Talking Therapies Focus Groups – Key Findings

April 2013

Contents

Introduction

1. As part of the public consultation process in respect of the re-commissioning of Improving Access to Psychological Therapies (IAPT) services in Liverpool, Liverpool Mental Health Consortium (LMHC) was asked by Liverpool Clinical Commissioning Group (LCCG) to consult with members of the public – particularly people from under-represented or seldom heard groups – regarding their experiences and expectations of talking therapy services.

2. In order to design and deliver a creative and 'different' approach to the task, LMHC worked in partnership with staff at Liverpool John Moores University (LJMU) to deliver a tailored programme of interactive qualitative data collection via 6 focus groups. The approach being to use a combination of 'visioning' and 'reflective' techniques to draw out opinions, experiences and suggestions.

3. The focus groups were targeted at a range of service users who may have specific mental health support needs which can be addressed through talking therapies but who may experience barriers in accessing them for a number of reasons. These included: older people; younger people (18-25); people from Black and Minority Ethnic (BME) communities; veterans; people with long-term health conditions (e.g. diabetes, asthma, coronary heart disease, COPD) and lesbian, gay, bisexual and transgendered (LGB&T) people.

4. The focus group participants were recruited by LMHC through direct contacts and via their stakeholder networks/partners.

5. The focus groups were run over 2 days (March 20th/22nd) and utilised 2 techniques.

   A) Group work using LEGO Serious Play™ techniques to aid discussion on what mental wellbeing looks like

and

B) an interactive session using LJMU's Distiller technology which allows participants to add anonymous comments and suggestions to a collectively generated 'mind map' in response to a range of questions relating to their experience and/or expectations of talking therapies.

6. Data from the sessions was distilled into thematic categories (attributable to the respective demographic groups) during the course of each session and provided to LMHC in Word format following completion of all 6 focus groups.

7. Workshops were facilitated by fully-briefed staff from LJMU and LMHC staff with additional support staff as required (e.g. Community Development Workers (CDWs) to support BME participants including refugees and asylum seekers) which ensured that participants with language or IT support needs received adequate support in contributing to the sessions.

8. A further focus group aimed specifically at Inclusion Matters Liverpool (IML) service users was held by LMHC on 10th April using exactly the same questions as had been used in the previous 6 focus groups. LEGO was not used in this instance but participants were asked to describe their ideal talking therapy service. Comments and findings from all 7 focus groups are included in Section One below.

9. People who were unable to attend the focus groups for a variety of reasons were encouraged to feed their comments in by a) attending the Stakeholder event held by LCCG on 27th March at The Women's Organisation *(see separate report produced by LCCG)* b) completing a questionnaire *(see separate report produced by LCCG)* or c) making comments directly to LMHC.

10. Comments made directly to LMHC have been included in Section Three below.

Section One - Focus Group Findings

A total of 71 people booked places to participate in the 7 focus groups although actual attendance was 40 people. Attendance at the 3 focus groups held on 22nd March was, unfortunately, affected by heavy snow.

A) Accessing Therapy

A1) How did you access the therapy?

The overwhelming majority of participants had been referred for talking therapies by their GP.

Others had contacted therapists directly, sought word-of-mouth recommendations from friends, been referred through university services, Asylum Link, schools, CAMHS, Mersey Care's Early Intervention Team, Barnardos, a psychiatrist, A&E or supported housing projects.

A2) What if anything was difficult about getting the therapy?

The main difficulty raised was waiting times for treatment.

Other issues of concern were anxiety about raising the topic with a GP/embarrassment/finding the courage to go, understanding what therapy entails (*BME/refugees and asylum seekers*), language and cultural barriers (*BME/refugees and asylum seekers*), feeling exposed/judged (*LGBT*), knowing who to talk to, cancelled appointments and some GPs being seen to be "less than sympathetic" (*long-term health conditions*).

A3) Was any other treatment/support offered or suggested to you at this point?

53% of participants had not been offered any other treatment or support at this point. 47% had been offered other treatment or support.

A4) Other treatment/support offered?

The other support or treatment offered included signposting to other organisations, medication/anti-depressants, self-help material, support around diet and sleep-issues, herbal remedies, yoga, gym and talking to family/friends.

Some participants disagreed with the use of medication to deal with anxiety or depression and others felt that it was prescribed too easily and not always reviewed often enough.

"Medication needs reviewing when CBT starts." (*Inclusion Matters Liverpool client*)

It was also recognised that GPs only have limited options and resources.

A5) Were you given any choices when your treatment was arranged?

64% had been given some sort of choice about their treatment. 36% had not.

A6) What choices were you given?

The most commonly offered choice was around dates/times of treatment.

Some participants were also offered choice about venue (particularly in relation to reducing waiting-time by attending a different venue), type, length and frequency of treatment and gender of therapist. In one case an individual was offered a choice between outpatient or residential treatment (*veteran*).

