Devon LINk Counselling & Related Therapies - CART

Minutes of the meeting in public held at the LINk Networking Event
10:30 – 1:30, Wednesday 27th January 2010
St Sidwells, Exeter

Present:
Caroline Lee (CL) - LINk Devon
Carol Jones (CJ) – Independent Counsellor
David Tarbox-Cooper (DTC)– Independent Counsellor
Simon Henderson (SHN)– South West Pound Ltd
Edwina Huggett (EH)
Robin Tay (RT) CAMHS Participation Worker
Edwina Huggett (EH)
Maureen Casey (MC) – DPT
Simon Henderson (SH) (Chair)

Apologies: Andrew Kemp (AK), MS Society
Louise Hawkins (LH) Dignity in Care
Caroline Woodherd (CW) – NAG North Devon

	ACTION
Minutes of a meeting held on 18th November 2009 **The minutes were passed.** Intros: CJ is part of Against State Regulation Alliance for Counsellors Programme DTC independent counsellors just wants to see how the system works RT – CYPS Mental health Devon wide, engaging young people in the development of the service role to see how we can engage young people - be a link to how YPS view CAMHS SH - Banking and financial inclusion and social landlords debt is a problem. Lack of counselling in south hams EH - Pam Hogan came to a NAG/Linda Stapleton and has experience of Mental health services - has not been able to access services satisfactorily	
Matters arising No matters arising	
Consideration and discussion of draft proposals, leading to formal agreement and adoption of CART 'Terms of Reference Working well together. Aims – AK wording accepted Question 1 for MC – can we influence IAPT? IAPT has to be looked at through commissioning as well as DPT. NHS Devon commission, DPT is responsible for the quality and experience of a service. DTC has a Jargon Buster written by Simon Heyes Andrew's wording with minimal changes. Areas of concern: IAPT; Dementia; Young People	**SH to look into a Glossary of terms/jargon** **Email pack of info/TOR proposals and expense forms etc to all participants**

Development of an action plan, to include discussion of how the group will: Undertake a baseline assessment of existing services and support i.e. With whom do we engage and how? What questions do we need to ask and how? Create an evidence base of need for future service development; Present evidence of such need to service providers and commissioners; Ensure a realistic, coherent vision for the future work of CART (to include a credible means of measuring success). Psychological therapy Maureen Casey – Business Development Manager. Development of a new psychological service in relation to general hospital and development of services in primary care humanistic counselling background, taught counselling and East Devon College supervisor. Clinical background – Humanist therapy. What do the group want to know? Psychological treatment and what it provides. What's happening in Devon O/S Trust but commissioners need to be identified. Questions re IAPT CJ – Clarification who provides Low and High intensity and Assessment (NICE Guidelines have to be observed) EH – concerned about management of risk in low intensity cases where things have been pushed through quickly, people might fall through the net. IAPT programme started about 5 years ago. Department of Health ran collaborative practices between GP practice managers and staff who reported back on trials. Pilots in Doncaster and Newham. Newham more traditional mental health service. Doncaster – radical, greater split between high and low intensity *telephone working; rapid response and referral A review has been held of 8 large scale pilots Locally, Swindon, Cornwalll & Dorset – decision to accept Lord Layards recommendation. Economic effect of lack of well being. £170 million available to promote and develop IAPT but money has taken time to come through. Development is in 3d wave of sites to access money – programme started in October 2009 comprising of service delivery and educational programme. There's no national programme of training of therapy modalities. IAPT has provided National Standards for CBT – Low Intensity (single strand), High Intensity. New staffing is in 3 waves. 3rd of available and trained staff (Oct 09) full trainee places. All but 1 high intensity CBT therapists. Couple of vacancies Low intensity posts taken a bit longer to establish. Staff were consulted and given the opportunity for retraining. A number of staff have gone to University – high proportion of trainees are staff which has been supported by the programme, particularly graduate Mental health workers 01/4/10 Next wave of Low Intensity Oct 2010 – last tranche of High intensity workers and trainees Old PCT services were very patchy reflecting old PCT configurations East Devon had considerable investments Each PCT had different modalities of treatment. South Hams etc individual practices employed direct, East Devon Hazel Broom * all practices accompanied by mental health workers Exeter was CBT	**Get Doncaster and Newham Report**

