



## Executive Summary

From the consultation document – ‘The Wellbeing service helps people with mild to moderate depression or anxieties. The aim is to help them return to meaningful activity or employment.... Now we believe it is right to review this service. We want to know whether it is providing the right help to the right people – and how it can be improved further.’ [www.norwichccg.nhs.uk](http://www.norwichccg.nhs.uk)

This NHS public consultation was conducted between 4<sup>th</sup> November 2013 and 31<sup>st</sup> January 2014. Feedback was provided to a survey and further feedback was collected from public meetings and written submissions. This consultation received 287 responses, including all forms of response. All data has been entered for analysis and formed the basis for developing this report.

This report addresses the three subjects of this consultation; the service, patient experience and the future.

### The Service - Findings

- Most people knew of the IAPT service by being referred into it.
- The time taken for the service to make contact after referral ranged from less than a week to over five weeks. There were also cases where no response was made. The mean time frame was 3.5 weeks.
- >41% said this was not a reasonable time frame, >32% said that it was and >26% remained undecided.
- Most of the related comments raised concerns around the impact of slow response.

### Service Quality – Findings

- The service, therapies, staff, process, information, and venues all were regarded as satisfactory or working well.
- The service was regarded as being straightforward, useful and prompt.
- Therapies, including CBT, telephone, workshops and face to face counselling were regarded as good, helpful and useful.
- Staff were regarded highly and considered to be professional.
- The process for accessing the service, the triage and appointments were considered positive, suitable and timely.
- Information provided to service users was helpful and impressive.
- Venues were regarded as suitable.
- The process, therapies, service, staff, communication and venues were also criticised as being unsatisfactory or not working well.
- The process for gaining support or treatment was regarded as difficult and was taking too long. The ‘stepped care’ model was considered unsuitable. Delays in treatment caused further problems. Too few therapy sessions were provided. The service seemed disjointed. The administration was flawed. Some referrals were inappropriate for this service. Appointments were not made or kept. Secondary care patients were excluded.
- Therapies were criticised. Telephone assessments were regarded as unsatisfactory. Telephone contact in general was regarded as difficult. Telephone therapy was not helpful. Group sessions were unsuitable for

service users with particular problems. One to one interventions were not available. Courses were not suitable and were not delivered very well.

- The service was not helpful and for some provided a negative experience. The waiting times were too long. Staff seemed under qualified, untrained and displayed poor service.
- Communication with and from the service was poor. The service was not explained to users. Phone calls were not received or made. Messages were not responded to. The service did not communicate with GP's.
- Venues were not suitable.
- Further comments were made regarding the need for the service, the need for quality assurance of the service, the structure, third sector involvement, publicity, staff and therapies.

### The Future – Findings

- Self referral and GP referral were the preferred methods for accessing the service.
- GP surgeries or primary care centres, specialist therapy centres and community centres were the preferred venues for service delivery.
- All of the proposed time frames were suggested as time when people would want to access the service, which included out of hour provision.
- The service could be made accessible by providing the service in a timely manner, at a range of physically accessible locations in the community, at suitable times with service users being able to self refer using a variety of access points. The service should be offered more broadly to a wider range of users, delivered by competent staff, be clearly signposted and integrated with other services. Communication needs to be reliable, straight forward and clear.
- Older people can gain access by having outreach or home visit services provided, through social networking opportunities. Third sector involvement is recommended. Telephone assessment or consultation should be avoided. Information should be provided and specific issues addressed.
- New mothers can gain access through social networking, primary care providers and other services. Venues offering child care and outreach services are suggested. Specific issues should be addressed.
- Offenders can gain access to the service through an outreach service, having attendance mandatory, connecting with other services, rehabilitation and probation programmes and secure venues.
- Carers can gain access to the service through local support groups, personal health assessments, access to training and support and through primary care.
- Children and young people can gain access to the service through schools and school based staff, related children's services, specifically targeted information, primary care and through social activities.
- People with disabilities can access the service through consideration of physical access needs, transportation, joint working with local charities, specific support depending on the disability, counselling and training, advocacy, and primary care.
- Further comments were provided regarding the service, the process, allied services, therapies, staff, information and venues.
- The service was regarded as being of a different standard in Suffolk and Waveney as compared with Norfolk. The introduction of the service was

regarded as a positive step. Mental health provision is regarded as inadequate overall.

- The process can be enhanced by raising awareness of the service, taking the service into the community, speeding up assessment and treatments, collaborating with other providers and providing funding.
- Allied services and other providers were interested in providing services, a wider range of services should be offered, GP's were highly valued.
- Therapies including counselling and courses could be extended.
- Staff shortage was of concern.
- Information and advertising could be enhanced.
- Venues, including rural access should be considered.

#### Family and Friends test findings

- >47% were likely or extremely likely to recommend this service. >27% were unlikely or extremely unlikely to recommend this service. >25% were neither likely nor unlikely or didn't know if they would recommend this service.

#### Meeting Notes – Findings

- General concern was raised regarding the suitability of telephone referral and services. Groups particularly concerned included BME minorities and sexual abuse survivors.
- Face to face therapies are preferred.
- The IAPT were not meeting the demands placed on the service.
- Access concerns were raised – in particular concerning BME service users, language and provision of interpreters.
- Waiting times for service are considered to be too long.
- The service needs to be quality assured.
- Awareness of the service has improved.
- Integration with other services is recommended.

#### Consultation – Findings

- Feedback should be carefully considered and listened to.
- The questions were too narrow.
- The questions were clear and user friendly.
- The survey was oriented towards the service user.
- Secondary care and third sector involvement in the consultation was suggested.
- Consultation advertising concerns.
- More clarity is needed regarding the service and how this feedback is going to be used.

Dr Steven Wilkinson  
Consulting the Community  
February 2014

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## 1 Background

From the consultation document – *‘The Wellbeing service helps people with mild to moderate depression or anxieties. The aim is to help them return to meaningful activity or employment.... Now we believe it is right to review this service. We want to know whether it is providing the right help to the right people – and how it can be improved further.’* [www.norwichccg.nhs.uk](http://www.norwichccg.nhs.uk)

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## 2 Process and Outputs

A database of all feedback is developed. A First Stage Analysis focuses on coding all responses. The Second Stage Analysis provides a summary of coded responses organised into themes. The first and second stage analysis documents are working documents and may contain personal information. Therefore, these are not available to the public except on request. This final report has been drafted using the analysis and can be made available to the public as all personal or identifiable information has been removed.

In the survey respondents were asked two types of question (‘rating’ and ‘open response’). These responses have been presented in this report in the order they appear in the questionnaire. Meeting notes have been included in the form they were provided.

This report has been written in the first person – that is, in the voice of the respondent, using as far as possible the words and phrases of respondents. Text in *italics* is quoted directly from the feedback.

The themes with the most open-ended responses are discussed first followed by the next in descending order. This provides a relative indication of the weighting of each response. Every attempt has been made to report the feedback provided for each of the respective questions, therefore there is some repetition.

None of the views expressed are those of the author or any organisation for whom the author may work.

### 3 The Service

#### Summary

Most people knew of the IAPT service by being referred into it. Service users sought help from their GP or health care professional and were either referred or provided with information so that they could self-refer. Other sources of information included professional associations and networks, the internet, advertising or through word of mouth. Others did not know of the existence of the service until being notified of this consultation.

The time taken for the service to make contact after referral ranged from less than a week to over five weeks. There were also cases where no response was made. The mean time frame was 3.5 weeks.

>41% said this was not a reasonable time frame, >32% said that it was and >26% remained undecided. The waiting time is unacceptably long for some service users. Others have not received any response. While some service users have found contacting the service difficult in the first place, delays and lack of response have added to health problems. While some found the waiting times acceptable, others had not received any response at all.

#### 3.1 How did you hear about the IAPT (Wellbeing Service)?

##### 3.1.1 Response Table 1

Answer Options	Response Percent	Response Count
I was referred to this service by a health professional	47.7%	92
Through the media	6.2%	12
Via the internet	8.3%	16
Word of mouth	13.0%	25
Other	30.1%	58
Please comment on any of the above		82
<b>answered question</b>		<b>193</b>

##### 3.1.2 Other

*I sought help from my GP - following periods of depression. After I had told him I did not want to go back onto anti-depressants as they made my anxiety attacks more frequent. GP referred me; organised counselling – or; told me, advised, gave me the details, gave me the phone number - and then I self referred or used the telephone service.*

*I was referred to the service by a health professional on the first occasion, but used self-referral on the second occasion. I have previously received treatment via mental health outreach services. Spent 10 days or so in Laurel Ward last year. I am member of local service users forum. A relative, family member, son, partner, was referred to the service. I heard comments from users, while supporting a service user to get support from MH services. I was advised to self refer myself. I have made the contact personally. Requesting On behalf of a service user.*

*Through professional networks. Involved in many organisations such as PPI Forum for mental health, Norfolk LINK, the NSF Trust, Healthwatch. PPG, CCG, Norfolk OCD support, Piece of mind. Through my job, email from Practice manager. Through contact with other organisations and while helping a client at Red Cross Refugee Service. Attending a carers working party, events. Counsellor offering counselling via the One to One Project. We refer women to the service who have mental health issues. Wellbeing was mentioned at one of the meetings. Through meetings I attended; meeting of SNCCG. I have attended a well being group to promote our service and hear about the service well being provides. Knew of it from meetings about its development. Sought them out at a public exhibition.*

*Through work, I work in it, I am an employee, a professional, I work in the trust. I have referred patients into the Well Being service. I work at West Norfolk CCG so was aware of the IAPT service through my work colleagues. We deliver counselling and older persons psychological well being practitioner work. We are a partner in Suffolk Wellbeing service. We have referred service users to the Wellbeing. Wife works there. When the Wellbeing Service was first set up they came into the jobcentre to introduce themselves and explain what they could offer and we had a contact service set up so we could directly refer customers to them for further help. As a health trainer I signpost clients to relevant services. The Wellbeing Service has also referred service users to our service.*

*I was given a self referral leaflet by my GP service. Advert in EDP/Evening News, Council literature, email from Your Voice. Received with local paper.*

*I didn't know it existed until I read your email about this survey, consultation. I have never been informed; never heard of it before; hadn't heard of it.*

*I was put on a waiting list for this service, shortly afterwards my mental state became critical , I called the wellbeing services and was told that basically this service does not help every one, but had said I was in a critical state of mind and was in need of urgent help, they simply said call your GP for help.*

*Through my degree in psychology. Whilst training for counselling diploma.*

*N&S MHT Website; Invited via the Your Voice website; trust intranet.*

## 3.2 How quickly were you contacted by the Wellbeing Service?

### 3.2.1 Response Table 2

Answer Options	Response Percent	Response Count
< 1 week	9.6%	15
1 - 2 weeks	17.2%	27
2 - 3 weeks	10.8%	17
3 - 4 weeks	10.2%	16
4 - 5 weeks	4.5%	7
> 5 weeks	13.4%	21

Was never contacted	34.4%	54
Comments:		66
<b>answered question</b>		<b>157</b>

### 3.2.2 Comments

*Initially I was contacted but then had a long wait until someone could call me to access me. I then had to wait a long time to see a link worker. These can take a long time, some of my customers have told me. I never bothered to as the waiting list was so long, quicker contact, response would have helped. I understand that it is now almost impossible to get in contact with the Wellbeing service. Have heard it takes a long time often to be contacted. I also supported a friend who took an overdose and was contacted by the Wellbeing service weeks after the event. GP's/Oncologist's referral, too long and had to be chased. I've only been waiting one week but I have sent two emails and not even received confirmation that they have been received. It often seems to take too long before patients are offered an assessment, however the waiting time from my previous experience had improved.*

*That was only contact to say they had my referral not the start of my treatment, we were not directed to the correct parts of the service initially. This was the call back for the service user to talk to a psychologist/adviser, for the initial phone call from a therapist/adviser.*

