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**North of England**  
Commissioning Support Unit

Darlington Clinical Commissioning Group  
Durham Dales, Easington and Sedgefield Clinical Commissioning Group  
Hartlepool and Stockton-on-Tees Clinical Commissioning Group  
North Durham Clinical Commissioning Group  
South Tees Clinical Commissioning Group

# **Communications and Engagement Summary Feedback Report**

## **Improving Access to Psychological Therapies**

May 2018



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## Executive summary

During March and April 2018, across Durham and Tees, a second phase of engagement was undertaken with past and current service users and local stakeholders to gather views about the proposed expanded Improving Access to Psychological Therapies (IAPT) model.

A range of engagement activities were carried out which included an online survey, local focus groups, service user engagement meetings and targeted engagement with groups with protected characteristics.

This executive summary provides some of the key headlines from all the engagement activities and full details can be found in the main body of the report.

Key points emerging from the online survey are:

- At the point of accessing services, telephone (53.4%) and face-to-face (43.9%) access are the most commonly chosen routes. Reasons for choosing a particular form of contact tends to be related to confidentiality (57.1%) and convenience (51.9%)
- Between referral and assessment, three quarters of respondents (75.0%) would like to be kept up to date about when their services and support will begin, for example by text message or phone call. Written advice and guidance (45.1%) and access to websites for self-help (40.2%) would also be welcome
- While 39.8% of respondents think that waiting times of up to 10 days for assessment and six weeks for treatment are reasonable, 60.2% think they are not reasonable
- There are several reasons why people think that waiting times are not reasonable, with the most commonly mentioned theme being that people who seek help for mental health may be in crisis, or have taken the step of asking for help because they know they need it straight away, and therefore they should be seen as soon as possible (39.1%). A further 31.5% simply stated that the time to wait is too long. Other reasons given included that a person's condition could worsen during the waiting period (16.3%), that the act of waiting itself could exacerbate a condition (12.0%) and the risk of self harm or suicide (9.8%). A fifth (19.6%) of respondents noted that the suitability of waiting times depends on the condition or circumstances of the individual

- When asked how people would like to access treatment, the GP surgery was the most commonly selected location (65.3%). However, other routes to access were also chosen, including community venues in group sessions (36.9%), telephone (33.0%) and in your own home (30.1%)
- In order to help people understand their treatment, both leaflets (70.1%) and online information (62.1%) would be helpful. The most important types of information required in order to help people understand their treatment are: when will the services happen - what are the waiting times (70.9%); which service is best for the type of treatment needed (70.3%); and is the treatment and support provided near to where I live (69.7%)
- The vast majority of respondents (96.5%) would like to be able to be offered an alternative if the way they receive their treatment is not working for them (for example, switching from online/telephone to face-to-face). Almost a third (62.9%) would like to be able to change the access option, while around half (50.9%) would like to be able to access a new type of treatment and support
- Thinking about appointments, nine in ten respondents (90.2%) feel that regular reminders about their appointments would be useful. By far the preferred method for such reminders is by text message (86.0%)
- When it comes to attending appointments, just over half of respondents think that daytime is the most appropriate time to access appointments (53.5%). Over a third (37.8%) would like to access appointments in the evening, while a further 8.7% feel the most appropriate time would be the weekend
- Access to out-of-hours treatment is important to the majority of respondents, with 43.1% rating it 'Very important' and 40.8% rating it 'Important'.
- Individuals may miss sessions for a variety of reasons. The most commonly selected factors for *not* attending treatment are: the service being offered is not the best type of treatment for my condition (56.2%); waiting times are too long (53.3%); and treatment and support is not provided near where I live (52.7%)
- Most people (87.1%) would like to be able to provide feedback during their treatment, if they felt it was not working for them. Some sort of feedback form, either on paper during the session or online at another time, would be welcomed

by 38.1%. A further 27.0% would discuss it with the person providing treatment, during the session

- Finally, respondents were able to comment on any other issues or concerns they would like to raise. A variety of topics were covered, however two themes were mentioned more often than others (each by 16.4% of those who provided an answer). These were to make access to services easier, in general (including shorter waiting times), and to reiterate the importance of personal contact (such as face to face sessions) rather than relying on remote contact with service users.

Alongside the online survey, a programme of public engagement was conducted to gather the views of services users and other stakeholders, including targeted approach to groups represented by the nine protected characteristics. A summary of engagement activities can be found in the Methodology section to this report.

