lists.

## **7. Other Preventative or Low Level Mental Health Resources**

The Primary Care Trust dominates the funding and commissioning of low level mental health services in North Tyneside. Of the services mentioned in this section only those provided by North Tyneside Council and Moving Upstream receive no funding from North of Tyne PCT. There are a small number of choices for people with common mental health problems outside of mainstream NHS provision. With the closure of MIND there is now no alternative provider of generic counselling services to the PCT/Relate service. Despite this there are examples of innovative projects such as the Taking Part Workshops and the Art Studio that help people through their creativity. The 4 Community Health Development Healthy Living Centres are examples of help for people's mental health by improving their physical health.

### **7.1 MIND**

Until April this year MIND provided a counselling service and hosted mental health support groups. The service was based in North Shields and employed a counsellor who would help people with common mental health problems such as mild or moderate depression and anxiety. Referrals could be made by GPs, health professionals or self referral. In its last year 102 people had been helped by its counselling service that offered a mixture of counselling therapies depending on the particular needs of the person needing help. Earlier this year there were difficulties between the service and North of Tyne PCT who funded the project. Apparently these were resolved but too late to stop the services' closure.

As well as counselling the service also hosted a women's group, a men's group, an art group and advice and information. These groups were open to people with common mental health problems.

## **7.2 North Tyneside Council provision of low level services**

The Council funds two mental health services, which are open to people with common mental health problems. Most mental health services have strict eligibility criteria that often restrict access by people with more moderate conditions so this openness is to be welcomed.

## **7.3 Margaret Road Fellowship**

The Council help fund this group who meet in Whitley Bay 3 times a week between 10am and 3 pm. It provides support and friendship to people experiencing mental health problems as well as help people access other groups and agencies dealing with mental health. It's open to people with common mental health problems such as depression, anxiety and isolation. It accepts self referrals and referrals from health professionals.

## **7.4 North Tyneside Art Studio**

The Art Studio uses art and creativity to help people with a number of different mental health problems. Based in North Shields they provide studio space, resources and advice to help people develop their creative abilities, build confidence and self esteem. They put on exhibitions and can help people to progress to further education in this field. The service is open to people with less severe mental health problems. A third of the 75 people registered with the service have common mental health problems according to a member of staff. The service is self referral but this has to be ratified by a GP to establish the person does have a mental health problem.

## **7.5 Council's Internal Counselling Service**

North Tyneside council also uses an Organisational counselling company called Paradigm Campbell Associates to provide counselling services to its workers. According to the 2009 Mental Health Promotion Plan this comes to 150 thousand pounds a year over 3 years. Given the size of the council as an employer this service represents a major provider of low level mental health services in North Tyneside.

## **7.6 North Tyneside PCT - Community Health Development Healthy Living Centres**

North of Tyne PCT have created 4 healthy living centres in Dudley, Battle Hill, Meadowell and Moor *Park* that provide gyms, health instructors and health training to people who are referred by their GPs. One of the ideas behind this service is that improved physical health can improve a person's mental health. This fits in with the NICE guidance on Depression. It provides an additional form of treatment that a GP can offer a patient with common mental health problems. Once referred it takes 2 to 3 weeks before the first induction that leads to a 12 week course.

## **7.7 Taking Part Workshops**

People in North Tyneside who are suffering from mild or moderate anxiety, stress or depression can access Taking Part's performing arts workshops and experience creative activities such as drumming, dancing and drama.

It's possible to self refer and then take part in a 1 hour a week project for 10 weeks. It aims to help people feel better about themselves by participating in creative group activities. The project has been going for two years and has received funding from the lottery and North of Tyne PCT and is led by a local GP Ruth Evans. Recent workshops have included Salsa Classes and African Hand drumming.

This very innovative project is about as removed from the traditional face to face counselling session as one could imagine. Its focus on preventing poor mental health through creative activity is a positive development in North Tyneside. It has advertised on flyers distributed around the borough and has experimented using a blog to promote its service.

## **8. Promoting Good Mental Health in North Tyneside**

It is widely acknowledged that helping people before they become seriously unwell is important and that mental health promotion is a necessary component of helping people. We are therefore going to briefly examine the mental health promotion work being carried out in North Tyneside. By this term we mean information that aids understanding of mental health problems and ways of alleviating distress either through self help or knowledge of services that can help.