*The contact period is acceptable. The initial appointment was within 2 weeks. Contacted to be told that they have given patient a date. Very good to be contacted straight away. I phoned and they got back promptly, in timescale. It is reassuring most are contacted within a week. I was referred within a few days. They responded very quickly to my emails, I was very impressed by how quickly I was contacted by the service and how soon treatment was offered after that.*

*Sorry I can't fully remember exactly, it's the best guess. I am not aware how long it took to respond.*

## 3.3 Was this a reasonable waiting period?

### 3.3.1 Response Table 3

Answer Options	Response Percent	Response Count
Yes	33.1%	47
No	40.8%	58
Undecided	26.1%	37
Please Comment		55
<b>answered question</b>		<b>142</b>

### 3.3.2 Comments

*Not for the service user. I think this waiting time is quite long, unacceptable and needs improvement. it was too a long wait without receiving help – over one month, 5 months' wait is 5 months is too long when you feel like that. For someone with severe issues, mental health crisis, relapses, I think they should*

*be contacted much sooner, asap, especially if they are at risk of harming themselves - other people in that situation may not have been as lucky in having friends around to support them. My problem worsened while I was waiting - If I were more anxious it would have been unacceptable. I was told that the waiting period was due to high volume of referrals, so I could not say if this was reasonable or unreasonable.*

*It's been really hard for me to accept I need help and make the first step. I felt positive after visiting my GP but having heard nothing from the wellbeing service I feel rejected and let down. You wouldn't expect someone with a physical injury to wait over a month just for an initial assessment so why do mental health sufferers have to. And even once you've been assessed you have to wait a further month to even start any treatment. The initial contact was quite quick but there was a long wait time after that to be accessed over the phone. Once they have decided this could help them I think they would like some contact within a couple of days or at least a week. It should be straight away. Everything has taken a long time, even when we contacted the Crisis Team. I would have benefited from quicker access to the services offered. GP/Oncologist became impatient and made referral to clinical psychologist.*

*For me personally, waiting 1 to 2 weeks wasn't too bad, I was contacted quicker than I expected. It appears that referrals are being acted upon in a timely fashion. I wouldn't have liked it to be longer.*

*It's a disgrace actually - no one contact me at all. Not contacted even though I have sent a self referral by email today. Waste of time really no one bothered to follow up.*

### 3.4 The Service - Findings

- Most people knew of the IAPT service by being referred into it.
- The time taken for the service to make contact after referral ranged from less than a week to over five weeks. There were also cases where no response was made. The mean time frame was 3.5 weeks.
- >41% said this was not a reasonable time frame, >32% said that it was and >26% remained undecided.
- Most of the comments raised concerns around the impact of slow response.

## 4 Service Quality

### Summary

The service, therapies, staff, process, information, and venues all were regarded as satisfactory or working well. The service was regarded as being straightforward, useful and prompt. The wellbeing service has reached and helped some people and has acted as a useful signposting service. Contact was made quickly and promptly and provided clarity about what was going to happen. The assessment, was thorough and specially good was the benchmarking throughout the period.

Therapies, including CBT, telephone, workshops and face to face counselling were regarded as good, helpful and useful. And will hopefully make a significant difference for those who need support to retain their independence. The 1-1 system has worked very well and is preferred. Less telephone support & more 1-1 support for longer period of time is requested. The initial telephone consultation was excellent. The Mental Health First Aid training was extremely valuable. Stress Control Workshops were very helpful as were the self-esteem workshop. EDMR [Eye movement desensitization and reprocessing], was also effective. Group sessions where participation was voluntary was very useful – service users got a sense of a shared experience.

Staff were regarded highly and considered to be professional. They listened and were empathetic and understanding. The process for accessing the service, the triage and appointments were considered positive, suitable and timely. Being able to self-refer without going through a GP was helpful however it was also good to be referred. Weekly appointments with the same psychiatrist and the psychologist worked well. Things ran on time and they clearly stated what was going to happen. They wrote to inform the GP what is happening. They were able to plan meetings around service users schedules.

Information provided to service users was helpful and impressive. Venues were regarded as suitable.

The process, therapies, service, staff, communication and venues were also criticised as being unsatisfactory or not working well. The process for gaining support or treatment was regarded as difficult and was taking too long. The 'stepped care' model was considered unsuitable. Delays in treatment caused further problems. Too few therapy sessions were provided. The service seemed disjointed. The administration was flawed. Some referrals were inappropriate for this service. Appointments were not made or kept. Secondary care patients were excluded.

People suffering from depression need to speak to someone urgently. Waiting times were unacceptable (up to 10 months). No communication or alternative support available between referral being made & support being offered. Complex multi factor difficulties are not necessarily identified. Patients report the assessments as rigid, causing difficulty in engagement.

Clients said they wished there were more sessions - therapy had only scratched the surface. The service are aware of the need for long term therapeutic support which they are unable to provide. You are not 'cured' of mental illness.

Whilst there is increasing evidence of a wish to work alongside other teams this is not as cohesive as it could be and has led to duplication in services. From a professional perspective not being able to contact fellow colleagues to promote a multi-agency approach is not in the service users best interest. Consultation between professionals would be more effective.

Accessing one-to-one therapy has been difficult. Service is not available evenings or weekends where our service users are most vulnerable. The administration seemed almost non-existent. The forms that one fills in at the beginning of each session could be worded more clearly and simply. Referrals are sometimes inappropriate (e.g. in crisis).

Inconsistent appointments, cancelled appointments, changing appointments all caused problems for service users. Service users in secondary care should not be excluded from CBT which is the therapy available from IAPT

Therapies were criticised. Telephone assessments were regarded as unsatisfactory. Telephone contact in general was regarded as difficult. Telephone therapy was not helpful. Group sessions were unsuitable for service users with particular problems. One to one interventions were not available. Courses were not suitable and were not delivered very well.

Being initially accessed over the phone was not very good especially the sensitive questions being asked by a complete stranger. It should be experienced staff at the front line and taking referrals so that they are able to prioritise and 'sift' referrals appropriately. Phone contact was hard, very impersonal, not helpful. Some people reported being unable to answer the phone due to their anxiety and were subsequently discharged, unable to access the service. Phone calls for contact could not be at specific times so caused problems. Quick fix CBT just does not work. Some material felt inappropriate, i.e. early discussion around suicidal ideas.

Group therapy large group sessions are inappropriate - with a mixture of up to 50 other people with different issues attending at once. It needs smaller groups. Service users would not attend or were not able to get there and were at risk of having their case closed. A wider range of interventions are needed. Accessing 1:1 interventions is very difficult.

Courses were got very boring – containing lot of information service users are already aware of. There was no real interaction. The delivery of the "presentation / slide show " was poor and a waste of time. Many people do not respond to on-line self help programmes or can not access any of the internet based services.

The service was not helpful and for some provided a negative experience. The waiting times were too long. Staff seemed under qualified, untrained and displayed poor service.

Some felt rather let down by the whole experience. They didn't feel they had a full analysis of problems. For some, the service has caused more harm.

Staff gave the impression of being totally uninterested in problems as they rushed through a tick-list of irrelevant "background" questions. Clients often felt like a number - part of a process, not an individual person. There was little support for people who have disabilities or carers.

Staff seemed inexperienced and undertrained. Therapists did not seem particularly proficient. They demonstrated no understanding of certain problems or needs. There were not enough staff to get help when required.

Communication with and from the service was poor. The service was not explained to users. Phone calls were not received or made. Messages were not responded to. The service did not communicate with the GP's.

Service users didn't understand the service, access, allocation of resources – they never explained what it was, who it was for, what was available. There is little communication about services. Feedback and contactability remains poor - phone calls are not made. Service users remain ill-informed. There are patients where promises and offers for work apparently made do not live up to the claims made or do not materialize. Some patients report that they are deactivated without their knowledge. There seems to be very little communication between initial assessor & the GP.

Venues were not suitable. Totally inappropriate rooms are being used.

Further comments were made regarding the need for the service, the need for quality assurance of the service, the structure, third sector involvement, publicity, staff and therapies.

The service is a great idea but managed by people who do not understand mental health, do not understand how vulnerable people think and feel. They also do not seem to appreciate the stigma associated with having a mental health issue or accessing mental health support through a clinical/NHS route. It works well for some and not for others, depending on their condition.

The service is commissioned to provide brief interventions for client with mild/moderate depression or anxiety. However, also attracts people with relatively severe depression or anxiety problems that require longer term therapy that it cant provide. There often seems to be no alternative service for these people. Their problems are too severe for IATP to be useful in its current form. At the same time these peoples problems are not acute enough for the few other services that are available.

There needs to be a top down experience- so people start with counselling rather than a step up model - as many are put off by the level of intervention

they receive- especially telephone assessments and the expectation to attend CBT as a starting point.

The lack of local beds is unacceptable. More health care mental health is needed. I think the staff are working as hard as they can but there just aren't enough of them to cope with the demand or to deliver a truly effective service.

Unfortunately, there are some doctors out there that still do not understand/believe in depression. GPs need a source of easily accessible telephone advice from a consultant since we are often having to deal with complex cases and currently feel very unsupported.

Ensure that the role of third sector is not over looked when producing the 'local offer.' Family Carers report a sense of disquiet about perceived difference in Norfolk and Suffolk - as an example Suffolk has specific Family Carers wellbeing elements.

The Wellbeing Service is restricted to Primary Care. The exclusion of this therapy in the Wellbeing Service to those in secondary care is unfair and lacking in equality.

#### 4.1 What did you think worked well about the service you received?

##### 4.1.1 Service

*The wellbeing service is very helpful, straight forward relaxed, it all worked really well, - it has reached and helped some people and has acted as a useful signposting service. Comforting to know it was available - I was really impressed with the level of care. I received very good advice and support for my anxiety disorder. More seems to be known about the disorder now and the advice is much better. The first point of contact when made felt like some help may be possible I was reassured. The Crisis Team acted very quickly. Those who get through to counselling overall are very positive about their experience of attending - I have had excellent feedback.*

*Contact made quickly. I was pleased to be contacted so promptly. They always rang on time and she was clear about what was going to happen. The assessment, was thorough I felt as though there was some support there for me. Especially good was the benchmarking throughout the period – it was invaluable in gauging my progress. The fact that I have been using Wellbeing for 20 years and this is the first thing that has worked.*

##### 4.1.2 Therapies

*The therapies delivered were good, and worked well. They are welcomed and will hopefully make a significant difference for those who need support to retain their independence.*

*As for the counselling treatment they received 77% were very satisfied. Counselling through the Wellbeing Service at Mind. It was Anger Management - worked well. Excellent counselling which helped me to pinpoint the issues at work which were causing me stress and assisted me in finding a way forward. Being able to meet weekly with a counsellor at the start.*

*I was referred for CBT when it was provided by Mind. I found it useful up to a point but have since found person centered therapy more helpful. Obtaining CBT which was good, very successful. The high intensity CBT at Hellesdon Hospital was brilliant and really helped me.*

*Face to Face. My customers tell me that the 1-1 system has worked very well for them. The first time I received help it was on a one to one basis, this helped me to work through my issues. One to one counselling worked very well with actions being reviewed etc. One to One Project receives referral from the service, suggesting they are aware of the need for long-term therapeutic support, which they are unable to provide. Less telephone support & more 1-1 support for longer period of time. The follow up one to one counselling I had was OK too.*

*The initial telephone consultation was excellent, worked well for me. Telephone assessment of service user was/seemed fine, OK.*

*I also recently undertook the Mind Mental Health First Aid training course, which I found personally and professionally extremely valuable, useful - very well ran and educational as well as helpful with my own mental health issues. Lots of engaging, but no pressure to which was very helpful to those who needed to talk, and those who didn't want to.*

*Stress Control Workshops - I found these very helpful, very useful and the booklets given for each session very informative. The CBT did not work for me, but the self-esteem workshop sorted out 40 years of misery. I wouldn't hesitate to recommend the service. I had EDMR [Eye movement desensitization and reprocessing], which cured my panic, attacks after 30 years. There were workshops, but only about 'breathing techniques'.*