Low Intensity therapists = counsellors, graduates, Mental health support workers Training – based on single strand, supported self help, assessment skills Workers are very closely supervised to national framework; very prescribed. Workers input data differently. Clinical management system on line IAPTUS. Workers use measurement tools or clients can actually do this themselves. CORE was a counselling monitoring system in terms of process from A – B but if someone dropped out you couldn't do measurement. IAPTUS = IT supervision and monitoring clients on continuous assessment and r/v so if they drop out can be measured SUPERVISOR has total overview – supervisor can decide to discuss RISK ISSUES. DPT staff – team leaders in IAPT and depression and anxiety services. Ay risk will be shared with well being and access and clinical leads in IAPT. Benchmark for sharing risk – PHQ9 (patient health questionnaire – depression module 9) GAD7 (General anxiety disorder assessment) CJ – Initial referrals mainly from GP – no self referrals are turned away but staffing is an issue Low intensity case loads – information not available CJ - in some areas there would be over 50 (from a website forum of graduate trainees) As a counsellor – 6-7 – akin to High Intensity therapists Trainees have to be intermediate level and next layer of training up to 18 – 20 sessions of CBT Low Intensity – making assessment from PHQ9 and GAD7 either by face to face, phone or supervisor or CPN referral CJ – concerned re humanistic side of things – initial assessments Vast majority mild to moderate with a problem that needs to get over not chronic. MC assured the group the programme has been really well evaluated MC – Dace Richards training was very good. Those who are not suitable for Low Intensity referred on. NICE guidance is very clear. Counselling is to be recommended for life crises. DPT want to retain counselling for this. IAPT programme will encompass interpersonal psychological therapy and EMDR – for post traumatic stress disorders/combat stress. DB Therapy - Dialectical and therapeutic modalities which will go into the IAPT programme but IAPT doesn't cover CBT for Psychosis, just for depression and anxiety RT – is there a basic philosophy of patient choice? If a client felt uncomfortable would they be able to move to a different model or therapist – MC yes but they don't commission NHS Devon have to be asked to provide the range of waiting times AR – on October 1st the DPT inherited old waiting lists of 1500 people from GPs waiting for a service. National 18 week standards don't have to be observed as Mental Health is not on the tariff Reduction of list. Phone contact and risk. A good 3rd had dropped out Risk – mental health team to establish situation A number of people are now in appropriate therapy Improvements will occur as staff are recruited	**NHS Devon to be approached re IAPT etc.**

New referrals – IAPT protocol will result in faster service systems under old PCT did not process people as rapidly as IAPT Information is available from DPT/PCT CJ - clinical management of non-diagnosable conditions: how do you quantify; questionnaires give a baseline – information which is corroborated by face to face interview with client Who (f..?) in the PHQs – self reporting – would they be capable of doing the forms – GP get paid through QAF to do it Assistance Indicators Psychological therapy being practitioners; not counsellors! GPs referrals differ in quality RT – asked about assessments – how do clients experience this system? Clients valued rapid welcome call -because case was having to deal with direct/email contract or self referrals. The lower age limit is18 for entry; no upper age limit; RTs clients are all CAMHS so not in this group. SH – How much influence will we have on commissioning and delivery? Group is about psychological therapies to be as broad a spectrum as possible Amanda Williamson from MIND in Devon could be asked to come along. Works with MIND at PHEW centre promoting positive well-being **Discussion - IAPT** NHS can't refer to counsellors unless commissioned and monitored GP referrals are informal and DPT can't employ person centred counselling because of evidence based Tax payers need to be ensured value for money and proof of returns	**Invite Amanda to next meeting**
AOB **MAPPING OF USER GROUPS** Forum: Mind / DPT website CJ – did a study in victim support. Counselling – presenting problem not always 'the problem' underlying factors might aggravate. Monitoring systems don't reflect the qualitative aspect CL suggested monitoring IAPT MC would like to see the development of a group that sports a range of therapies CJ – dementia care and dementia cafes counselling CL suggested general purpose – gaps in service and patient choices MC – that's why phone services are liked in Devon; R&D in DPT - persistent self harmers using text There is an Access group for IAPT Kristy. LD Kate Dandridge. Faith Stafford for BME perspective User Network and regional advisor.	**CL to follow up**
Date & Time of next meeting 3rd March 3pm – 5pm St Sidwell's Centre, Exeter	