A7) What choices would you have liked to have been given?

The principle common thread for all groups was a desire for a choice of therapist and therapy type – provided that adequate information about therapy options was provided and understood.

The other major theme was choice about the number and frequency of sessions with a basic 10-week programme of 60 minute sessions (50 minutes of talking therapy and 10 minutes reflection) suggested as standard – rather than 6 weeks of 30 minute sessions as currently offered within IAPT.

"Maybe a better discussion beforehand about what could be/was offered." (*LGBT*)

"A choice of possible therapies but only if properly explained." (*Long-term conditions*)

"Didn't know what was involved or what choices were available." (*Older people*)

"I wasn't offered a choice of therapist but in fact my therapist was a similar age to me which I felt was helpful in developing trust and empathy." (*Inclusion Matters Liverpool client*)

"A one-size fits all approach isn't appropriate it needs to be more individual – weekly, every other week or monthly as suits the person." (*Inclusion Matters Liverpool client*)

Other options that would have been helpful included LGB affirmative therapist (*LGBT*), gender of therapist, more frequent appointments, choice of venue, choice of interpreters (*BME/refugees and asylum seekers*), information re therapist's competence (*BME/refugees and asylum seekers*), alternative therapy – not trauma focussed (*Younger people*).

A8) If you had to wait for your treatment, what impact, if any, did waiting have on your symptoms?

Participants had experienced waiting times of between 1 week and 5 months between referral and the start of therapy. The waiting times for CBT were generally considered to be shorter than for counselling.
The biggest impact of waiting for treatment for all groups was an increase in stress and anxiety levels with "life at a standstill", "symptoms amplified" and "wellbeing levels going backwards".

"Having to wait even a week would have had an impact because I didn't go to my GP until I was *in extremis*." (*Older people*)

"Treatment not in sync with difficulties." (*LGBT*)

"The longer the depression lasts the worse it gets, generally." (*Long-term conditions*)

"Waiting for counselling is a big negative." (*Inclusion Matters Liverpool client*)

A number of individual impacts were noted including admission to an acute ward due to deepening depression, exclusion from school, missing exams, anger, feeling forgotten and fear because IML letters look similar to Home Office letters (*BME/refugees and asylum seekers*). The knock-on impact on partners/families was also noted with some participants reporting that their partners had also started to show signs of depression or anxiety during this waiting period.

However, some people felt that the wait did not have an undue impact:

"Anxiety but glad something was planned." (*LGBT*)

"No impact because I knew it was going to come." (*Older people*)

"You can have hope even when waiting because you've put the wheels in motion." (*Inclusion Matters Liverpool client*)

"Reflection time can make you dissect your symptoms which can be both positive and negative." (*Inclusion Matters Liverpool client*)

A9) What, if anything, would you improve (or change) about the process of accessing therapy?

The principle improvements to accessing therapy focussed on quicker access, better information about, and explanation of, available options, self-referral, direct referral from voluntary and community organisations (*BME/refugees and asylum seekers*),

cultural intermediaries (*BME/refugees and asylum seekers*), improved awareness about metal health and talking therapies amongst GPs, community workers and the public, increased numbers of therapists.

Other suggestions included online access rather than waiting for a GP appointment, explicit statement about options and perspective on sexual diversity (*LGBT*), it should be offered/mentioned to all students at the start of each year instead of having to seek it out.

Older People's services at Mossley Hill were thought to be more easily/quickly accessible than general services. It was also suggested that people with alcohol dependency need somewhere to 'check in' on a daily basis as they can be "devious" about alcohol use when they aren't required to see a therapist.

Physical access can be hampered by e.g. "dark stairs or over-lighting" (*Older people*).

A specific recommendation was that regular telephone calls during the waiting period would provide re-assurance that clients hadn't been forgotten and that they were moving up the queue. Re-assessment would also be welcome if the wait became particularly long.

A 'starter pack' including leaflets about practical 'self-help' things to do whilst waiting for therapy as well as what to expect from the process would be as helpful/more helpful than information on medication.

A10) Looking back is there anything else that would have helped your symptoms before your therapy started?

Answers to this question were in some ways similar to the previous one with a focus on better access to information, clearer explanations of the types and purposes of therapy and what to expect from the process, more information about talking therapies available at GP surgeries, more time with GPs to explain the problem, access to information in a range of languages (*BME/refugees and asylum seekers*).

"More general information about a range of therapies would be useful. CBT is favoured because of factors such as cost and time but other options exist e.g. solution focused therapy." (*Inclusion Matters Liverpool client*)

"It wasn't clear to me when a referral was made that I would be having CBT. I thought I was being referred for counselling and this had an impact on my levels of contact with my family as I didn't want to discuss or dwell on certain issues with them. I think if I'd known I would be getting CBT, and if I'd understood what that meant, that I might have had more contact – more *positive* contact – with my family." (*Inclusion Matters Liverpool client*)

Although the majority of participants would have valued more access to information, a minority were concerned that too much information may be confusing or have a negative impact.