### **8.1 Moving Upstream**

There is a North Tyneside Mental Health Promotion Action Plan dated July 2009 that puts forward some timescales for promotional activity. The activities most closely connected to helping inform people at risk of common mental health problems are for the Moving Upstream project to deliver self help materials to GP surgeries in 2008 and 2009.

Moving Upstream is a voluntary project that tries to improve the mental health of people in North Tyneside by "connecting GP practices and patients with voluntary and community partners". It tries to promote early intervention and alternatives to medication by encouraging GPs to access the skills of voluntary organisations. They have tried to do this by writing and distributing a leaflet of the various agencies that can help someone with their mental health problems, alcohol issues and poor housing and employment.

They are currently working on updating their website with resources on how to help GPs support their patients with mental health problems in broader ways. They have also received funding to help train GPs in the use of self help material. Their organiser Dr Dave Tomson plans to offer free mental health training programmes to all GPs and Nurses in practice in North Tyneside.

## **8.2 M H Promotion by North of Tyne PCT and Newcastle and North Tyne Community Health**

North of Tyne PCT employs 1 worker to help with mental health promotion. His role also includes informing people of young people's health issues and alcohol education. In the last year the PCT has participated in the drafting of the mental health promotion activity plan, helped the World Mental Health Day activities and supported the Taking Part Workshop.

Unfortunately the Books on Prescription service appears to have ceased activity. This service placed self help materials in GP surgeries and local libraries and encouraged GPs to prescribe these books and resources to their patients who were experiencing low level mental health problems. The worker who ran this service has left her post and does not appear to have been replaced. The PCT does not have a role in producing or distributing self help material and this is the responsibility of individual surgeries to source this material.

## **8.3 Future work of IAPT**

We asked the Integrated Psychology Service if they were going to be responsible for mental health promotion and they replied that their service was treatment focused and promotion was not their prime responsibility but that of the wider health system. Despite this statement the recent introduction by the low intensity IAPT service of a 3 week group course by on lifestyle and stress is a positive example of mental health promotion. This mental health education course was advertised in GP surgeries and was open to self referral. Hopefully the development of the low intensity IAPT service will increase mental health promotion and fill some of the existing gaps.

## **9. Case Studies**

Over the spring of 2010 we interviewed people who had used low level mental health services or had tried to access these services. These were semi structured interviews that asked people to describe their experience of the services they used and their opinions of the service and what improvements they felt could be made.

### **Case Study 1: Alison**

#### **Unable to communicate with her GP**

Alison is a middle aged woman with caring responsibilities for her Mother who has dementia. Towards the end of 2008 she found her life becoming very stressful and found it difficult to cope with her caring role as well as with stresses in other areas of her life. She felt that if she could talk to someone about the stress she was feeling it would help so she visited her GP.

She told him about her problems and that she wanted to be able to talk to someone about it. Her Doctor referred her to Relate in November 2008 and she was on a waiting list until February 2009. Alison was forced to cancel her first appointment because of the wintery conditions. She was informed by the surgery that another appointment would be arranged. Months went by and she didn't hear any news about a subsequent appointment.

She has seen her GP on 3 subsequent occasions and hasn't raised the issue of the appointment to see a counsellor. The subject was not raised by her GP either. When I asked why she had not talked to her GP she said she didn't want to fight for another appointment. The times she had seen the Doctor were when she was accompanying family members who need assistance for physical problems. She said she was also deterred by what she felt was the attitude of her GP. He had told her his opinion about his adult patients,

*"Adults don't have much wrong with them, they're all malingerers."*

She said she has the impression that she is a nuisance to her GP and she thinks he is not interested in her. His comments have put her off from asking for further help with her emotional problems. She feels she has a poor relationship with her GP and doesn't want to ask more of him, that she doesn't have any power over him. She also doesn't want to spoil her children's relationship with the same GP.

Alison chose instead to see a private counsellor at her own expense. This was successful and she says she has benefited from seeing the counsellor. Over a year after the cancelled appointment there has still not been any contact from the surgery or Relate.