*Group sessions where participation was voluntary was very useful - allows each person to find their own comfort level. The well being class I attended was very useful, I enjoyed it - seeing just how many people felt like you do.*

#### **4.1.3 Staff**

*The individual I spoke to listened to what I had to say and was extremely empathetic really good and understanding - a credit to their profession. My psychologist, enhanced psychotherapist, psychiatrist, counsellor, nurse, provider, cognitive behavioural therapist, course instructors, link worker, DIST team, staff were good, very caring, nice people, very approachable, welcoming, excellent, very reassuring and helpful, showed empathy, was very knowledgeable, showed compassion, approachability and helpfulness, was supportive, sympathetic, well presented and professional, very friendly non-judgemental and easy to talk to and listened to what I had to say - put me at my ease, engages with me very well, which makes it easier to talk about my issues and resolve the ones I can. They are a credit to their profession. I cannot fault the staff. When I had my relapse and I felt it had improved a lot compared to previous years. They said what info would be posted, and what info found out and phoned back. 95% of respondents said they were very satisfied with their counsellor.*

#### 4.1.4 Process

*Admin was good.*

*Being able to self-refer without going through a GP. I think it is useful to have a "tier" of the service into which patients can self refer, but there should be a separate line of access at a more senior level for GP referrals. It was good to be referred. I think the various points of access to the service are positive as some people prefer more anonymous methods.*

*The telephone assessment, triage system was very useful as it allowed the assessor to decide what help would suit me.*

*Weekly appointments with psychiatrist and the psychologist worked well. The continuity of the service, regular appointments with the same person. The counsellor always kept their appointment with me. Things ran on time. Things clearly stated about what was going to happen, comfort breaks, facilities.*

*The signposting to other services that might help. I wish the style of service had been available to me years ago when I first experienced anxiety in about 1990. Unfortunately then the service wasn't very joined-up, Joint working regarding a "Feeling good group"*

*Very positive that they are writing to inform the GP what is happening.*

*Didn't have to wait too long to get an appointment. They were able to plan meetings around our schedules.*

#### 4.1.5 Information & Resources

*Lots of information. I was impressed with the quality and resources available and the information provided was clear and comprehensive and helpful.*

#### 4.1.6 Venues

*Being able to access the service locally Health professional visiting me in familiar surroundings - home visits, Being able to have an appointment that was easy for me to get to such as my local surgery.*

#### 4.1.7 Other

*None, nothing, not much, very little about the service was good. I found it very frustrating - made feel worst. Some good, some bad.*

*From my experiences, Norfolk does not provide a good service, as against Suffolk. However, since joining the users forum I have become aware that there is very little provision, if any, south of Great Yarmouth. For people to benefit from the service and have input in the forum etc there must be more local facilities as many people find involvement too time consuming and expensive.*

## 4.2 What did you feel did not work well about the service you received?

### 4.2.1 Process

*The initial referral and triage took longer than I would have liked. I was suffering from depression and needed to speak to someone urgently. Waiting time was far too long, unacceptable length of time. It took – a few weeks, 4 weeks, months, 2.5 months, 3 months, a good few months, 4 months, +16 weeks, 6 months, 10 months - for a telephone assessment, before I actually got to see a counsellor or received support, to be seen, received voluntary counselling. These need to improve. No communication or alternative support available between referral being made & support being offered. Had the assessment in March 2013 and assessed as needing therapy but still not had first appointment. The 18 week wait time rule should apply to all mental health services, not just those that are consultant led. The clinical psychologists report that complex multi factor difficulties are not necessarily identified and the assessment focuses on only one aspect of the problem. The patient report the assessments as rigid, causing difficulty in engagement.*

*The clinical psychologists do not think that the stepped care model is working well. The complex patient still needs to move through all of the steps rather than enter the service at the appropriate level. It is difficult to obtain the appropriate level of expertise for complex patients.*

*Usually when you are very unwell you need help fast or you end up becoming worse if you do not get treatment quickly. Waiting is not an option when you are currently experiencing a distressing situation it adds to a persons' problems. The late service was likely to do harm than help. Meanwhile I became worse and ended up with time off work. This in-turn caused distress. I had severe anxiety and panic attacks, and was very depressed, but had no help for a while. By the time the therapy came through, I had stopped having panic attacks. Would have been more beneficial at the time. When you are at your lowest, the help needs to be there. I feel the waiting periods lead to a lot of behavioural issues to cope, and sometimes even suicide.*

*Needed to see MH service Doctor - this took months again - 3+ months have since passed and NO letter yet so we have been repeatedly phoning and told a letter should be sent within days but still waiting for said letter. I waited about 4 months to start the sessions and found them just up-setting and frustrating. Had to wait too long for starting CBT.*

*Clients said they wished there were more sessions - therapy had only scratched the surface. They did not want it to end. Another said there was not enough time. The service are aware of the need for long term therapeutic support which they are unable to provide.*

*I am concerned that the NHS only provides 6 sessions, 7 phone calls, 8 sessions – which is not sufficient. For some clients more sessions than the 8 on offer (or indeed the 12 sometimes provided) were needed. There appeared to be occasions when customers who were accessing this service were discharged from it too early. A set amount of session with not any flexibility.*

*The one call I had took just 20 minutes out of the allocated 40. The time between appointments became longer and longer.*

*Just when they think that they are improving and moving forwards the funding runs out and they can have no more help. Number of weeks available should be equal to the number of weeks needed by the client. The length of the service is limited where the need is. I worry that 8 sessions is not enough for my counsellor to get to know me and my history, and by the time I have given her all this information, I probably could have talked to her about a lot of problems I have, but not have any time left to really work on solving them. You are not 'cured' of mental illness. Follow up treatment.*

*I found the whole process to be somewhat disjointed. No joined up service, no referral notes/risk assessment. Feeling like your being pushed from person to person for various treatments no chance to build 'relationship' with any one person. Whilst there is increasing evidence of a wish to work alongside other teams this is not as cohesive as it could be and has led to duplication in services. From a professional perspective not being able to contact fellow colleagues to promote a multi-agency approach is not in the service users best interest. Consultation between professionals would be more effective. There has been an appalling lack of knowledge about Asperger Syndrome and the related problems that can go along side it within the mental health professionals that we have encountered. We were even denied an appointment to get a diagnosis for this through the mental health service, which delayed my daughters eventual diagnosis for many years and has therefore affected her badly as help was not given.*

*I also fell 'through the net' as I moved into a different area (still covered by the NSFT) and was told I'd have to revisit my GP and go on the waiting list once again for more treatment. When I said I was receiving help from the Pain Clinic they told me I could not have help from two sources at the same time and I had to choose which one. My daughter was referred to the primary level of the service, when she clearly needed the secondary level, but even the GP was not really aware of the differences in levels. It is a nightmare to navigate around the services and even the professionals seem unclear as to what is available.*

*If only we could connect work/state benefits with healthcare - so that we have more financial support to act on the support we are receiving from healthcare professionals.*

*Accessing one-to-one therapy has been difficult. Service is not available evenings or weekends where our service users are most vulnerable. The service was not available at local GP's, some of our service users had to use GP surgeries further away. My daughter was still managing to work, but appointments were only available 9-4 so caused distress as trying to get time off - without me my daughter would not have been able to access this. It is also now more difficult and stressful for those with mental health problems to access the service as many people are too unwell to make the phone call or conduct an interview over the phone.*

*The administration seemed almost non-existent. Once I'd completed the Stress Control course, the service seemed to fall apart. At my final session of the Stress Control course, we were all asked to fill in a form saying what we'd like to do next. I put my name down for a Mindfulness course, but I never heard anything more from the Wellbeing Service. It felt as if I'd fallen out of the system. Also I was sent a form with the questions on several weeks before which I filled in and could not see the point of then being asked the same set of questions again on the phone when I could have just sent them in. The forms that one fills in at the beginning of each session could be worded more clearly and simply.*

*Referrals are sometimes inappropriate (e.g. in crisis). Once when we called the crisis team told us they are not an emergency service, so we called an ambulance. A reluctance to see patients that we feel appropriate. My doctor wanted me to see a psychologist but in the assessment I was told I was not ill enough. In the end I paid privately to see a psychiatrist.*

*Inconsistent appointments, cancelled appointments, changing appointments promised, last minute cancellations. I ended this course of treatment early, because the staff member cancelled the appointment twice. By the time I answered their questionnaire each time I only had 10 mins conversation to explain the work I had done and what to do next before the appointment was finished.*

*I think such a service which is easily adapted to SUs in secondary care should be available to them. The service was initiated to serve only mild depression and anxiety - these conditions are not exclusive to those in primary care. SUs in secondary care should not be excluded from CBT which is the therapy available from IAPT*

#### **4.2.2 Therapies**

*Telephone assessment - I felt that being initially accessed over the phone was not very good especially the sensitive questions I was asked by a complete stranger - not sure how anyone can be accessed by phone and I think this needs to change. It should be experienced staff at the front line and taking referrals so that they are able to prioritise and 'sift' referrals appropriately. Someone phoned me and did a short 5 minute consultation and did not ask me how my mental illness was or whether I was having any thoughts of suicide or self harm, even though I have a history of this.*

*Phone contact was hard, very impersonal, not helpful, not suitable and more difficult to engage with - stressful waiting for call and talking to stranger about very personal things - how you may be feeling at that time, awkward. I have tried to get contact with the wellbeing services - I made the phone calls with the service user present. I was passed from one phone number to another - eventually the service user got a date/time for a call back in three weeks time - this is someone with memory difficulties and would not have remembered to be about for the phone call. The patients have reported that the telephone assessment is impersonal, causes difficulties in engagement and occurs at inappropriate times. Some people reported being unable to answer the phone*

*due to their anxiety and were subsequently discharged, unable to access the service.*

*Phone therapy - phone calls for contact could not be at specific times so caused problems. Missed call then had to wait again.*

*I had telephone CBT which was absolutely pointless. I feel this quick fix CBT just does not work. Some material felt inappropriate, i.e. early discussion around suicidal ideas.*

*Group therapy large group sessions are, not helpful, inappropriate, would not have been any benefit - with a mixture of up to 50 other people with different issues . It needs smaller groups or more 1-1 availability as the groups have been too large which puts customers off going. I was encouraged to go a mixed group workshop even though I had said I was anxious around men. When I questioned the benefit of the session and said how uncomfortable it was all making me feel I was told that there would be less people there next week because "this always a big drop out". The service user would not attend - was not able to get there had no transport or money and was not feeling in the 'right place to discuss his situation in a group session. The wellbeing team said if he didn't go they would 'close his case'.*

*The people running the service were disagreeing with how the service should operate. There were too many people in the room and it was difficult to discuss the range of emotions and stress she was experiencing. That was the only support offered. Timings of the sessions did not fit in with the working day which meant I had to take half a days leave for each group session.*

*Have had very little support except for the offer of drugs, which I declined. Medications shouldn't always be the first line of treatment. Mainly CBT intervention, CBT is the only methodology. - one size does not fit all. NLP not offered. No eating disorder support. Information only - disappointing content. I am a retired mental health professional with a broad knowledge of therapeutic methodology and I was looking for Rogerian counselling. I was told this was all that was available to me and that if I wanted any more I would have to private. People like me need on going long term support not quick fix.*

*Need a 1:1 intervention but it seems accessing this is very difficult. I had to take off annual leave to have telephone appointments from home as no face to face time was offered. A face to face assessment was not offered. when I had face to face I would rate this as excellent. To access some 1:1 support means that we may have to pay privately, at the moment this is not possible as my partner is on reduced pay.*

*Discharged at the end of the course – further continued support is need. I feel that we have just been left to get on with it. It seems that mental health support is still seriously lacking. If it was a physical illness we would have received the support we needed weeks ago - people who suffer from serious depression need more support to manage their condition.*