Other suggestions included: sign-posting to appropriate resources/other organisations/social groups/peer support groups/drop-ins or activities, more supportive GPs, choice of therapist/therapy, better trained staff in schools/colleges including learning mentors and more support from families.

As specific recommendation in terms of the Navy was that alcohol and drugs awareness should be given a greater priority.

"If the Navy hadn't issued alcohol every day I wouldn't have been in such a serious position." (*Veterans*)

B) Receiving Therapy

B1) What, if anything, was good about your therapy?

"Can I say 'everything'? If so, 'everything'!" (*Young people*).

There was considerable positive feedback about the benefits of talking therapies. Positives included: time (to talk), empathy, confidence, moving forward, keeping a diary, challenge, motivation, breaking the cycle, a good environment, a rational/logical/concrete approach.

Other positives were listed as: felt validated, listened to instead if talked at, time given was flexible as didn't speak English as first language (*BME/refugees and asylum seekers*), felt safe/listened to/understood/valued, learning to become your own therapist.

Professional staff were also referred to positively:

"Warm, empathic, therapist." (*LGBT*)

"Counsellor was amazing." (*LGBT*)

"Psychologist took a long time to get to know me (weeks) before she started any therapy so that I was able to trust her before we had to do some fairly unpleasant hard work – a contrast with the block of weeks that get offered to younger people." (*Older people*).

"Therapist – listening, understanding, being honest, challenging your thought process." (*Inclusion Matters Liverpool client*)

"Being active in the process of getting better. Reconstructing myself – not as the 'old' me but as a 'new' me who can manage." (*Inclusion Matters Liverpool client*)

"Setting small, manageable, targets and reporting my achievements back to someone who isn't emotionally involved and who I know I'm not a burden on." (*Inclusion Matters Liverpool client*)

"Saying something out loud isn't as bad as thinking it in your head." (*Inclusion Matters Liverpool client*)

However, there was some criticism of initial assessors in contrast to therapists:

"My initial 'assessor' (before the CBT) - her approach was a 1 size fits all and didn't listen to what I was saying." (*LGBT*)

"After the assessor, I was given much better help and support." (*LGBT*)

The most negative feedback was in relation to ex-service personnel:

"I don't think there was anything good really. There was no rapport between me and the therapist. I felt looked down on. No sense that the therapist was there to support - it felt more judgemental. The initial contact is crucial – need to let the service person open up to you - don't just fire questions at them. A lot of them are at a critical stage by the time they seek help." (*Veterans*)

"Counselling felt like talking to a brick wall but CBT was more constructive and forward-looking." (*Inclusion Matters Liverpool client*)

B2) What, if anything, was disappointing about your therapy?

Despite the generally positive experiences of focus group participants, there were a range of less positive comments. The principal concerns for all groups were that there were not enough available sessions and that sessions were too short. Other issues related to cancelled sessions and the negative impact this can have on the process of moving forward and reporting back on progress made – advance notice of changes to sessions would help. There was also a preference for face-to-face sessions over telephone sessions and a request for a book about CBT and what to do next which could be used as an on-going resource – not just leaflets.

Specific concerns from individual focus groups included:

"CBT needs enough knowledgeable interpreters." (*BME/refugees and asylum seekers*)

"Lack of cultural understanding." (*BME/refugees and asylum seekers*)

"I felt judged/pathologised because of my sexuality." (*LGBT*)

"Lack of LGBT understanding." (*LGBT*)

"No understanding of ex-service people." (*Veterans*)

"Too trauma focussed." (*Young people*)

"Therapists seemed to want to argue rather than talk." (*Older people*)

"Computerised CBT." (*Older people*)

"Form filling can be off-putting. Scaling is confusing and too vague – it would help to have a box at the bottom for 'further information'." (*Inclusion Matters Liverpool client*)
"A follow-up appointment would be good – maybe 4 to 6 weeks after the end of therapy – to review how things were going, tailored to need." (*Inclusion Matters Liverpool client*)

Again, there was some criticism of the assessment process:

"Initial assessor didn't listen to what I was saying but pushed more of her beliefs and ways in which I should get better. I had to tell her what I needed... then the CBT sessions were a lot better." (*LGBT*)

B3) How could your experiences of therapy have been improved?

Again, the common themes were around earlier access, more signposting/information, better explanation of therapy types, improved choice based on individual need/person focussed, longer sessions.