Feedback across the many engagement groups was, of course, varied - in particular, groups discussed issues related to their own experiences. These groups have been reported separately; however key themes and feedback are summarised in this report.

On the whole, feedback about the proposed IAPT model was positive, provided it can be delivered appropriately. Participants discussed aspects of the model that are particularly important, or could be improved. These included:

- Awareness and promotion of IAPT to both individuals and professionals;
- The benefits and drawbacks of the various channels of access, and the importance of face to face interaction as well as telephone, online, etc.
- Waiting times and support for individuals between appointments; and
- Specific aspects of the model such as long term conditions, counselling and Cognitive Behavioural Therapy (CBT), staffing and resource, and self-referral.

## Background

Improving Access to Psychological Therapies (IAPT) is a programme that began nationally in 2008, to transform the treatment of adult anxiety disorders and depression in England. The programme now aims to increase the number of people seen and treated from 900,000 in 2015 to 1.5 million in 2021, which is an increase of 66% nationally. Two thirds of the expansion will focus on people with long-term conditions including medically unexplained symptoms.

IAPT services need to change in line with the Five Year Forward View for Mental Health. Five health commissioners across Durham and Teesside are working together to re-commission an expanded IAPT across the region that is safe, equitable and supports people with long-term conditions to maintain good mental wellbeing. The expanded service will be in place by March 2019.

In 2017, the five collaborating health commissioners reviewed current services which included engaging with members of the public, service users, GPs, stakeholders and providers to capture their views about what the issues were, if any, and how we could improve IAPT services to meet national requirements set out in the Five Year Forward View.

This feedback has been used to help develop a proposed expanded IAPT model. In spring 2018, services users and local stakeholders were encouraged to further influence the development of the model by providing feedback through local focus groups, public meetings and the completion of an online survey.

## Methodology

The engagement work reported on in this document took place jointly across five Clinical Commissioning Groups (CCGs):

- North Durham CCG
- Durham Dales, Easington and Sedgefield (DDES) CCG
- Darlington CCG
- Hartlepool and Stockton-on-Tees (HAST) CCG
- South Tees CCG

The engagement activity comprised:

<b>Patient and carer survey</b>	<p>An online survey for both service users and carers was made available on the CCG's websites, as well as sharing the link via all stakeholder groups for promotion within their own groups and organisations.</p> <p>Copies of the survey were also distributed at all services user engagement events and focus groups up until Friday 20th April 2018.</p> <p>189 people completed the online survey, although not all respondents answered every question.</p>
<b>Targeted engagement with groups with Protected Characteristics</b>	<p>Across South Tees, Hartlepool, Stockton-on-Tees and Darlington, 109 groups with protected characteristics were contacted between 14th and 23rd March, requesting permission to attend a scheduled meeting to present and receive feedback on the new proposed IAPT model. This resulted in invitations to attend 12 meetings.</p> <p>Three voluntary community organisations (Middlesbrough Voluntary Development Agency, Healthwatch Darlington and Catalyst) were also commissioned to facilitate targeted engagement with groups with protected characteristics in accordance with the CCG public sector equality duties, as defined by the Equality Act 2010.</p> <p>Across North Durham and DDES, a series of targeted sessions were also held with groups such as chronic pain</p>



	<p>patients, individuals with learning disabilities, substance misuse groups and individuals with hearing loss and deafness. By working in partnership with Investing in Children, young people were given the opportunity to contribute directly.</p> <p>Demographic data was also requested on the surveys and event evaluation forms.</p>
<b>Public focus groups</b>	<p>Groups were held across the five CCGs between March and April 2018, attended by past and present service users and some service providers.</p> <p>68 people attended.</p>
<b>Stakeholder briefing</b>	<p>Across South Tees, Hartlepool, Stockton-on-Tees and Darlington a stakeholder briefing was sent to approximately 377 relevant stakeholders (including the 109 groups mentioned above) with a link to the online survey on the 29<sup>th</sup> March 2018. Stakeholders were asked to cascade this within their community/networks.</p> <p>ND &amp; DDES sent out their engagement information which included a stakeholder briefing and information about focus groups to approximately 450 stakeholders on 9<sup>th</sup> March 2018.</p> <p>On the 12<sup>th</sup> April 2018, across South Tees, HAST and Darlington, a second wave of stakeholder communication was issued. This included a poster publicising the five public focus group events and the survey link, which again was sent electronically to all 377 stakeholders.</p>
<b>Online and social media activity</b>	<p>The IAPT engagement was highlighted on all five CCG's websites, on a dedicated page under the 'Involve Me' section, as well as via a news post (which also provided a link to the dedicated page). It also went on websites and in newsletters of appropriate partner organisations.</p> <p>Information was sent via MY NHS to all members (approximately 2,015), for all CCGs.</p> <p>Social media was used to raise awareness of the opportunity to participate in the engagement about the</p>

	proposed IAPT model (see table below).
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### Social media activity summary