## **Case Study 2: David**

### **Referred for secondary services and saw a counsellor as a temporary measure**

Between January and April 2009 David was experiencing a combination of depression and anxiety and had asked his GP for help. His GP had referred him to the Student Counsellor who was doing a placement at his GP surgery. In April the student counsellor left and his support came to an end. His GP decided it would be best for David to refer him to Claremont House for psychotherapy. He was told to expect to wait 13 weeks.

Initially the GP tried to fill the gap while he waited for an appointment with Claremont House. As 3 months went by and the appointment with Claremont House failed to appear, David made enquiries to discover why he was waiting so long and found out the GP surgery had made a mistake with his referral and he hadn't actually been referred.

As a stop gap measure the GP referred him to another Counsellor attached to the surgery. He then went on to see this Counsellor for another 3 months while waiting for secondary services to contact him. When Claremont House did contact him in October he was reluctant to stop seeing the Counsellor as he felt he was in the middle of his treatment. He made the decision to continue to have sessions with the counsellor until December when he and the counsellor decided to finish the sessions. David then began seeing the psychotherapist at Claremont House in early 2010.

## **Case Study 3: Kath**

### **A straight forward success story**

Kath is an older person and in January 2010 was feeling down and went to her GP for help. She was experiencing difficulties looking after her husband who is seriously unwell. The GP decided to refer her to see a Counsellor from Relate. There was a 6 weeks waiting list until her first appointment. She saw the counsellor at her GP surgery for 5 sessions, each lasting 45 minutes.

Kath was very complimentary about the help she had received from Relate. She said it had been excellent and she would recommend it. She had not been informed of any other services and said both the location at her local GP surgery and its timing during the day was perfect for her.

## **Case Study 4: Helen**

### **Issues over choice of service**

Helen recounted that her problems seemed to begin in 2007 after the birth of her first child. She experienced anxiety to the extent that her friends persuaded her to go her GP. She saw her GP in 2008 who immediately offered her tablets and referred her to a Mental Health Nurse. She saw the Nurse in the middle of 2008 who saw her for an initial assessment. The nurse said she wasn't depressed and wouldn't benefit from seeing her. The Nurse said to ask her GP to see a counsellor if her problems recurred.

Her problems did recur and in June 2009 she visited her GP ostensibly because of a problem with ear ache. During the appointment with her GP she began discussing her emotional problems. The GP again offered her medication. Helen told the GP she didn't want to take tablets. She said she was surprised both the GPs she had seen had immediately offered her tablets and she had decided she didn't want to take tablets in case they made her unable to look after her children. He then suggested CBT therapy but told her it would take a while until she would be able to see someone. Then six weeks later she received a letter for an appointment.

At the first meeting she was surprised to discover it was a counsellor rather than a CBT worker. As she had heard about CBT and was looking forward to using this therapy she was disappointed. The counsellor wanted to talk about the past which she didn't. She wanted advice on coping here and now. She said she felt the counsellor wanted her to be emotional which she also wasn't comfortable with. The appointments were difficult to fit into her life of looking after two children and she wished she had more leeway or choice on the times of her appointments. At the fifth session she was told the counsellor was poorly and she took this opportunity to stop seeing the counsellor as she was told to ring back to re-arrange an appointment with him. She also didn't like how she felt she was given the responsibility for arranging the appointment. She thought the sessions had helped a little bit but were not what she wanted.

Helen is still feeling anxious. She hasn't asked her GP for more help and doesn't want to re-explain her problems to someone else. She says she is trying to sort out her problems

herself. On the matter of finding herself seeing a counsellor she said she would have liked to have been given a choice of a different type of therapist possibly in letter form telling her about the different options.

## **Case Study 5: Paula**

### **A five-month wait**

Paula went to her GP in mid November 2009. She was feeling in extreme distress because of a succession of life events that were overwhelming her; both parents were seriously unwell, she had being refused access to her son and had lost half of her income due to changes at work. She was also recovering from an operation at the start of the year when she successfully had a tumour removed.

Her GP referred her to Relate who gave her an assessment meeting in early December. She was told he wouldn't be able to be seen until April 2010. Paula was still waiting as of April 6 2010 for confirmation of date of Counselling sessions that were supposed to take place that. She had been thinking of going to see a private counsellor but couldn't afford one at the time. Given the length of time she spent waiting she had begun to feel more positive and questioning whether she still wanted to see the counsellor if the appointment arrived.