Other suggestions included: a contract at the start of sessions, more private waiting area, more input from me about the goals of therapy,

Specific suggestions were:

"More awareness of LBGT issues from therapist." (*LGBT*)

"Therapist with specific training in gay affirmative models and proof of this." (*LGBT*)

"Choice of interpreter." (*BME/refugees and asylum seekers*)

"Break midway through talk." (*Young people*)

"There are medics, psychiatrists etc within the services but where do they go afterwards? These are the people who would understand and should be encouraged to go into specialist services for ex-armed forces personnel." (*Veterans*)

B4) How, if at all, did therapy have a positive impact on you?

Answers centred on validation, improved confidence, self-esteem, gaining strategies and techniques for staying positive and becoming better at problem-solving. Some individual responses included:

"Doing what it said on the tin, helping to get me back on track." (*BME/refugees and asylum seekers*)

"I got referred to a service I'm now VERY happy with." (*Young people*)

"Getting out was the first step on my road to recovery." (*Veterans*)

"Regained a sense of reality." (*Long-term conditions*)

"I still set myself targets and practical goals and reward myself. I wouldn't have been so kind to myself prior to therapy." (*Inclusion Matters Liverpool client*)

"I'm not ashamed about anxiety any more, now I can talk about it openly. Therapy makes you more human. You don't mind if people judge you – you can deal with it." (*Inclusion Matters Liverpool client*)

Other benefits included learning enough to pass on to others and improved relationships with colleagues, partners and friends.

B5) How, if at all, did therapy have a negative impact on you?

The negative impact of therapy tended to focus on feeling judged, becoming too reliant on services, reliving the past, setting off negative triggers and anger.

Comments included:

"I got stuck in it – too reliant – and therapist got stuck with me." (*BME/refugees and asylum seekers*)

"One experience made me feel as bad as when I'd started - no feeling of empathy from counsellor." (*LGBT*)

"Some things I had to go through were hard but I knew I had to do it." (*Older people*)

"I sometimes felt down after sessions and was left wanting more." (*Inclusion Matters Liverpool client*)

"I wish I could do things more naturally and not always stop to think what my therapist would say." (*Inclusion Matters Liverpool client*)

"Tasks that I was given to help deal with my OCD could be overwhelming – precisely because of the OCD. But this was eventually modified for me and became easier." (*Inclusion Matters Liverpool client*)

"One issue is that since I've been treated for anxiety my GP now tends to attribute everything to anxiety which can be frustrating." (*Inclusion Matters Liverpool client*)

B6) What other services/who else did you use for support?

The vast majority of participants mentioned friends and family as being invaluable sources of support – although some people did not have strong friendship or family networks and others mentioned that they could only confide in some, selected, family members or friends. GPs were also cited as being important.

Other useful sources of help included self-help books, walking and exercise, reading, drop-ins, group therapy, exercise, volunteering, drug and alcohol services, low dose anti-depressants, the Advocacy Rights Hub (now Healthwatch Liverpool) – for signposting to helpful agencies, Trade Union welfare services, a Mum's Group and a workplace Women's Group.

Specific sources of support for each group included:

Asylum Link, refugee support projects, Sola Arts, Community Development Workers, mosque. (*BME/refugees and asylum seekers*)

Lesbian and Gay Foundation, Queer Notions. (*LGBT*)

School, Mary Seacole House, MYA, Barnardos, YPAS, Inclusion Matters. (*Young people*)

Everton in the Community, Breckfield Centre, The Brink. (*Veterans*)

Psychiatrists home visits, CPN, wrap-around services at Mossley Hill, neighbours. (*Older people*)

Psychiatrist, nurses, physiotherapists. (*Long-term conditions*)

B7) Did you complete the course of therapy?

80% of focus group participants had completed their course of therapy and 20% had either not completed or not yet completed.

B8) If you didn't complete the course, why not?

In several cases the course of therapy was still on-going but other participants had stopped their therapy prematurely for the following reasons:

- no contract
- offered strange alternative therapies as well as counselling
- therapist retired and wanted to refer my on but after my experience with him I walked away from it. Later found another therapist that I re-engaged with by through private means
- no clear information of what therapy was offered
- changed address
- wasn't helping enough
- didn't like therapy type
- didn't like therapist
- just didn't want to go
- too invasive
- wasn't working
- I backed off once therapy my partner was receiving improved and our home life also improved

B9) Looking back is there anything else that would have helped your symptoms while you were receiving therapy?

The most frequent response to this question was "peer support".

"More places to go where people understand you." (*Veterans*)

Other suggestions included social opportunities/support groups/networks, a more accepting atmosphere at work/school/college, an online community, more tailored support and information for partners and families, quicker referral, not being moved from worker to worker, yoga, knowing more about the illness, signposting, more stable home life/accommodation and being able to telephone someone at a crisis point for help in calming down.

C) Exiting Therapy

C1) How did you feel when your therapy ended?