*Stress control course - probably helpful to people who haven't been in the mental health system for as long as I have, and probably helpful to newcomers dealing with problems. I found it educational but got very bored at times as it was a lot of information I was already aware of. There was no real interaction, so didn't keep me engaged. Delivery of the "presentation / slide show ". Poorly designed, delivered and at best a waste of time. Might work for people who are having difficulties day to day coping, but is in no way therapy for someone struggling with a mental health issue.*

*Many people do not respond to on-line self help programmes. It hasn't proved possible to access any of the internet based services.*

*If I am in denial or reluctant to engage help with my depression then those methods would not appeal to me as I would continue to ignore my condition, allowing it to get worse and lead to more serious actions.*

#### **4.2.3 Service**

*None of it, there has been no help - I am no better than I was as a result of using the service. I feel rather let down by the whole experience. Our experience of the service has not been good. Clients have expressed mixed experiences of the well bring service sadly mostly negative ones. All they asked is what kind of treatment I was looking for. I feel this is unacceptable. The practitioner decided I didn't need any help as I was 'well presented' and 'articulate' NB doesn't stop me being manic and or depressed! The session was a disgusting waste of both my time and of public resources. I also don't feel like I had a full analysis of my problems. She was let down. It is very hard to say that anything has been straightforward or very helpful. In fact I would say that the service has caused more harm.*

*After 7 phone calls asking for some intervention response was 'go back to your G.P for a referral' - that is where she had started 3 weeks ago and got no where! Gave the impression of being totally uninterested in my problems as they rushed through a tick-list of irrelevant "background" questions, said that my problems were exaggerated and self-invented and at one point even accused me of "suffering from an alcohol problem", even though this is certainly not the case and nor was it in any way related to any of the issues that led to my being referred to the service in the first place. It would seem that if there are periods where you do not access the service you have to effectively start from the beginning.*

*After waiting nearly a year, I gave up and bought a self-study Mindfulness course book and CD package so I could learn the skills in my own time. It has been reported that the service is not person-centred. Clients often felt like a number - part of a process, not an individual person. Lack of understanding of my individual needs. At the time it took a lot for her to except the help. It felt like a tick box exercise and not therapy which was very structured rather than being about me. The 'Therapy' was actually only a power point presentation. I felt the 'self-help' option was impersonal and not supportive.*

*Supporting people who have disabilities (and who also happen to have mental health diagnosis of depression).*

No help for carers.

#### 4.2.4 Staff

*The person treating me did not tell me what level of training they had. They told me they wish they did my job but didn't get in to the course. The person also told me 'oh right well I haven't really met anyone with anxiety before' this was not reassuring or professional from a wellbeing service. The crisis team were not as compassionate or caring as they might have been. They may be seen by a relatively inexperienced team member. Inexperienced*

*The therapist had no idea of my issues and seem to not understand that my mobility issues mean I could not go out for a walk or take a bath to relive my anxiety. It felt like the therapist was reading it out of a book! When I was seen by the health professional I do not feel he was particularly proficient at his job. I felt it was of no benefit to me. The individual he spoke with had no real understanding of his problems or need. The face-to-face consultation was extremely disappointing; poorly conducted, unhelpful, the person I spoke to left me feeling belittled and ignored. They do not understand how bad an illness can get.*

*They told me they had other appointments and I had to hurry up and make a decision - in the end I chose the Pain Clinic to avoid having any further contact with this person. She did not engage with me as an individual - she didn't ask or acknowledge my personal circumstances and level of knowledge that I have. The person calling was condescending when I asked them to repeat their explanation – they said 'now this really isn't that hard you know'. Phone helpline wasn't much use as we were told to make the patient a cup of tea!!!!!!*

*Not enough staff to get help when required.*

#### 4.2.5 Communication

*IAPT's communication is none existent.*

*Didn't understand the service, access, allocation of resources – they never explained what it was, who it was for, what was available. There is little communication about services. They said they wanted to help but didn't give me a 'shopping list' of what the help could be - having self referred didn't understand what system I was in and what was available even if it was something I might have needed. They assumed you knew all about it. The clinical psychologists and patients do not readily understand which parts of the service have particular roles.*

*From a professional perspective feedback and contactability remains poor, has limitations. I reminded the service user on the day to expect the phone call. The phone call was never made. I researched as to why the phone call had not happened on behalf of the service user and apparently her case was closed on the same day as the initial phone call was set up as workers had talked to G.P and closed case. No one had informed the service user.*

*Subsequently discovered IAPT had made decision but did not communicate this to service user or carer. I missed one call and they never phoned me back*

*The first point of contact I had assessed me but then didn't get back to me despite saying he would in a week or two. No communication about waiting lists, she kept saying she would send me documents and didn't. There are patients where promises and offers for work apparently made do not live up to the claims made or do not materialize.*

*Lack of or difficult communication between services and service users - because the phones are rarely answered and voicemail messages are not answered. I was passed from one phone number to another. Never available, did not return calls. I always left a message with no acknowledgment that the message has been received. People never rang back when they said they would which added to the anxiety and depression. Was told IAPT would phone in 2 to 3 days. After 2 weeks service user phone IAPT as no call received. Could not make contact left messages at IAPT which were not returned. There is virtually no communication and liaison with other services about patients, especially on discharge from the well being service.*

*In the end the service stopped as my daughter tried to return calls in her lunch hour and couldn't get through. The letter from the well being service said that she had failed to contact them. Some patients report that they are deactivated without their knowledge and the wait for therapy for complex cases is unacceptably long.*

*The map was poor. I went to the wrong place. I was 5 mins late and they have no reception. The wrong information was sent by post,*

*There seems to be very little communication between initial assessor & GP, or told whether I should return to the GP if I had further problems. No contact no referral no information!*

*I did email about my experience following the sessions, no one responded.*

*Some patients report that they are deactivated without their knowledge and the wait for therapy for complex cases is unacceptably long.*

#### **4.2.6 Venues**

*The initial appointment was in a totally inappropriate room. I turned up at the first session there were 25 of us squashed into one small very hot room with no windows.*

#### **4.2.7 Questions**

- *If your leg was broken or you required an operation, you wouldn't expect to wait such a long time to receive treatment, so why are people with MH issues left to suffer in silence?*
- *Where has the NHS cradle to grave gone!*

### 4.3 Is there anything else you would like to share with us?

#### 4.3.1 Service

*I was happy and have recommended it. Finding it good, useful, excellent, vital. The CBT worked well and gave me confidence again. Felt the service was great help. The homework given put everything into context. Still read the booklets I was given. The care I received from the staff was excellent and this includes the phone support of the Crisis Team - without them many people would have no help at all. You attend the sessions thinking you're the only person in the world feeling the way you do, in the depths of despair, and leave realising you're not alone because you're there with others in a similar situation. I did not know that this type of service was available and was surprised how heavily the sessions were attended, and how good they were. Good support from Chatterton House team.*

*Save this service! Do not let this service disappear. It has rescued me, and I want to see it stay to help others rebuild their lives.*

*1000+% better than inpatient service. It should be kept going and improved because it is helping a lot of people move forwards. Individuals don't necessarily know where to turn and who can help them or even realise that they have a problem. It's much better and proactive than putting someone on anti depressants for a long while and I would have thought cheaper in the long term. I can see a huge improvement in the services from when I first used them between 2008-2011*

*Was very impressed with the follow-up call a few months after I'd used the service as depression can linger/return. Felt this showed excellent after-care and preventative care. Perhaps it doesn't need changing.*

*I think the service is a great idea but managed by people who do not understand mental health, do not understand how vulnerable people think and feel and by people who do not fully understand their responsibilities to the taxpayer and society at large.*

*They also do not seem to appreciate the stigma associated with having a mental health issue or accessing mental health support through a clinical/NHS route.*

*I felt that the counselling session was not beneficial, as she seemed to feel that I was not depressed but just lonely and that I should lose weight and stop drinking. I did not feel that this advice was very helpful and just made me feel worse about myself. The well being service as it's become is a waste of time. Overall this service was slow, unorganised and unprofessional. Due to a lack of alternative services I have since asked to be re-referred, I am anxious that my next experience does not prove a repeat of the previous one which, I am sad to say, did not reflect well on the service in general. With few exceptions, the service has not worked well with existing providers. It was rubbish, I would not rely on them again.*

*When I told my GP about my experience she said unfortunately I was not the only one who had found the experience unhelpful. I ended up quitting and going through my workplace health and wellbeing 8 months later when off work. My workplace support was much superior with face-to-face contact, good explanation and paperwork that was simple and broken down. Health suffered further. This has also had an impact on my health - need support for my family members. All adds to further anxiety problems. I have personally registered 2 complaints, their failings the first time nearly cost life.*

*It works well for some and not for others, depending on their condition. I think it's important that all community services offered by NSFT are considered in terms of their effectiveness. If there aren't robust community treatment services, then the reduction in adult inpatient beds will most likely result in further deaths or people coming to serious harm. It's important for people who are accessing or have tried/are trying to access these services to have a voice. People on the waiting list, like me, do feel abandoned, isolated and forgotten about. We feel like nothing will ever get better, and no one wants to help us. Things do need to improve in terms of community mental health services, not just here but also across England.*

*Have any of the promised changes been made? - No not a single one I could see and in fact the service has got far worse I found. The stress caused in families trying to find support for their Dyslexic children is substantial. Reduce stress by making the EHC plans work well in the future.*

*The service is commissioned to provide brief interventions for client with mild/moderate depression or anxiety. However, also attracts people with relatively severe depression or anxiety problems that require longer term therapy that it can't provide. There often seems to be no alternative service for these people. Their problems are too severe for IATP to be useful in its current form. At the same time these people's problems are not acute enough for the few other services that are available. It would be so good to be able to provide longer-term therapies/counselling for these people as part of the well being service in its future form. Low cost counselling services currently do some of this work but often service provided by trainee counsellors is not suitable and clients won't or can't pay the discounted fees. Many on a low income are unable to access our services and get the support they badly need. As professionals I believe we have a duty of care to provide the best possible service for our clients and passing them between services without any in depth exploration of their needs is not helpful or ethical. I feel there is a need for a joined-up approach with this particular problem, especially as the large amount of research in recent years points to a huge cost to the NHS, social services and society as a whole.*

*I consider it needs to be a top down experience- so people start with counselling rather than a step up model- as many are put off by the level of intervention they receive- especially telephone assessments and the expectation to attend CBT as a starting point. Puts many people off.*

*The lack of local beds is unacceptable. More health care mental health is needed. I think the staff are working as hard as they can but there just aren't enough of them to cope with the demand or to deliver a truly effective service.*

*The strap line - are you 'ready for change' implies that my illness is of my choice and that I choose to be ill. I felt an implication of being 'worried well' as opposed to someone experiencing a mental ill health. It also fails to recognise the earlier preventative and Early Help work that should be made available to address emotional wellbeing issues that if left unsupported risk becoming mental health issues.*

*Doctors - unfortunately, there are some doctors out there that still do not understand/believe in depression. It doesn't make you feel 'normal', and probably makes depression feel worse when people don't understand. It would be good to have doctors working at surgeries in the mental health sector that deal specifically in mental health. GPs need a source of easily accessible telephone advice from a consultant since we are often having to deal with complex cases and currently feel very unsupported. We also note that the Wellbeing Service is available to young people aged 16+ and have a real concern with regard the lack of proper cohesion with CAMHS.*

*Ensure that the role of third sector is not over looked when producing the 'local offer.' Not all those I have spoken to have had an unhelpful experience and it is difficult to give individual care. Need is far more than is available but more joint working with local charities does benefit the patient / client. Really useful working together to delivery services to vulnerable mothers.*

*Family Carers report a sense of disquiet about perceived difference in Norfolk and Suffolk - as an example Suffolk has specific Family Carers wellbeing elements.*

*I have always been critical of the way the Wellbeing Service is restricted to Primary Care. The exclusion of this therapy in the Wellbeing Service to those in secondary care is unfair and lacking in equality. Exclusion occurs for all secondary health users in Norfolk.*