I spoke to Paula for a second time in early June and she said the letter asking her to begin her sessions with the counsellor came shortly after the April interview. She began seeing the counsellor in late April and has been told she will receive 6 sessions. She sees the counsellor every fortnight but is currently waiting a month to see her because the counsellor's holiday clashes with a session. She is finding it difficult to remember her original difficulties because of the 5 month wait but says she is benefitting from her appointments.

## **10. Findings**

Listed below are a summary of the findings we have gathered in the research of this report. They are organised by the main providers of low level mental health support and their future prospects. In summary:

### **Primary Care and Relate Counselling Services**

The Primary Care Counselling service and Relate service are well respected by patients and GPs alike but suffers from inequality of access. People's access to the service depends on their GPs historical use of the service with some patients having less access to this service. This situation appears to have existed for a number of years without it being resolved by the PCT. Equality of access according to need with a central referring pool would bring a quicker and more fair service.

The waiting list for the service is currently 15 weeks but each practise has a separate waiting list with varying times some as high as 8 months. The waiting list has improved over the last year when it stood at 36 weeks in June 2009. The PCT says this lengthy waiting list was due to a doubling in the number of referrals by GPs.

Both services were unable at the time of publication to produce detailed information showing the outcomes of their service on patients.

## **The Improving Access to Psychological Therapies Service**

The introduction of the new service has changed the overall provision of low level Mental Health services:

Positive developments include

- Significant increase in the capacity of low level mental health services in North Tyneside. The recruitment of 26 new workers to treat low level mental health problems
- The use of Cognitive Behavioural Therapy by these workers, a therapy with a body of medical evidence in its favour.
- Plans to use telephone, group and Computerised CBT that enable larger numbers of people to receive treatment
- Increase in choice for GPs who previously had only the choice of counsellors or medication as options.
- Employment of 2 dedicated employment workers to help people to stay in work or to move off benefits.

The introduction of the IAPT service has encountered some difficulties especially with regards to planning and communication. Problems that have emerged are

- Lack of communication with GPs on how to correctly refer to the service, GPs were told there was going to be a new service and an increase in capacity without warning them of the constraints on the service in its first couple of years. This led to GPs referring people they had managed within practices for a long time and an increase in waiting lists.
- Large amounts of the service's time devoted to training instead of seeing patients.
- The waiting list for the Psychology service has increased dramatically (37 weeks) as psychologists' time is spent helping supervise and train the new workers.
- The waiting list of 30 weeks for the High Intensity Service and 9 weeks for the Low Intensity Service means patients are waiting as long as they did before the introduction of the service. The figure of a 34 weeks wait for CBT last Autumn was one of the longest in the country in a national survey. Individual GPs are reporting waiting lists as long as 1 year.
- Inability to resolve their data systems so they have been unable to share waiting list times with GPs which has exacerbated the problem. Other areas have successfully introduced these data systems.

- GPs choosing to refer to one part of the IAPT service so that the High Intensity team are over-referred while the low intensity team do not appear to be seeing as many people as low intensity teams in other areas. In January 255 people were waiting to see the High IAPT service compared to 39 people waiting to see the low IAPT service.
- Slowness in recruiting, despite the service opening its doors in September 2008 it didn't recruit its full complement of low intensity workers until November 2009.
- Delays in introducing the innovative aspects of IAPT that are intended to treat large numbers such as telephone therapy and Computerised CBT. The service began its first Group therapy in February.
- Lack of Self-Referral. Other areas such as Northumberland have introduced self referral for its IAPT service and the difficulties some people have with their GPs suggests self referral would be a positive move.

The hope is that with the new trainees shortly becoming fully operational the capacity of the service will increase and bring down the waiting list. The Integrated Psychological Therapies Service has also said it will do more to inform GPs of the referral criteria and referral rates for this service.

## **Other Low Level Mental Health Services**

With regards to the rest of the low level and preventative services available in the area, there are major shortfalls with the MIND service closing in April. Only a handful of organizations provide low level mental services in North Tyneside and beyond the NHS, Relate (also NHS funded) and the Council there is only the Taking Part Workshops.