On a personal level the feelings reported at the end of therapy were split relatively evenly between "happy" and "sad" – in one case both "happy and sad".

Whilst some participants reported feeling a lot better, more confident, relieved and lighter. Others were disappointed, angry as not enough time was allocated, let down, worried their condition would recur or felt "worse about myself than when I started."

The most common concern was that people would have valued more sessions than they had been allocated.

"I felt like it was a positive milestone I'd reached." (*LGBT*)

"Not over the moon but glad I'd done it." (*Veterans*)

"My problems were the same." (*BME/refugees and asylum seekers*)

"Devastated – I'm just getting somewhere and now it's stopping!" (*Inclusion Matters Liverpool client*)

"A sense of achievement. Like I'd graduated!" (*Inclusion Matters Liverpool client*)

C2) How did you feel about the way your therapy ended?

This question was designed to look beyond people's personal feelings about the end of therapy and to focus on the 'exit process' itself.

Again, the response was mixed with some people having had a very positive experience and others less happy with the process.

The main concerns related to a lack of control about the ending, the perceived abruptness of the ending and a lack of onward referral.

However, when these things were in place, the experience was viewed much more positively.

Some sort of written summary of achievements and personalised key points to keep in mind was also felt to be helpful. Some participants reported receiving a document of this type, some had been shown it by their therapist but not given their own copy and others had not had sight of such a document. A more consistent approach would be welcomed.

"You're only given so many sessions but I was away with the fairies when I was told that. Then one day I was told that the last session would be the next week. I was shocked and felt that I may just as well end the therapy right there and then... I know it's draining on resources but people need support for as long as they feel they want it." (*Veterans*)

"Use of an "ending session" where I could talk to my counsellor about it and sum up." (*LGBT*)

"I thought it was managed very well. Parting comments between therapist and myself were very upbeat, supporting and positive." (*LGBT*)

"It was a gently handled process, almost a hand-over in the way it was reduced at my control." (*Older people*)

"Poor as session was not long enough and support was not put in place." (*Young people*)

"Left high and dry." (*Long-term conditions*)

"My therapist told me all the positive things I'd achieved and it felt positive." (*Inclusion Matters Liverpool client*)

"The first time I had therapy it was going well but the lack of promised follow-up set things back. The second time was totally different." (*Inclusion Matters Liverpool client*)

C3) Were you signposted to any other services/organisations/groups?

As was highlighted in the responses to the previous question, the lack of signposting or onward referral was an issue of concern. Three quarters of participants (76%) had not received any signposting whilst a quarter (24%) had.

C4) Which services/organisations/groups were you signposted to?

Signposting was mostly back to the individual's GP but also included support groups or organisations (e.g. YPAS and British Epilepsy Association), Mindfulness Therapy, the Advocacy Rights Hub (Healthwatch Liverpool), the Inclusion Matters website and action oriented activities including volunteering.

C5) At the end of your therapy were you offered any on-going support?

63% of focus group participants had not been offered any on-going support – whilst 37% had.

C6) On-going Support

The most common source of on-going support offered was the individual's GP (who could re-refer if needed).

Other forms of support or treatment offered included to engage with another therapist, to contact the service again direct, drop-in days, YPAS, referral to CMHT, possible referral to a psychologist, contacting Mersey Care's Crisis Team ("which seemed daunting"), self-help leaflets, Inclusion Matters website and different medications.

C7) Looking back what, if any, additional services / support would you have liked at the end of your therapy?

Once again, the most frequent requests were for onward referrals and signposting to relevant support services and more follow-up at the end of therapy.

"Maybe signposting to something not as formal as a doctor's surgery or CBT sessions but something in between." (*LGBT*)

"More follow-up – such as a review session after a month – would help to deal with the feeling of abandonment and would also benefit the service in terms of client feedback." (*Inclusion Matters Liverpool client*)

Specific requests were made for:

a) "Improved support for BME communities designed to meet their cultural needs and for better awareness by talking therapy providers of the range of support available from BME community groups." (*BME/refugees and asylum seekers*)

b) "Better sign-posting to veteran's support e.g. Inside Right at Everton and social support groups/networks. Also the Breckfield Centre - volunteer schemes - gives you something to keep yourself occupied and something to get up for in the morning. Lads who had served in the forces are living in the Whitechapel - don't know how to pay a bill or look after themselves and regress to being 16 year olds after they leave the services. No experience of civilian life." (*Veterans*)

c) "A crisis number/website for young people to access – similar to Childline." (*Young people*)

d) "Better feedback/handover to GPs at the end of therapy in letters such as consultants send from hospitals – with a copy to the client. A 'score' for how you progressed in therapy should appear on the GP's file and may reduce stigma or the tendency of GPs to attribute everything to anxiety etc." (*Inclusion Matters Liverpool client*)

There were also a number of requests for 'easy access' to talking therapy services if needed in the future and for a CBT Helpline.