*Please look at working hours and how to support those still able to work.*

#### **4.3.2 Process**

*I haven't seen much publicity for this service. Suggest more signposting through support agencies, mid wives & anti-natal to make sure the service is available to a wider range of people.*

*Wouldn't bother going through the GP again, would rather find someone myself. We were denied an appointment to get a diagnosis through the mental health service. If self referring is available this should be more widely promoted.*

*The One to One Project is not an appropriate service for ALL and expect that colleagues make some effort to understand our services so as to only make appropriate and suitable referrals.*

*Having been a service user on and off for a few years I've always only been offered short term help when a longer term service would be beneficial.*

*Its wonderful that you can ring up - someone answers, or you can email and someone replies - although you wait to see someone for quite a long time, at least you're told this will be the case, rather than being kept in the dark.*

#### **4.3.3 Staff**

*Good staff who were very approachable. She was brilliant. My therapist was excellent at returning messages. Staff have always been friendly open and easy to work with. They were very patient and understanding. I think the relationship with the therapist is as important as the type of therapy. I have been fortunate to have had CBT with a very caring and professional woman and am currently have counselling with yet another caring individual. My GP was excellent.*

*There has been an appalling lack of knowledge about Asperger Syndrome and the related problems that can go along side it within the mental health professionals that we have encountered. Need trained specialists who really know what an illness is like and what it does to the family around the sufferer.*

*I was told that I needed to seek counselling before starting CBT. I had to pay for 5 months of counselling by myself, during some of that time I was homeless. As I am not under the age of 25 or anorexic or suffering from a bereavement or in any of the other groups who can access free counselling I had to pay for mine which didn't feel very fair at the time. Despite seeking advice from GP I am access private counselling at huge cost to me personally even though my income is low.*

*I think there should be more staff on the Crisis Team to answer the phone 24hrs a day and if they are on change over times, the phone should still be answered. There needs to be more workers available to meet the demands put on the service as this will lead to better outcomes for service users.*

#### **4.3.4 Therapies**

*I'm certain there is not a lack or commitment just resources. There's no money or provision for mental health, even when in crisis. It is a shame the allocated appointments is not more flexible such as 20 sessions could be extended if required.*

*NLP should be offered. The follow-up service once a patient has completed the Stress Control course needs to be much better.*

*I'd like to see a more comprehensive service in place, one that really helps people get on with their lives. As a former member of the Armed Forces I am most concerned with men and women returning with Post traumatic stress disorder. The range of approach and therapies is far too narrow. I was looking for Rogerian counselling. Please consider more than just CBT. It's only one*

*type of therapy! The various treatments/options are not discussed adequately if at all on entering the service. hence the service is 'done to' the client.*

*I think the value placed on friendships that can be formed in these groups should be 'sold' to new 'clients'. At the end of the sessions, I was actually sad they'd finished. There ought to be centres so people can talk to other mentally ill people.*

#### 4.4 Service Quality – Findings

- The service, therapies, staff, process, information, and venues all were regarded as satisfactory or working well.
- The service was regarded as being straightforward, useful and prompt.
- Therapies, including CBT, telephone, workshops and face to face counselling were regarded as good, helpful and useful.
- Staff were regarded highly and considered to be professional.
- The process for accessing the service, the triage and appointments were considered positive, suitable and timely.
- Information provided to service users was helpful and impressive.
- Venues were regarded as suitable.
- The process, therapies, service, staff, communication and venues were also criticised as being unsatisfactory or not working well.
- The process for gaining support or treatment was regarded as difficult and was taking too long. The 'stepped care' model was considered unsuitable. Delays in treatment caused further problems. Too few therapy sessions were provided. The service seemed disjointed. The administration was flawed. Some referrals were inappropriate for this service. Appointments were not made or kept. Secondary care patients were excluded.
- Therapies were criticised. Telephone assessments were regarded as unsatisfactory. Telephone contact in general was regarded as difficult. Telephone therapy was not helpful. Group sessions were unsuitable for service users with particular problems. One to one interventions were not available. Courses were not suitable and were not delivered very well.
- The service was not helpful and for some provided a negative experience. The waiting times were too long. Staff seemed under qualified, untrained and displayed poor service.
- Communication with and from the service was poor. The service was not explained to users. Phone calls were not received or made. Messages were not responded to. The service did not communicate with the GP's.
- Venues were not suitable.
- Further comments were made regarding the need for the service, the need for quality assurance of the service, the structure, third sector involvement, publicity, staff and therapies.

## 5 The Future

### Summary

Self referral and GP referral were the preferred methods for accessing the service. Some would liked to have been able to self referral – it would be a more direct way of getting treatment. It is important that the GP supports this and is involved. A health professional is better placed to activate contact. A multi referral systems can be useful - the best option will very much depend on the individual.

GP surgeries or primary care centres, specialist therapy centres and community centres were the preferred venues for service delivery. Somewhere local, easily accessible to all. Most service users prefer to travel as little as possible. Outreach programmes that can be run to enable access for those in rural locations.

It would be more beneficial to have a range of locations - as many, multiple locations as possible, GP surgeries offer the best chance of confidentiality, security and sound proof rooms and are widely distributed. Ensure a professional service in an appropriately confidential, private and safe setting. Some common ground where there is certainty of not being interrupted. The staff would need to be professionally qualified.

All of the proposed time frames were suggested as time when people would want to access the service, which included out of hour provision. Many people have difficulty taking time off work for health appointments, which is stressful in itself. It is vital that flexibility is inherent in the system, as different people will have different needs at different times. Mental health problems do not have a timetable! There needs to be a 24hr service especially for the Crisis Team.

The service could be made accessible by providing the service in a timely manner, at a range of physically accessible locations in the community, at suitable times with service users being able to self refer using a variety of access points. The service should be offered more broadly to a wider range of users, delivered by competent staff, be clearly signposted and integrated with other services. Communication needs to be reliable, strait forward and clear.

Services could be delivered in a range different locations in Norfolk. This would need arrangement from partner organisations and selected GP surgeries to provide rooms or budget for them and agreements to provide room space - binding and centrally managed for each CCG.

Offering different venues- visible in community settings - this will help break down barriers - less intimidating. Appropriate and easily accessible premises with transport links and car parking.

Offer a variety of times. Open day time, evening and weekends with reception support.

Shorter waiting times by keeping waiting lists to a minimum so that people can access these services in a timely manner.

Self referral, booking and support through internet and telephone. Ensure that the telephones are answered.

Broaden the scope of the service and make sure it is focussed as much as possible on prevention and Early Help. Be creative. More face to face appointments.

Ensure trained staff are engaged. It is only as good as the therapist delivering it. Educate all professionals as to where to send people initially, so that the right service can be accessed as soon as possible. GP's should have more up to date information.

More information on how to access services and what to do if you feel unwell in simple language is needed. Advertise the service and be honest to its remit and boundaries.

Engage willing previous patients give accounts of their experience of the service in literature or in videos on the website. Use the Social Model of Disability and Normalisation in all policies. 'Wellbeing Service' is a better title due to there being less stigmatization.

More referral pathways, from any source - increase access to service. Have a choice of face to face, phone and internet referrals. Be prepared to travel and to home visit is necessary, in extreme cases. Or allow for transport issues - easily accessible by public transport.

More interaction with other registered local charities and support groups - more integrated working.

Use email for communication where available and if service user/carers prefers.

More funding, and frequency of appointments. There is nowhere near enough staff in place to deal with people needing to be seen.

Make sure it is widely known - marketing effectively is essential. Use lots of channels. By providing available referral information at GP surgeries, libraries, community areas, post offices, chemists that customers can pick up and take away.

Make it easier to make phone access at specific times, so that calls can be planned. Ad hock receiving calls from the service does not work for everyone. Enable other professionals the ability to contact workers directly. By confirming appointments via a letter from a GP or practice manager. Acknowledge referrals immediately. Communicate with service user/carer directly and copy in GP.

Use less technical words, use simple language, Plain English. Dyslexia friendly literature. Language barriers can be an issue so access to translation services

needs to be included in any funding together with employing some people from minority groups.

There should also be a leaflet or something to be given to people who have used the services in the past in case they need to use them in the future - perhaps information packs to be sent out.

Older people can gain access by having outreach or home visit services provided, through social networking opportunities. Third sector involvement is recommended. Telephone assessment or consultation should be avoided. Information should be provided and specific issues addressed.

New mothers can gain access through social networking, primary care providers and other services. Venues offering child care and outreach services are suggested. Specific issues should be addressed.

Offenders can gain access to the service through an outreach service, having attendance mandatory, connecting with other services, rehabilitation and probation programmes and secure venues.

Carers can gain access to the service through local support groups, personal health assessments, access to training and support and through primary care.

Children and young people can gain access to the service through schools and school based staff, related children's services, specifically targeted information, primary care and through social activities.

People with disabilities can access the service through consideration of physical access needs, transportation, joint working with local charities, specific support depending on the disability, counselling and training, advocacy, and primary care.

Further comment were provided regarding the service, the process, allied services, therapies, staff, information and venues.

The service was regarded as being of a different standard in Suffolk and Waveney. The introduction of the service was regarded as a positive step. Mental health provision is regarded as inadequate overall.

The process can be enhanced by raising awareness of the service, taking the service into the community, speeding up assessment and treatments, collaborating with other providers and providing funding.

Allied services and other providers were interested in providing services, a wider range of services should be offered, GP's were highly valued. Therapies including counselling and courses could be extended. Staff shortage was of concern. Information and advertising could be enhanced. Venues, including rural access should be considered.

## 5.1 How would you prefer to access this service in the future?

### 5.1.1 Response Table 4

Answer Options	Response Percent	Response Count
Self referral	64.3%	90
GP referral	55.0%	77
Nurse referral	17.9%	25
Other	12.1%	17
Please comment on any of the above		53
<b><i>answered question</i></b>		<b>140</b>

### 5.1.2 Other

*Some prefer, appreciate or would liked to have been able to self referral – it would be easier, a god idea, a more direct way of getting treatment, strait away if the condition worsens. It could act as a boost. Now I know the service is there I would self refer but until referred by GP I was unaware of it. I am not really happy with the way the GPs have dealt with me as a person and therefore if I felt I needed help, I would rather self-refer. This will provide consistency but other professionals need to be informed of active involvement to reduce a duplication of services*

*I use my own GP or GP nurse. GP referral suits my clients. GP referral letters provide useful information for assessment. Some people may not be able to admit they have a problem, unless they had seen their GP first. GP referral if necessary. I think it is important that the GP supports this and is involved - may restrict the access to those who need it. A health professional is better placed to activate contact. GP referral was often more effective for customers. This will work if GP's are aware and that other professionals have access to the fact that a referral has been made.*

*All of these routes, multi referral systems can be useful, important, should be possible as it makes it easier to access - the best option will very much depend on the individual. Computer based assessment at surgery? It seems to me to be vital that flexibility is inherent in the system, as different people will have different needs at different times. So long as it actually worked! Getting any access would be a bonus!*

*With no exclusions also via Social Services / Advocacy / other organisations. The refugee who came to me had great reluctance to use the service because of his experiences and background. He needed support from someone he trusted to take the step to use the service, The promotion of a multi-disciplinary approach is required.*

*Agency referrals. Through local community groups/charities eg the Mancroft Advice Project. Referral route in place from the one to one project to your service and visa versa. Any support group who feel that this would be beneficial for group.*

*The wait time to be significantly reduced so people can access MH services in a timely manner - must have contact within 2 weeks. Access to mental health should be the same as physical*

*I wouldn't - I would look for effective help. Therapy, medication or specialist services.*

## 5.2 In the future, from where would you prefer the service to be delivered?

### 5.2.1 Response Table 5

Answer Options	Response Percent	Response Count
GPs/Primary Care centres	73.3%	107
Specialist therapy centres	43.8%	64
Community centres	32.9%	48
Libraries	13.7%	20
Colleges	13.0%	19
Other	18.5%	27
Please specify:		44
<b>answered question</b>		<b>146</b>

### 5.2.2 Other

*Somewhere local, easily accessible to all. Most service users prefer to travel as little as possible and will prefer whatever venue is nearest to them. Service delivery locations must take into account transport needs. Many places are inaccessible and even GPs prove difficult to access by the most elderly. Its not always easy to get to just one of them. Outreach programmes that can be run to enable access for those in rural locations would be beneficial. Using someone' s front room in a rural setting. Somewhere in Thetford rather than going to Norwich. The service must be offered in the place most convenient and appropriate to both the nature of the service being provided and the service user.*

*It would be more beneficial to have a range of locations - as many, multiple locations as possible, GP surgeries offer the best chance of confidentiality, security and sound proof rooms and are widely distributed. Some community centres and village halls might have suitable rooms. It seems to me to be vital that flexibility is inherent in the system, as different people will have different needs at different times. Any small venue around Norfolk. Don't mind. What matters is that a quality service continues to be available to all.*

*I think there needs to be on going support with fully qualified and experienced Psychologists or Psychiatrists. trained professionals, with resources , time and knowledge of effective interventions, tailored help. A quiet, peaceful, airy, comfortable environment, absolutely private and conducive to treatment.*

*Locations that are easily accessible with good transport links/car parking facilities. At my own home would be good, beneficial when appropriate. Seeing people in their own homes has to be an option for several reasons. 1) the rural nature of Norfolk and the challenges of travelling on public transport. 2) it is sometimes it is important when working holistically with people, to see*

where they live and to understand the reality of their lives 3) Adult services need to be more involved in Safeguarding and sometimes home visiting may be relevant in order to assess risk to children.