<b>CCG</b>	<b>Facebook posts</b>	<b>Twitter posts</b>	<b>Link clicks</b>	<b>Total reach</b>
South Tees CCG	13	13	269	41,907
HAST CCG	12	12	140	17,702
Darlington CCG	12	12	134	27,100
DDES CCG	9	9	75	11,114
North Durham CCG	11	11	120	26,688

### About this report

Themes and interpretation in this report are intended to give a general overview only.

The number of respondents to each question (base) is shown below the corresponding graph. Please note that percentages may not total 100% due to rounding.

A copy of the online survey can be found in Appendix 1 to this report.

## Focus groups and public engagement groups - Summary of key themes

This section summarises the key themes arising during:

- Public focus groups carried out among past and present service users in the five CCGs;
- Service user engagement meetings; and
- Targeted engagement groups carried out among groups with protected characteristics (summarised at the end of this section).

These groups each sought feedback using a discussion guide - questions are detailed in the breakdown of results below.

Please note, this is a topline summary of themes only and should not be interpreted as exhaustive thematic analysis of the groups. The targeted engagement groups were conducted by three separate organisations – Catalyst, Healthwatch Darlington and MVDA in association with Healthwatch South Tees - and reported individually by those groups. This report contains a summary of information prepared by each group, at the end of this section.

### The proposed IAPT model

#### ***Q1. What do you think of the proposed IAPT model?***

##### Focus group results

##### **Key themes**

Overall, feedback was positive with five of the seven groups commenting that the model looks good/makes sense. One group felt that speed of access would improve, and ongoing intervention is a good idea. However, the positive reception for the model is dependent on actually delivering, and getting the details right.

Three groups discussed funding, and the importance of ensuring services are adequately funded to ensure quality provision.

No other themes were consistent across the groups, although several issues were discussed by two groups each:

- Patients need to get the correct diagnosis at the outset to ensure they are on the right pathway (although one group commented that new pathways should improve support and getting the right treatment at the beginning);
- One group considered that a telephone services will take the therapist/call handler's attention away from the patient and miss making a vital connection, however another group discussed the merits of both telephone and face to face referrals;
- Individuals, who were familiar with the title 'IAPT', did not think it was a good way to explain the service. Whilst those who were unfamiliar with the title 'IAPT' did not understand what it was and what it did,
- Are timescales realistic and will they be met?
- Individuals should be told about the services that are available/accessible to them (people want help but don't know what they actually need);
- Criteria need to be flexible rather than fixed, and based on the needs of the individual (CBT is not a 'one size fits all' treatment);
- The model should include employment support officers (including to help young people);
- Long-terms conditions (LTCs) were discussed - is this LTC pathway for all? Is cancer included?
- Where does substance misuse/addiction fit into this model?
- The model needs to link in with other services, such as third sector and hospitals;
- What happens when the sessions come to an end - are care plans in place for longer-term support? and
- Concern about reliance on Wellbeing practitioners - overstretching VCS services.

### **Other issues discussed**

Across the groups, a wide variety of additional questions, concerns and suggestions were made. The following were discussed by one group each:

### ***Questions about the model***

- How does the crisis team fit into the model?
- Where does domestic abuse fit into the model?
- How will the model actually be delivered in terms of capacity, when it is already stretched?
- What will the appointments format/location be (e.g. home, GP, out of hours, digital/online)?
- As the evidence base continues to change, will the model change?
- What happens to patients in the system during the transition period/handover of contracts?

- How are prevalence rates calculated? Who is identified?

### ***Concerns/comments about the model***

- The current range of services needs to be expanded;
- Crisis and access needs to go across the whole model;
- GPs need to move away from being quick to diagnose depression/anxiety and prescribing tablets;
- The model should embrace non-commissioned groups, not just commissioned organisations;
- There is a need to determine why people *don't* get into the service;
- There needs to be cooperation at the first point of contact;
- There should be a procedure to provide feedback on the service;
- Patients should be offered choice, and this offering needs to be evidenced;
- There should be strict contract checks/performance management;
- There should be a step-care model;
- It is important to have clinicians with different backgrounds;
- More training needs to be provided for over-run children's services;
- Every GP surgery should have a CPN or trained mental health nurse;
- The model needs to work closely with GPs to ensure appropriate referrals;
- The whole family should be treated;
- The demands could cause practitioner burnout;
- Psychoeducation to understand things more;
- GAD7/PHQ9 at every session could cause anxiety/demotivation if progress is not being made; and
- Previous poor experiences could put people off accessing the service again.