"The possibility of easy re-access to services according to my needs at a later time; not GP and/or the dreaded Royal Liverpool Hospital." (*BME/refugees and asylum seekers*)

Further suggestions included: information on online resources, self-help material and self-help groups, a document containing "what now" help, community based support and activities - non clinical, and a 'blueprint' of what has been achieved in therapy, possible problems to come and information about how someone may be able to handle this based on their previous therapy discussions.

C8) Other issues

At the end of the sessions, participants were offered an opportunity to make any further comments or add suggestions that they felt they had been unable to contribute elsewhere. These included:

- assessment and actual therapy differ in terms of quality
- specific questions about how therapy interacted with sexuality
- how the actual building where the service was could be improved
- information that therapist had some training to do with LGBT issues
- the availability during the day time - could sessions be available after 4/5pm because I felt to have regular sessions means taking time of the day every week or 2 weeks
- questions about period leading up to accessing therapy. I was in contact with psychiatric services as an adolescent and no-one ever asked me about my sexuality therefore this opportunity was missed
- who else should/could be involved in the signposting process
- what is the assessment process? Who undertakes it?
- I recently started a new job where I was introduced to a PSS which is helping
- therapy in general has been an amazing thing for me

- longer sessions
- I think that schools should be more involved in referrals and general other services
- listen to us we are no different
- the chairman of my organisation has been hiding some secrets, and he's not running the service correctly
- that trauma focussed therapy is not the answer to all issues and the other therapies should be looked at e.g. CBT is not the answer to all issues
- felt like talking therapy was not for me
- better advertising of services such as GYRO within YPAS

- therapy isn't very child friendly from younger ages they find it hard to talk to professionals and with them treating us like kids makes it hard to want to talk to them an ask for help
- therapy for me was terrible, as I wasn't listened to, the therapist always talked down to me and was judgemental of past events in my life, I found that highly unprofessional and distressing
- YPAS is great I would have been stuck without it
- that when therapy is finished a real exit strategy should be in place with support not leaving person with nothing
- Merseyside Youth Association is a wonderful place. Accessing them has really changed my life
- being thought of as just a file number doesn't make it very friendly environment to be in, not personal at all
- there should also be more locations to access it as my nearest one was Chester which was an hour away
- it didn't help me at all
- I got forced into counselling by Shaw Street or they would kick me out because they think I'm nuts because I don't live there perfect life but it's my life not theirs so why can't people just leave me be and not bitch and moan at me. I'm not nuts I just don't see the point of all this college wife kids job house crap - I'll do what I want
- I think more money should be put into services by the government across the UK as many young people now suffer with depression and the like and do not get the help they deserve or need. We as a generation are being overlooked by greedy politicians who don't know what to do with their money apart from buy a new house and revel in tons and tons of money. I think it's pathetic that they can live the high life and leave kids to suffer with their problems rather than allowing the support and money that is necessary to save lives
- by going into YPAS has turned my life around I was in a bad place when I first moved to Liverpool like I couldn't find a way out but now I have a place where I can go and talk to people my own age
- At the start of therapy you need to be made aware of policy and procedures – including how to request an alternative therapist or treatment
- It would help if your therapist could ring if you don't turn up for a session – there could be various reasons for this and it might help with the two strikes and you're out rules.

Section Two – Modelling an Ideal Talking Therapy Service

Participants in the 6 focus groups held on 20th and 22nd March were offered the opportunity to build a Lego model of a what they saw as key aspects / outcomes of their ideal talking therapy service. They were then asked to describe what their model represented to them.
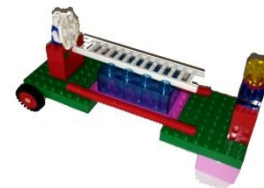
Some examples can be seen below.

Finding the pathway in amongst the chaos.

Flexible, compassionate, transparent.

Culturally inclusive with a strong foundation.

Me in the driving seat.

Needs shared, a vehicle to connect you to community.

The whole person.

Onward and upward to the goal.

Not one size fits all.

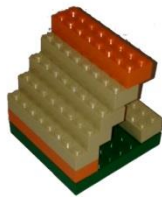**Safe enough to fall and be picked up.**

Solid and on going.

A fully transparent and safe environment to open up in.

A nice environment, not scary more than just flowers.

Respect - to be there for me, listen and help.

An equal and empathic human exchange.