A domiciliary service raises the problem of staff safety. Ensure a professional service in an appropriately confidential, private and safe setting. Some common ground where there is certainty of not being interrupted. The staff would need to be professionally qualified.

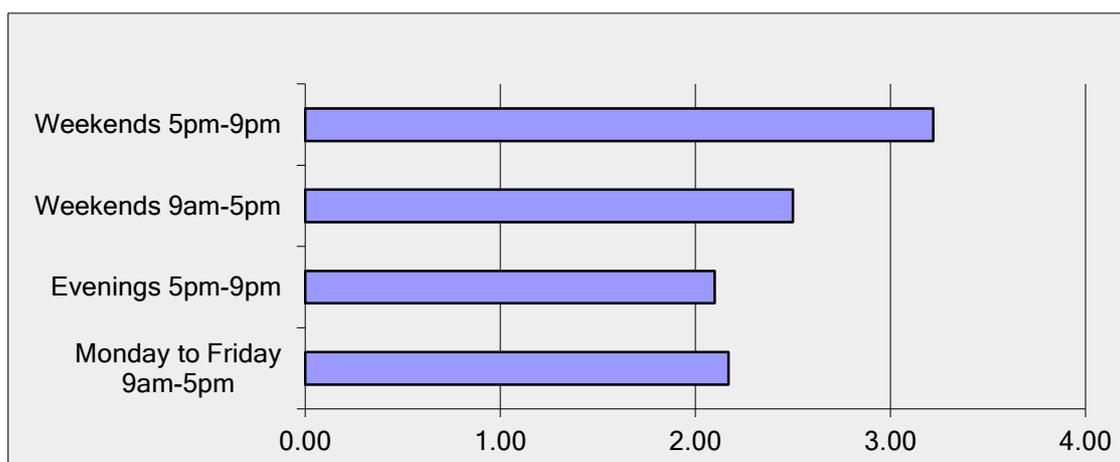
Specialist therapy centre, schools, youth service's, Children's Centre, voluntary sector, Online, private provider, Counsellors clinic/office, Hospital, any drop in facility - having someone based at a college would be very beneficial to many

NOT libraries, colleges or public buildings - I would have felt very uncomfortable doing that. Not sure GP surgeries staff have the empathy or discretion required. Anywhere but GP surgery.

Some fellow IAPT providers seem to dislike sharing a room.

### 5.3 In future, when would you feel it most likely people would want to access the service?

#### 5.3.1 Response graph 1



#### 5.3.2 Other

Service hours is always a difficult issue. Although a 9-5 5 days a week service works for me, I am aware that many people have difficulty taking time off work for health appointments, which is stressful in itself. An opportunity to be seen before and after work would suit many people but I am aware it may still be necessary to offer at least morning appointments on a Saturday. We try to see clients 9-5 Mon - Friday. We see 8% of clients 5 - 7 pm. We see 6% of clients Saturday 10 - 1. It seems to me to be vital that flexibility is inherent in the system, as different people will have different needs at different times. Mental health problems do not have a timetable!

I think there needs to be a 24hr service especially for the Crisis Team. This is difficult to rank as ideally support should be available over any given 24hr

*period. A 24 hour service is absolutely vital. Crisis care needs to be at times of crisis .*

*All of the above as a carer, all times are needed - again access to those who find this difficult has to be made as easy as possible.*

*Emergency 9pm to 9am. A selection of times including during the day and early evenings for those that are working. Evenings. Some time for workers and home-based - flexible for all. Weekends.*

#### 5.4 How can we make sure the service is accessible?

##### 5.4.1 Other Suggestions

*By ensuring services are delivered in about 20 different locations in Norfolk. This would need arrangement from partner organisations and selected GP surgeries to provide rooms or budget for them in those 20 locations. The agreements to provide room space would have to be binding and centrally managed for each CCG.*

*Offering different venues- visible in community settings - this will help break down barriers - less intimidating. Appropriate and easily accessible premises with transport links and car parking. Make it more local instead of having to travel to Norwich. Ensure there is a link up with any public service building so access to a suitable room is easily organised. Variety of venues and times, local areas. When planning locations and times to deliver, consider what transport is available to the people likely to be attending. Community transport providers can be part of the solution and we will be happy to discuss this with the well-being service.*

*Check accessibility of buildings.*

*Offer a variety of times. Open day time, evening and weekends with reception support. Times clash with working hours - fit in with service users lifestyle. Take into consideration that some people want to maintain full time employment as well as get treatment. Times and location by mutual agreement, flexible hours. This may be impractical and unaffordable. It is often evenings and weekends that people feel vulnerable. Have a 24 hour help line. Case workers to be available via phone within 24 hours. Ask service users at initial assessment /appointment what times work best for them.*

*Shorter waiting times by keeping waiting lists to a minimum so that people can access these services in a timely manner, and do not feel isolated and abandoned. More rapid response. Deal with referrals within 14 days. More staff.*

*Self referral, booking and support through internet and telephone. Another improvement that I think would be helpful would be to provide personalised online therapy for people who might feel uncomfortable speaking to a therapist face-to-face or on the telephone. A good example of this is <http://www.psychologyonline.co.uk/>*

*I have heard very little positivity about the service. I have heard of service users who felt they weren't taken seriously - where they can fully assess you empathetically and if necessary get you emergency help instead of making a phone call for somebody to ring you back - who may forget the message or cannot see you. Not encouraging. I took off 3 days annual leave to do appointments that were not worth my time. The person who delivered my face-to-face consultation was woefully inadequate. Acknowledge referral immediately. Follow up referral within 14 days. State 'the next step' and stick to it. Have the right people to talk to when people call. Ensure that the telephones are answered.*

*Broaden the scope of the service and make sure it is focussed as much as possible on prevention and Early Help. Be creative. More face to face appointments.*

*It should not have to be a matter of luck whether who a patient speaks to is appropriately trained or not. A more even keel of training among service staff is crucial. It is only as good as the therapist delivering it. Educate all professionals as to where to send people initially, so that the right service can be accessed as soon as possible. I think that GP's should have more up to date information. Staff need to be polite and friendly at all times and also letters sent out need to be less formal and more friendly.*

*More information on how to access services and what to do if you feel unwell in simple language - leaflets at GP surgeries. Ensure it is publicised in the workplace Advertise the service and be honest to its remit and boundaries.*

*There is still so much prejudice about mental health. I never take time off work even when I should as I don't want it on my record as people think you're flaky and unreliable. I think you could have willing previous patients give accounts of their experience of the service in literature or in videos on the website. The myth that therapy is frightening, embarrassing or a sign of weakness needs to be broken down. Appeal to men. Use the Social Model of Disability and Normalisation in all policies. 'Wellbeing Service' is a better title due to there being less stigmatization.*

*More referral pathways, from any source - increase access to service. Have a choice of face to face, phone and internet referrals so that those lacking confidence in one area will have choice. Make it available through GPs by enabling GP's to directly refer you to a counsellor where necessary.*

*For the practitioner to be prepared to travel and to home visit is necessary, in extreme cases. Or allow for transport issues - easily accessible by public transport.*

*More interaction with other registered local charities and support groups - more integrated working.*

*Use email for communication where available and if service user/carers prefers.*

*More funding, and frequency of appointments. There is no where near enough staff in place to deal with people needing to be seen.*

#### 5.4.2 Communication

*Make sure it is widely known - marketing effectively is essential. Use lots of channels. Direct mail shot to anyone with a national health number. I knew nothing about it until my GP mentioned it. Use the NHS website. By providing available referral information at GP surgeries, libraries, community areas, post offices, chemists that customers can pick up and take away. Ensure that posters are displayed in surgeries but also lots of public places i.e. bars, cafes, library, charity shops, via benefit information, on town notice boards, local supermarkets, local organisations. Visits to local areas, community groups to raise awareness. Make use of social media/emails - use different formats - person to person, telephone, tablet apps*

*Make it easier to make phone access at specific times, so that calls can be planned. Ad hock receiving calls from the service does not work for everyone. Enable other professionals the ability to contact workers directly. By confirming appointments via a letter from a GP or practice manager. Acknowledge referrals immediately. Communicate with service user/carer directly and copy in GP.*

*Use less technical words, use simple language, Plain English. Dyslexia friendly literature. Language barriers can be an issue so access to translation services needs to be included in any funding together with employing some people from minority groups.*

*There should also be a leaflet or something to be given to people who have used the services in the past in case they need to use them in the future - perhaps information packs to be sent out.*

#### 5.5 In particular, how do you think we can support;

##### 5.5.1 Older people

*Outreach to peoples homes when they can't get out. Home visits - a domiciliary. More outreach support, offering therapy at home to those less mobile. Bring services into where they live so there is easy access. Perhaps more trained volunteers to call for a chat and look for signs that require a professional. Provide services to in-reach into hospitals and homes where older people often face life changing decisions. Care homes specialising in mental health issue.*

*Support groups and social cafes. Help them engage with others and minimise loneliness. Support workers could possibly run "surgeries" in old people's clubs?*

*Drop in community groups, libraries. More activities - run clubs where they can engage each other. Meetings in GP surgery to meet other older people. Adopt a Grandma - buddy system.*

*Connection/liaison with Age UK, care homes, care providers, regional age organisations, joint working local charities.*

*Ensuring the service is local, close by, day centres. Appointment rooms with good access and higher chairs. They need to feel safe to attend. Arrange transport -particularly in rural areas.*

*No telephone assessments. Client patient choice. 1-2-1 and group therapies. Telephone based services, GP practice services. Phone contact not email. Regular contact. Offer other means of access and not just phones and internet.*

*Giving talks. Information to be available for everyone to access. By advertising, leaflet dropping to make them aware of the service. Provide an overview of services and areas in which risks can be minimised. Question and answer sessions to point older people to the right service. Think about how you sell the concept of wellbeing.*

*Access to all types of IAPT services - bereavement, dementia and caring, loneliness. Having it available in daylight hours, Offering as a discrete service to carers of people with Alzheimer's. Provide psychological support to lessen anxiety and recognise depression in older persons. Appropriate support with diagnosis of cognitive impairments required and support to remain independent.*

*Liaise with carers, doctors, GP's, family*

*More money. Fuel poverty. Teach computer skills to open up communications or online social networking. Not treating older people differently, they deserve the same care as everyone else*

### **5.5.2 New mothers**

*More local support groups, clubs, postnatal support groups, Mother's groups, Mother and Baby groups - provide access to other mothers, GP surgery, library, child centres. Counselling and resources to feel less alone.*