## **Mental Health Promotion**

This is another area that would benefit from more support. Aside from the good work done by Moving Upstream the main Mental Health Promotion work aimed at people with low level mental health problems is World Mental Health Day. Currently North of Tyne PCT employs one worker to spend a third of his time on mental health promotion. The introduction of IAPT with its group work and Computerised CBT could widen the number of people who are educated about good mental health. The revival of the book on prescription scheme would also be a positive development.

## **Future of Common Mental Health Services**

The future of low level mental health services in North Tyneside holds a mixture of possibilities and worrying challenges. There are positive developments such as the IAPT trainees becoming fully trained and plans to re-organise the Counselling services so they are fairer to access. This is balanced by the concern that the PCT will be tempted to use these changes to introduce cuts to the counselling service. As IAPT has a high political profile and the contract with IAPT lasts another three years it is a possibility that the PCT will look for some of the £3.7 million pounds of cuts it is due to make in mental health from the counselling services. Other areas that have needed to make cuts such as Buckingham

PCT have taken the path of ending their counselling services. This is a concern given the already high waiting lists for common mental health problems and because the IAPT service only uses the CBT model of therapy.

The Counselling services offer a choice of therapies and have a good reputation and play an important role in meeting the mental health needs of the area. It should be made clear the PCT has not announced any changes to the Counselling service apart from their intention to look at making access to the service more equal.

## **11. Recommendations**

Based on the findings of this report the following recommendations should be considered as future actions to improve services and respond to the concerns of patients we talked to.

### **Introduce more GP training on referring and improve communications between the IPT Service and GPs**

The Primary Care Trust should begin training of the GPs in the area on how best to refer their patients with common mental health problems. This should include drawing up clear referral criteria for the different services and informing GPs of the merits of the low intensity service. With this increased knowledge GPs would be more likely to refer to the low intensity service and so reduce the waiting list for the High Intensity Service.

Regular sharing of information about waiting lists and referral rates by the Integrated Psychological Therapies Service with GPs and Counsellors would aid patients needing help. It would help GPs to be aware of which services were under the most pressure and so allow them to make alternative decisions for their patients. A monthly email from the service to all GPs telling them the latest waiting lists and any other relevant information would be a cheap and effective solution.

Efforts also have to be made to increase the contacts between GPs and IAPT workers so that GPs have more knowledge of how the service could benefit their patients and there is more feedback on how patients are responding to treatment.

### **Increase Patient Choice**

The patients we interviewed raised similar issues of how decision making was in the hands of their GPs. Some had experienced difficulties talking about mental health with their Doctor or of their GP choosing what type of therapy they should use. Both issues could be remedied if the IAPT service and the Counselling services were opened up to self referral. Other areas have introduced self referral and appear to be thriving. If self referrals were managed by a telephone assessment it is unlikely either service would be overwhelmed. To accommodate choice GPs should be advised to discuss alternative treatments with patients where it is appropriate and a patient could benefit from either low intensity IAPT or counselling.

At present all IAPT and counselling appointments take place during work hours and the IPT service should commit to introducing evening and weekend sessions. It goes against the whole rationale of the new IAPT service that to help someone stay in employment they have to take time off work. There are cost implications to increasing the hours of the service but they are justified in increasing access to people who would otherwise be deterred from going to appointments.

### **Retain a choice of therapies for patients**

Given the debate about the merits of different types of therapies and NICE's increasing openness to therapies in addition to CBT there is a strong case for retaining the use of counselling therapies in North Tyneside. The present use of a mixture of therapies by

Relate counsellors depending on circumstances is a non-dogmatic and flexible approach. There should be a commitment to supporting counselling as well as CBT by the PCT and a willingness to consider the use of different therapies by IAPT.

## **Re-distribution of Counselling Services**

The unequal distribution of counselling services across North Tyneside must be resolved. A new way of delivering counselling services according to need should be developed. Counsellors could still work out of GP surgeries but referrals would go through a central referral pool where they would be evaluated. This might mean patients having to travel further to see a counsellor but this would be balanced by removing the inadequacies of the present situation. It would mean an end to the situation where the GP practise you belong to determines whether you wait 4 weeks or 8 months to see a counsellor. It would also allow more flexibility over absences and holidays and help reduce the waiting list. The new system could conceivably still maintain the joint Primary Care Counselling and Relate services with a division between the roles of evaluating referrals and allocating counsellors and that of line managing workers.