The most common words in the participants' descriptions of their models were:

- Transparent
- Safe
- Comfortable
- Flexible
- Equal
- Solid
- On-going

Participants in the Inclusion Matters Liverpool (ILM) focus group did not have the opportunity to create models but they were asked to describe their ideal talking therapy service. Their list of ideal attributes was:

- Empowering
- Individually tailored
- Accessible
- Non-judgemental
- Approachable
- Comfortable environment
- Practical
- Positive
- On-going
- Flexible
- Peer support available (in addition to one-to-one)
- Explains the process
- Defined programme of treatment with safety net at the end
- Friendly
- Available to young people (as well as adults)

Section Three – Additional information from people unable to attend focus groups

A number of people contacted Liverpool Mental Health Consortium with information or comments that they wished to contribute but were unable to attend focus groups or LCCG's stakeholder event.

These comments have been grouped together below under the following headings.

Benefits of Talking Therapy

- More sustainable and effective than medication.

Preferred ways to access Talking Therapy

- Self-referral and through GP
- For self-referral: I asked my GP to refer me for counselling for anxiety/dealing with a chronic health condition, but she just directed me to a website on anxiety. Admittedly, she did tell me to come back if the info/tips on the site were no help but I was discouraged by her attitude. I thought about going back to the GP but given what I had seen from my partner's experience (3-month wait after referral for first appointment, 6 x 45 minute sessions only, appointments during office hours only…unless you are suicidal), I thought it would be a waste of time and effort with no guarantee of actually getting counselling.
- For GP-referral: Some people may not have thought of seeking therapy or may need a push in the 'right' direction.
- There's some kind of web-based service in Holland that can be accessed 24/7 but I can't see anything like that happening here.

Preferred locations

- City centre and/or locations outside the centre with good public transport access.
- Somewhere with a private entrance. Big signs advertising the service might put people off if they are embarrassed about taking therapy.
- I think the quantity of services is more pressing than the location.

Locations for information/publicity about services

- GP
- Specialist clinics at hospitals

- Through charities/groups supporting suffers of conditions that might benefit from therapy (e.g. National Association for Colitis and Crohn's Disease). That said, I was not able to access therapy for anxiety relating to my colitis, so I would question whether it's worth publicizing a service that may not be accessible.

Potential barriers

- Stigma
- Cost (private)
- Waiting time – even though waiting times have reduced there is still a perception that the wait is long, this needs to be addressed
- Lack of choice of therapist
- Restricted appointment times
- Lack of awareness/understanding of benefits of therapy
- Apathy associated with depression
- Having to be referred through GP
- Being discouraged from accessing by GP – GPs can leave things too long "Things may have shifted in a few months, come back then and we'll have another look."

Assessment

- Assessment is crucial in providing information and choices – "CBT can address this, this and this. Does this feel appropriate for you? If not, we can offer other options or signpost you elsewhere."

Therapy Exit

- Need to manage expectations and plan an exit strategy from the point of entry – including signposting and peer support from the point of assessment with recaps at each therapy session
- The offer of access to a peer support group following therapy would mitigate against isolation and provide a sense of community
- Aftercare projects are helpful
- People aren't in control of the exit process – they can feel that they've only just got started and are then left without on-going support

Gender

Some men, including those in contact with CALM (Campaign Against Living Miserably) commented on the perceived 'femininity' of IAPT and other talking therapy services. The majority of counsellors and therapists were thought to be women, the décor of talking therapy premises – including strategically placed boxes of tissues – were also thought to be designed with female clients in mind.

Men were also thought to be under-represented in services due to their reluctance to approach GPs or other professionals direct about their mental health or issues of concern to them.

Public health messages about good mental health and information about talking therapies may need to be placed creatively in order to reach a wide variety of men.

The issues thought to have an impact on women's ability to access and benefit from talking therapies are largely set out in Liverpool Mental Health Consortium's Women's Charter (*see Appendix A*) and include a need to contextualise women's therapy in terms of relationships, motherhood, childcare responsibilities and experiences of violence.

Women (including mothers) were said not to have access to information about the availability of IAPT services and often had an expectation that they would be referred to Mersey Care for support. They also benefitted from the support of 3rd Sector organisations when requesting talking therapies from GPs – since such organisations were unable to make direct referrals to IAPT.

Other comments received specifically in respect of women's experience of talking therapy included concerns that CBT was not the best model for women as evidence suggests that it works least well to address the issues that women present with most often, such as post-natal depression and post-traumatic stress. There was also a concern that a focus on changing behaviour in order to feel better could send out potentially dangerous messages to women within violent/abusive relationships and re-enforce a belief that it is the victim who is responsible for her situation.

"You've got to acknowledge the factors for women even if you can't 'fix' them."

Motivation could often be an issue for women, particularly when they had caring responsibilities or needed childcare support in order to attend appointments. Talking therapy sessions in isolation from addressing other issues were said to have only limited benefit and women were also said to a) want to avoid the stigma of being seen not to cope and b) blame themselves for feeling bad, which could have a knock-on effect on their children.