*Through GP surgery's and midwives, health visitors and through anti natal clinics. Drop-in clinics at appropriate times either held in the GP surgery. In particular being able to refer or advise new mothers of the support available & be able to refer them to the service. Special unit for mothers. Reduce social isolation.*

*Link with or a talk or something similar at sure start, joint working local charities during anti natal classes, NCT meetings, new mothers at home, community centre coffee mornings, social events . Advertising through mumsnet and other parenting forums and community groups and schools. Where child care can be offered - ensuring there are suitable crèche's available.*

*Outreach at home support, home visits, so that mother can manage this around child commitments.*

*Offering service in a different room, same time as crèche, at playgroups and schools, libraries or at child-centred groups/clubs.*

*Information to be available for everyone to access. Help to cope with the stress motherhood can bring.*

*121s, workshops/courses, mentoring, and education - run lessons in manners, finance, childcare and wellbeing. Sensory workshops; advice surgeries if mothers need advice or reassurance. Drop in 'mother & baby group sessions. Support them. Rapid access is essential.*

*Better mental health training for health visitors. client patient choice*

### **5.5.3 Offenders**

*Go to them if incarcerated - visits in prisons - in reach services, offering this therapy in prisons. This should be provided mandatory as part of their sentence plan. Voluntary referral through to service- not mandatory. These patients can be dealt with within HM Prisons, to the best of my knowledge they already receive funding!*

*Through court diversion. Connections/liaison with young offenders services, prisons. Jointly commission with new probation community services organisations. Work more closely with other agencies, i.e. some have drug issues as an example. Joint working local charities. Groups for offenders. Via probation.*

*At secure accommodation. May be restricted - location and security.*

*Care that can be continued after release, client choice. Mentoring.*

*By contacting prisons and probation & having readily available information & referral facility available for everyone to access. Distribute leaflets in prison, borstals, by police libraries.*

*Helping the community - some kind of rehabilitation, counselling, clubs, they need occupying. Group sessions with professionals and victims. Help with re-integration (if the offender has been inside). Rehabilitate where possible. Support through floating support preparing them for release and continuing after release to minimise reoffending.*

*Also it is probably worth taking an idealistically similar approach that would be taken to the mental wellbeing of service/ex-servicemen/women. Offering access to local groups without revealing background. Offering accommodation in local areas so they can become part of the community. Help finding work and accommodation. Ongoing support socially, positive reinforcement and improve self worth.*

*More mental health nurses -secure units in hospital. Allow several points of access as they may access other services.*

#### 5.5.4 Carers

*Careers groups - away from their charge if possible, group scenarios, local support groups, carer support groups, libraries, agencies, GPs/carers charities, tea and talk regular meetings and information. Talk to organisations that currently support carers. Joint working local charities. Specialist project such as Suffolk. Signposting to peer support groups. Don't forget young carers. Young carers groups, MTM is great. Carers are extremely isolated.*

*Stop unnecessary hospital admissions (if carer gets ill, cared-for needs looking after too!). Flexibility is key, offering therapies at flexible times to suit people with commitments at home.*

*For them to have access to counsellors. If necessary arrange cover. Talk too, involve, invited to sessions if allowed. Carers need extra support, family therapy and CBT, respite, befrienders. Listen to carers view. Validating carers and acknowledging stresses associated with role. A more creative approach to bereavement support. Locally based services.*

*Keep Informed, communicate. Information to be available for everyone to access, information courses. Leaflets that explain the mental health service and all its sections/parts so that people gain access to the right areas and do not waste time and finances. Talk to them and involve them with the treatment. Ensuring that they have access to ongoing support and access to advice when needed. Telephone contact/email, helpline. A central access point for information and help. 24 hour online support for those who are technically able to access the internet but unable to get much time away from home. Advice on how to deal with difficult situations.*

*GP, nurse, social services, community nurse, - patient choice. Carer's are entitled to a carers assessment and offer this at the outset.*

#### 5.5.5 Children and young people

*Through schools - presentations at assembly, schools programme. All schools should have a counselling service that students can access as and when they need to - Engage with school counsellors. Offering therapies in schools or colleges to fit around their timetable. Parents info from school.*

*Connections, liaison with schools, youth clubs, after school clubs, scouts, guides, joint working, local charities, play groups - through existing services aimed at children & young people. Special unit for under 16's. Accessible venues - in young people orientated venues but not schools as it linked to bad experiences.*

*Information to be available for everyone to access. Ensuring that social workers & teachers are made aware of the support available and how referral can be made. Online forums or chat option online social networking sites or other webpage's. Helpline. Libraries. Advertise in schools but deliver outside due to stigma.*

*Through the GP, CAMHS, specialised social workers, teachers - client patient choice. More rapid assessment is essential. Children and young people need to be supported through their families.*

*With lots of activities which will encourage motivation and confidence building, NLP, mentors, groups, play therapy. Around stressful points in the school calendar it might be worth doing school/year wide group workshops & seminars to make sure that the students are dealing with the stress. Workshops tackling bullying, organised park activities, 121 support sessions away from school. Family talks.*

*You don't support this group in the well being service - start to offer something; you are offering virtually nothing at present.*

### **5.5.6 People with disabilities**

*All locations need to be accessible, better access, more accessible rooms, bigger, with windows. Financial support for transport required to attend appointments. More money and no more cuts. In their homes or day centres. Special unit for disabled.*

*Joint working with local charities, NCODP, GPS, disability charities other orgs via appropriate charities. Groups for disabilities*

*Support will vary depending on 'disability'. I have both a mental and physical disability. Particular ability groups will need very specific types of support which should only be delivered by specialist practitioners. A better understanding of range of disabilities and impact they have on MH issues. All providers need to be appropriate with people with comprehension or communication problems.*

*Counselling and listening services, training. Flexible approaches and locations. Monthly talks and phone calls.*

*By communication with Jobcentres, libraries, GP surgeries & groups to make people aware have info readily available. Information to be available for everyone to access.*

*Library, parents, carers, health professionals, websites, health visitors, nurses, doctors, support groups and clubs. Helpline, coffee mornings, support groups.*

*Enabling them to have a voice. Helpline. Buddy. Home benefits,*

*Referral from GP, nurse. offer other means of access and not just phones and internet. Allow several points of access as they may access other services.*

## **5.6 Anything else you want to tell us?**

### **5.6.1 Service**

*The locality you fit into should not mean you don't have the same services to access as other localities i.e Norfolk seem to have more facilities and services*

*than Suffolk, Having recently swapped from Norfolk to Suffolk/Waveney, Suffolk/Waveney seem less able to offer the services I was accessing in Norfolk. The needs for support are so individual, depending on situation, personality, specific symptoms/ diagnosis/ problem etc that the support strategies would have to be equally diverse. Treatment from the wellbeing service should be equal and fair to all of those who need it, not better for those who fit the desired demographic. Needs and treatment should be assessed on an individual basis and structured to meet the needs of the patient.*

*The introduction of the Wellbeing Service was the most productive and positive move the MH services had made for years. This is an invaluable service. I feel as if wellbeing in the workplace is a growing issue, due to increased stresses and targets. Without access to this service, many more people will struggle to cope with workplace pressures. My hope is that this service continues, is enhanced. Please don't cut it, cut corners, overload staff. Its a false economy to have people on unemployment benefits, at the GP surgeries, using expensive anti-depressants, rather than being supported by talking therapies. Not least the human cost of feeling isolated. I think it is invaluable support and vitally important that it should be continued It is a lifeline to many people, especially those who are isolated in this vast rural county of ours. Indeed given the statement within the introduction to this survey with regard exploring the possibility of expanding the service to those with "more complex needs" unless additional resources are going to be allocated then there is a danger of even less focus on prevention and Early Help.*

*A specialist, service with reception is essential. Have more services eg NLP and EFT, support for who have just come out of hospital, self-help groups - use more practitioners.*

*The whole mental health service is wholly inadequate in this area. The service is in crisis. I believe this service has a long way to improve to an adequate level. As a young adult under the age of 30, I get the impression from my own experience that far too little an interest is paid to the mental well-being of young adults save for the most extreme cases. I have read the consultation paper, and am of the opinion that fragmenting a service results in less care.*

*There is no contact with the carer, this is the person who has to live with the sufferer and knows what's really going on as the sufferer does not always tell the truth Frustration for carers.*

*Needs to be a delivered in conjunction with Social Services.*

*Sadly the terms mental/psychiatric/ psychological still carry stigma. Stress and depression are all to readily seen as weaknesses and whilst these attitudes persist it will not be helpful to include them in any title. I think it should stay the Wellbeing Service.*

### **5.6.2 Process**

*I think raising awareness is the biggest issue to make more people aware of it. It is important that people know that the service exists and therefore it is essential to have posters, leaflets etc...distributed widely and displayed in*

*surgeries, schools and public places. There needs to be cross-service co-ordination to ensure that those that need the service know it exists be aware that it exists though. Communications are the imperative by whatever means available*

*Bring the service into the communities for everyone. Direct contact with professionals and direct face to face meetings are better than phone and maybe input from those known to users, as user can easily con professional provider. Help with childcare and travel costs are important in making services accessible to groups such as asylum seekers and mothers. Most but not all are based in Norwich.*

*Waiting times between initial assessment, step 2 work and step 3 counselling have been successfully reduced from a peak of 6 months to just one month. Whatever the problem with long waiting times for therapy it needs sorting out, fast. Waiting lists to receive assessment and treatment are impossibly long, so that desperate people are driven to seek private help.*

*All of these people could be helped more by having workers out in to the community. Local small charities that understand the needs of their specialist groups and who have earned the trust of service users are best placed to help all people regardless of their age/position/status to access services to improve mental health. Close working with the charity is desirable. I would like the opportunity to tell you about Family Actions services - in particular our WellFamily Service and our Perinatal Support Service.*

*At the user forum we considered the possibility of telephone appointments being offered, not at a set time but within a time slot e.g 20 minutes between 2-3pm and specific times.*

### **5.6.3 Allied Services**

*We are a large counselling service accredited by the BACP (British Association of Counselling and Psychotherapy) - we cannot offer support to those who can not pay. Referrals form GP's and the Wellbeing service have increased dramatically over the past 2 years. Those who are unable to afford our low cost sessions are also increasing. If we were able to work in conjunction with the IATP service and receive even a small amount of funding we could support a lot more people in the local area who suffer from mild to moderate depression and anxieties. If people can not access the venue then all the other possibilities need to be available with no fee to the provider.*

*It is clear that there needs to be a variety of options available for service delivery as well as a range of services. Spending cuts have since destroyed many aspects of the service and starting to turn into a mess. Please continue to fund it. As with all services, the availability of this service would crash if all those who would benefit from it applied. There are few acute beds for pts in crisis. Mental health should not be under funded as the problem just goes out into the public and back on the streets.*

*Many GP's really value their GP counsellor - IAPT needs to ensure it supports and invests in the counsellors that are in the region and to not put all its money in to CBT as it has been doing over the last 6 years.*

#### 5.6.4 Therapies

*Mind mental health first aid training and mind associates community and program events is a non-IAPT part of the Wellbeing service that we are also very proud of and wish to expand. Consider inclusion of support networks when appropriate in meetings to assist achievement of set goals. The service needs to be available through a variety of methods to suit all users to meet individual needs.*

*Counselling that is offered by qualified and accredited practitioners is an essential benefit to wellbeing and 'Counselling for Depression' is an IAPT supported intervention. Hopefully the IAPT Counselling for Depression service is going to be supported in the East, as it is in the rest of the country. There is not enough support for people who are depressed.*

*Too many less extreme cases are swept aside and expected to "just put up" with their problems despite clearly lacking the tools and the ability to do so. The end result that we suffer in silence which only leads to a further deterioration. Surely prevention early on is far preferable to dealing with the worst case scenario later?*

#### 5.6.5 Staff

*The best way of improving services would be to employ more staff and so make more appointments available and services more accessible to a wider range of people. It needs to be sufficiently staffed to improve the delivery. If we are as a service promoting this I really hope there is enough professional staff to deliver this service to all individuals. Training staff and carers would be useful. The current service seems to be slow and over-loaded with little support for GPs and the bulk of assessment and treatment being attempted by relatively junior/inexperienced nursing staff. Trust and consistency are key indicators of therapeutic success. Make sure all staff have equality and basic awareness training.*

#### 5.6.6 Information & Resources

*I think that in addition to the leaflets there could be access to a drop in information session to facilitate person to person contact to give information and advice about the Wellbeing Service and Mental Health First Aid Training and NHS Mental Health provision. Most people do not know this service exists or how to apply or what exactly CBT consists of. Counselling for Depression training for counsellors is being funded across the country and the Eastern region has been slow to get it off the ground. There are signs this is changing. We (counsellors) have much research based evidence and this is continuing to build. Many GP's and practitioners are not aware Counselling for Depression exists. There is an NHS leaflet available and this describes Counselling for Depression <http://www.iapt.nhs.uk/silo/files/which-talking-therapy-for-depression.pdf>*

### 5.6.7 Venues

Access to suitable venues is an issue in rural Norfolk. People don't wish to be 'seen' attending sessions due to stigma so nearby alternatives may need to be found. A permanent dedicated space is important as many people like the atmosphere of calm is not to be underestimated in terms of the benefit.