## **Replacement for MIND**

The closure of MIND means there is a reduction in the overall counselling services available. The PCT should begin developing a new replacement service to deliver counselling services. One possibility would be to replicate the successful use of student counsellors by mental health charities in other parts of the country. In this model a coordinator organises the service and supervises the student counsellors on placement at the project. This would allow a modestly financed service hosted most likely by a Mental Health Charity to help a number of people with low level mental health problems.

## **Improved Recording of Outcomes**

A recurring issue in the writing of this report was the difficulty receiving information on the outcomes of the IAPT and Primary Care Counselling Service. This was partly due to the problems the IAPT service had using their old computer system to record their new service. Increased efforts should be made to record standard data such as waiting lists, numbers referred and numbers recovered for both of these services. Patient satisfaction surveys should be used and recorded so it is possible to have some insight into the work of these services and support public accountability.

## **Rolling out of the innovative IAPT treatments**

The IAPT Service is beginning to roll out innovative treatments such as Group sessions and Telephone therapy and efforts should be made to introduce Computerised CBT as quickly as possible. These new treatments should be offered to all those who might benefit from them and so help them and reduce the existing waiting lists. People should be given choices as to whether they would like to use these services and assured they can choose more traditional face to face sessions instead.

## **Support Mental Health Promotion**

More support is needed to educate and inform the public about good mental health and the services that are available to them. At present only a small amount of resources are going into this area which should be a priority for its potential to prevent people from becoming ill and needing a great deal of help.

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- <sup>xiiii</sup> Relate Northumberland and Tyneside (nd). *relate-nt.org.uk* [online]. [Accessed May 2010]. Available from: <[http://relate-nt.org.uk/department/training\\_and\\_approaches/](http://relate-nt.org.uk/department/training_and_approaches/)>
- <sup>xlv</sup> National Institute for Clinical Excellence (2010). Depression: The NICE Guideline on the Treatment and Management of depression in Adults I Updated Edition : p265 [Accessed August 2010] Available from: <http://www.nice.org.uk/nicemedia/live/12329/45896/45896.pdf>
- <sup>xlv</sup> North of Tyne PCT (2010) *Qs to Paul Cusack from Keith Metcalf*. Email to: Johanne Mears. 20/04/2010 [20/04/2010.] Personal communication
- <sup>xlvi</sup> Newcastle and North Tyneside community services board (2010). *Newcastle and North Tyneside community services February 2010 Contract Report p 15,16* [internet]. [Accessed May 2010]. Available from: <<http://www.newcastlepct.nhs.uk/about-us/the-board/provider-board-agenda-and-minutes/2-february-2010/contract-report-month-8/enc4 2.2 10 pdf.pdf>>
- <sup>xlvii</sup> NHS Improvement (2008). *Outpatients: Did Not Attend (DNA) Rates* [online]. [Accessed 07/06/2010]. Available from: <<http://www.improvement.nhs.uk/heart/sustainability/outpatients/dna.html>>
- <sup>xlviii</sup> Case Study, 4,5 (2010). *Interview with Keith Metcalf*. March 2010. North Tyneside
- <sup>xlix</sup> Newcastle and North Tyneside community services board (2010). *Newcastle and North Tyneside community services February 2010 Contract Report p 16* [internet]. [Accessed May 2010]. Available from: <<http://www.newcastlepct.nhs.uk/about-us/the-board/provider-board-agenda-and-minutes/2-february-2010/contract-report-month-8/enc4 2.2 10 pdf.pdf>> and correspondence with IPT service, "Re-allocation of resources needs to be based on equity and discussion has taken place about achieving this. However it is a sensitive issue which requires the active involvement of GPs and other partners including commissioners. There are a number of possible models but each would require a re-balancing of resources across North Tyneside". North of Tyne PCT *Qs to Paul Cusack from Keith Metcalf*. Email to: Johanne Mears. 20/04/2010 [20/04/2010.] Personal communication
- <sup>l</sup> North East Commissioning Team for Mental Health (2010). *In: Community Based Mental Health Review handout at public meeting, 26/04/2010, County Durham Community Health Service, The Greenhouse, Stanley, County Durham,*



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