"Don't keep telling me to think about 'me' when other aspects of my life have to take precedence."

A case was made for a specialist talking therapy service for women, including assessment of complex issues, and for involving women in the co-production of

Liverpool's Recovery College curriculum as well as in the full range of Primary Mental Health interventions – such as advice, individual mentoring, peer support.

It was suggested that women should have the offer of rapid access to services (with or without childcare) and that all service users should be automatically asked whether they had a preference for choosing the gender of their therapist.

"Don't put the onus on the client to ask. Assume a lack of assertiveness, poor self-esteem, trauma. Think about what they may need – anticipate that."

A request was also made for an analysis of data by gender in terms of who gets referred for talking therapy services, who takes the offer up, onward referral following treatment (including community-based referrals and referral 'upwards' to Step 4 Services (i.e. specialist mental health support services) and recovery outcomes.

Family Therapy and Systemic Psychotherapy

It was suggested that the re-commissioning of local psychological therapies provided an opportunity to widen access to a range of therapies which may not be widely known about by the public or offered by professionals at present.

Systemic Family Therapy was suggested as a method of focusing on relationships between individuals (often, but not exclusively, family members) as well as promoting individual change and growth. Therapists are trained to work with individuals, couples and families in a versatile and creative way and the emerging evidence base for efficacy for a wide range of presentations (symptoms) and client groups is growing all the time. This may be a useful alternative to individualised talking therapies such as CBT.

Physical and Mental Health Services – Co-working

Concerns were raised in respect of people suffering from chronic physical ill health and the lack of effective co-working between services in terms of dealing with the impact of physical ill health on mental wellbeing.

An example was given of an individual who had been receiving community-based counselling (following GP referral) in addition to anti-depressants but was admitted to hospital for a year due to a number of physical conditions before being discharged to die at home.

On admission to hospital the counselling came to an end as the counsellor was not insured to provide a service to in-patients. Despite requests being made to the Consultant in charge of the patient's care and an acknowledgement from the hospital that the lack of counselling was a "significant deficiency in our service", the patient received only one visit from a psychiatrist in a year. He also received one counselling session when he was fitted with prostheses nearly 8 months after a double amputation but nothing at the time of the surgery which was when he was at his most in need of mental health support.

The patient's partner now regrets not having acted on his request to take him out of hospital and to ask his GP to re-arrange counselling in primary care since no support was available in an acute hospital.

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What Women Want Group

Women's Charter

Many people have advocated for the development of gender-specific responses to mental distress, arguing, amongst other things, that women's experience of society is fundamentally different from that of men. Acceptance of the social determinants of mental health & distress has been a challenge over the years but, more recently, the social factors at stake have found credibility. Women's Mental Health into the Mainstream (Department of Health, 2003) set out a clear case, outlining the areas where mental health outcomes for women differ from those of men & listing protective & risk factors which are sociological, physiological & psychological in nature. Above all, women's particular experience of abuse & violence, both in & beyond the home environment, is cited as a major causal factor pertaining to women's mental distress.

The What Women Want group, coordinated by Liverpool Mental Health Consortium, has been providing a platform for the views & aspirations of women service users for several years. The most recent engagement process, Inspiring Futures (March 2012), brought together service users, carers, community members, managers & practitioners to look at what ground has been gained to improve women's mental health, how to hang on to achievements during a time of great change, & what future opportunities might be. Evidence from this event reflected similar concerns to those articulated at the Inspiring Women events (November & December 2010):

Women requiring dedicated mental health support services are those identifying themselves by:

- Cultural background or religious belief
- Lesbian, bisexual or trans
- Family role
- Motherhood

- The support they need (e.g. Crisis services, therapeutic interventions)
- The experiences they have had (e.g. Survivors of sexual violence, war/civil conflict, forced marriage, criminal justice system)

Women say that they need:
- Safe space away from men in which to heal
- To talk & be listened to
- A break from family & caring responsibilities
- Non-judgemental, flexible support that can be accessed in a variety of ways
- Support in parenting
- Combating social exclusion
- A response to particular issues affecting women, such as anxiety/depression & borderline personality disorder
- Mutual support & self-help

To address these needs, women want services to:
- Address mental health issues within the context of general wellbeing for women
- Offer access to specialist support, such as therapy, debt advice, anxiety management, community-based activity, personal development, educational & employment support & support with domestic violence
- Offer a whole-family approach & be aware of the caring role
- Promote social inclusion & recovery approaches & be flexible to individual need
- Be accessible in the widest sense of the word, including geographical location & access to appropriate childcare
- Offer a women-only service, staffed by women workers & volunteers, & with a high level of cultural sensitivity

Stakeholder mapping carried out at these & other events confirms the remit of the What Women Want group to support the broader theme of wellbeing & continue to reinforce the message from women service users of the need for women-only services.