### 5.6.8 Questions

As most mental health awareness literature is constantly informing us (the public) that mental health issues can affect anyone at any time, and that no group or section of the population is immune to suffering from these issues, why is it that the NHS feels the need to target certain demographics?

Why are certain people excluded from the groups above? Just because I am single, working, in my thirties, do I not deserve the same support as the people in the above groups?!

## 5.7 The Future – Findings

- Self referral and GP referral were the preferred methods for accessing the service.
- GP surgeries or primary care centres, specialist therapy centres and community centres were the preferred venues for service delivery.
- All of the proposed time frames were suggested as time when people would want to access the service, which included out of hour provision.
- The service could be made accessible by providing the service in a timely manner, at a range of physically accessible locations in the community, at suitable times with service users being able to self refer using a variety of access points. The service should be offered more broadly to a wider range of users, delivered by competent staff, be clearly signposted and integrated with other services. Communication needs to be reliable, straight forward and clear.
- Older people can gain access by having outreach or home visit services provided, through social networking opportunities. Third sector involvement is recommended. Telephone assessment or consultation should be avoided. Information should be provided and specific issues addressed.
- New mothers can gain access through social networking, primary care providers and other services. Venues offering child care and outreach services are suggested. Specific issues should be addressed.
- Offenders can gain access to the service through an outreach service, having attendance mandatory, connecting with other services, rehabilitation and probation programmes and secure venues.
- Carers can gain access to the service through local support groups, personal health assessments, access to training and support and through primary care.
- Children and young people can gain access to the service through schools and school based staff, related children's services, specifically targeted information, primary care and through social activities.
- People with disabilities can access the service through consideration of physical access needs, transportation, joint working with local charities, specific support depending on the disability, counselling and training, advocacy, and primary care.

- Further comment were provided regarding the service, the process, allied services, therapies, staff, information and venues.
- The service was regarded as being of a different standard in Suffolk and Waveney. The introduction of the service was regarded as a positive step. Mental health provision is regarded as inadequate overall.
- The process can be enhanced by raising awareness of the service, taking the service into the community, speeding up assessment and treatments, collaborating with other providers and providing funding.
- Allied services and other providers were interested in providing services, a wider range of services should be offered, GP's were highly valued.
- Therapies including counselling and courses could be extended.
- Staff shortage was of concern.
- Information and advertising could be enhanced.
- Venues, including rural access should be considered.

## 6 How likely would you be to recommend it to a friend or member of the family?

### 6.1 Response table 6

Answer Options	Response Percent	Response Count
1 Extremely likely	27.2%	37
2 Likely	19.9%	27
3 Neither likely nor unlikely	15.4%	21
4 Unlikely	14.7%	20
5 Extremely unlikely	12.5%	17
6 Don't know	10.3%	14
<i>answered question</i>		<b>136</b>

#### 6.1.1 Family and Friends test findings

- >47% were extremely likely to recommend this service. >27% were unlikely or extremely unlikely to recommend this service. >25% were neither likely nor unlikely or didn't know if they would recommend this service.

## 7 Meeting Notes

### 7.1 Contributors

Consultation and public meetings were held with the following organisations;

- Norwich Older Peoples Forum
- Sue Lambert trust
- Oak Street medical Practice
- MIND BME network
- Deaf Connexions
- NHS Norwich Community involvement Panel
- Mind Carers Forum
- North Norfolk Mental Health Forum
- North Norfolk District Council Older Peoples Forum

### 7.1.1 Issues raised

Issues/comments raised at meeting with organisations regarding IAPT and feedback for the consultation from meetings held.

Concerns it will become fully telephone referral service and predominantly treatment through internet and self help sessions - as older people find it difficult to not only hear/understand on phone but have issues around discussing sensitive issues such as mental wellbeing. BME minorities experience language barriers. Referral process should not just be by telephone or email nor should treatment, patients should be offered alternatives including group and one to one sessions. Sexual abuse survivors would not be able to discuss issues over phone and need face-to-face with specialist counsellor.

Referrals from IAPT/Wellbeing services are received as the service is unable to cope with issues around domestic abuse and sexual violence. Lack of access for a large number of older people. Easy referral process to the IAPT both self-referral and GP referral.

Easier access to service around IAPT needed. Stigma attached to mental health issues for some BME communities. When agencies were allowed to book the appointments it was easier. Better signposting of carers to social care assessments is needed.

Concerns no access to interpreters and translators for face to face and any documents. Did not like to use interpreters with counsellor. I didn't feel they understood the issues and context'. Would prefer deaf counsellor who can sign fully one to one. IAPT won't book interpreters and lots of cancellations so big gaps between seeing people.

Face to face assessments are available for those who require it

The service helped a little bit. Patient need to have opportunity to choose their preferred method of engagement. More access to face to face care (at least initially) is preferred.

Waits for current service too long needs to be addressed in new system,

Patient feedback needs to be taken into account when new service is up and running and allow flexibility for changing when things are not quite right, and

Contracts need to be managed more closely to make sure providers are delivering against the contract.

Much better awareness in Norfolk among carers of what the service can offer. The improvement of awareness among older people in North Norfolk

More clarity around what this service will do compared to secondary care mental health. Better communication with patients and other services. Integration with other pathways. Focus on how the interface with Youth

Services can be improved, particularly branding of the service and thereby attract more young people. Confusion between IAPT and secondary care mental health. Across all three arenas there was a great deal of confusion between what is IAPT and what is secondary care mental health.

## 7.2 Meeting Notes – Findings

- General concern was raised regarding the suitability of telephone referral and services. Groups particularly concerned included BME minorities and sexual abuse survivors.
- Face to face therapies are preferred.
- The IAPT were not meeting the demands placed on the service.
- Access concerns were raised – in particular concerning BME service users, language and provision of interpreters.
- Waiting times for service are considered to be too long.
- The service needs to be quality assured.
- Awareness of the service has improved.
- Integration with other services is recommended.

## 8 Comments regarding this consultation.

### 8.1 Comments

*Take note of service users opinions and get them involved to help others and spread the good work of the service. Hopefully the comments made by myself and others will be acted upon. I sometimes feel with the NHS that service users views are not always heard, they tend to use the same people on a lot of the decision making panels which is not representative of service users views. It feels sometimes like a tick box system just to say service users are involved but not sure how effective this is. I really hope that this helps to keep the service available with more funding. I never fill these things in but felt I had to when I saw this. Thank you. I hope views are taken on board and improvements are made. I hope views expressed are truly listened to and considered when reviewing the service.*

*We fully appreciate the need and desire to gain information from individual service users but given the questionnaire is also to be used by organisations I do feel more care and thought should have gone into its design and wonder if it was trialled by organisations prior to wider circulation. Our major concern is the consultation is too narrowly focussed on the IAPT service and therefore there is a real missed opportunity to properly consult in Tier 1 to 3 mental health services. The nature of this consultation feels rather ill-conceived. It really misses a great opportunity to consult fully on emotional wellbeing and through that prevention and Early Help, a great shame as this is one of the three priorities of the Norfolk Health & Wellbeing Board. This consultation survey really hasn't asked much or looked for a great deal of information. I do not feel that the right questions have been asked here to make the survey viable. This is a very limited survey and did not allow me to express all of my concerns. As a GP surgery the survey was not relevantly phrased for us to reply Proper provision of mental wellbeing needs: an understanding that only 10% of people are psychologically robust (see Harvard study) i.e. unlikely to*

*need help with their mental health. 90% of the population will need roughly as much help as they do with physical health. This consultation is tinkering.*

*The questions were very clear and user friendly. It is good to ask for our views. Thank you for this consultation. Keep up the good work, thank you for consulting with the public. Glad that its happening. Well done.*

*The questions are very curious. Initially you asked what category of respondent I am - I ticked service provider but all the questions relate to service users - there should be a short cut to the few relevant questions if you are not a user. Much of this is already covered in the answer to 'any other comments', perhaps another example of a slightly poorly constructed questionnaire. It consults largely on an existing rather narrowly focussed service (IAPT) and yet with the question above invites a wider contribution e.g. it asks about children and young people but the Wellbeing Service is specifically for those aged 16+.*

*Individual charities were not contacted to share some helpful valuable experience in the case of the one to one project Nelson house kings lynn over 25 years of working with local community helping those with mental health problems and those supporting people struggling with mental health problems . Please do consider contacting us to help with the consultation.  
[www.onetoneproject.com](http://www.onetoneproject.com)*

*You have not found the right people to consult in general. I only know about it through my own efforts despite being a County Councillor and being involved in a Charity.*

*It is only because I am Chairman of a Charity that I was informed by NCAN about the Consultation. The consultation was advertised at work.*

*Very poorly advertised. I was looking for the recent consultation about saving money and came across this one. It's such a pity that this consultation was not published via local media. This needs to be conveyed to individuals either through GP or media.*

*It is certainly not clear from the nature and content of the survey how the information provided will inform if the service is appropriate and needs expanding for those with more complex needs. It would be really good if as a part of the information gathering specific workshop(s) were offered for the Voluntary Sector.*

*There does not appear to be any thought of the logistics of this plan, by which I mean all the additional travel expenses incurred by asking adults in care to move to new areas outside their comfort zones this will lead to disorientation all concerned. It is far from clear how you will be 'talking to people' and how you will recruit to focus groups and recruit representatives.*

*There was a huge amount of information beforehand which I am sure some people found off putting. There's no description of the existing service so I've no idea what you have been able to put in place.*

*I think surveys are a really good idea but only if the information is used effectively and the people evaluating this feedback is from a wide cross section of the community including service users, carers and professionals. It is also important that the evaluation and outcomes and staff involved remain impartial.*

*Again given the IAPT service is for those aged 16+ there is a real missed opportunity to include CAMHS. Page 7 of the survey itself is incorrect in that it states the service offers "adults" yet of course it is available to children aged 16+.*

*I think this consultation process is very necessary and perhaps direct access via a printed form could be sent to previous users for those people who do not have access to consultation via the Internet.*

### 8.1.1 Consultation – Findings

- Feedback should be carefully considered and listened to.
- The questions were too narrow.
- The questions were clear and user friendly.
- The survey was oriented towards the service user.
- Secondary care and third sector involvement in the consultation was suggested.
- Consultation advertising concerns.
- More clarity is needed regarding the service and how this feedback is going to be used.

## 9 Report Outcomes

This report has been developed independently using the feedback provide. All queries concerning this report can be forwarded to the author. All further correspondence should be forwarded to the Wellbeing service.



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\* Consulting the community is a research centre of academics from the social sciences. This method for analyzing feedback has been developed by colleagues from this centre. Enquiries can be made at the email address above.  
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