### **Service user engagement meeting results**

Similar themes emerged in the service user engagement meetings. The following list summarises the most commonly mentioned themes, though please note that due to the complex/overlapping discussion this list is not in order of number of mentions.

- The model was generally well received but groups provided feedback on queries or points of concern, especially those relevant to their own area of specialism.
- *Face to face and other routes for access* - the issue of access routes was a key point for discussion, with several groups stressing that face to face contact is essential and must be maintained as an option. However, they acknowledge that other methods of access such as telephone and online are also important, for example for those with anxiety in public situations, those with mobility issues, or for younger people more comfortable with online channels. Therefore a variety of access models should be offered alongside face to face.

- *Counselling* - there was concern expressed about the lack of counselling services in the model, and the perception that CBT is not a suitable treatment for every individual.
- *LTCs* - several groups discussed the need for LTCs to be included in the model, or questioned which ones would be part of the model. Various groups noted specific LTCs that are of relevance to them, such as deafness, IBS, chronic fatigue.
- *Provider awareness* - in particular, GPs, nurses and VCSs need to be well informed about the services on offer so they are able to support patients in accessing the right services. On a related note, some commented that GPs are currently too quick to prescribe medication so provision of alternative services would be welcome.
- *Waiting times* - too long.
- *Staffing and resource* - concerns were raised that there is insufficient staffing in mental health to support services.
- *Self-referral* - this was highlighted by some groups as a good option, and should be retained. However increased visibility/promotion of services is needed so that individuals know that this is an option, and know how to access the service.
- *Choice and accessibility* - as with the focus groups, the importance of choice, individual flexibility and accessibility was mentioned across the engagement sessions. This included ensuring accessible times and locations for those at work or relying on public transport, and ensuring patients are kept informed and given choices about the treatment they receive. On a related note, several groups commented that the terminology of the model is off-putting or hard to understand in general, as well as lacking equivalent BSL signs.

## Single Point of Access (SPA)

### ***Q2. What would you think of a Single Point of Access (SPA) for telephone assessment and referrals?***

#### Focus group results

Overall, this offering was well received with groups agreeing that it could work well in theory - provided the service is joined up and well-coordinated. Two groups commented that a central access point could standardise waiting process and provide consistency. A commonly discussed theme, was that the model would require a trained telephone team, including trained LD workers, MH trained, and preferably suicide intervention skills.

Another commonly discussed issue was that of the method of access, with four groups commenting that access channels such as emails, web links and social media should also be provided. Three groups commented that some people would prefer, or be more suited to, face to face interactions; they also pointed out that telephone contact may not be suitable for people with certain disabilities (COPD, hearing loss, poor coordination) - one group asked whether such people could go straight to a face to face assessment. Two groups commented that telephone is suitable for some people if done properly, however others expressed concern that professionals won't get the full picture of the patient's needs over the phone. Two groups discussed the ability of GPs to identify the type of appointment a patient needs.

Other issues were mentioned each by one group:

- A single telephone number still requires services in localities;
- Some concern that it will limit choice;
- The service must be accessible 24/7/365;
- The service could become overwhelmed with volume of patients;
- It should avoid a 'call centre' feel for those accessing the service;
- Concerns around email referrals, where it's not known if the person has received it;
- Could the service contact the individual instead?
- Service needs links with third sector/charities/housing;
- How will patients find out the number?
- GAD7 should be done face to face, to support patients and ensure it is done properly;
- What is the process if people disagree with the assessment?
- Concerns around meeting caseness - how can it be determined for people who cannot use the telephone?
- Could people inflate/deflate their responses to meet caseness or get counselling?
- Home visits need to be an option for assessment;
- Need to strongly communicate to people about direct access, how they can be referred or go through self-referral.

## Service user engagement meeting results

Similar issues were raised in the service user engagement meetings, particularly in relation to discussions around the method of accessing the service. Several groups several stated that face to face is the *only* suitable method for assessment (to ensure an accurate assessment, trust building, confidentiality, etc.) while others commented that many people are not able to use the telephone due to, for example, hearing impairment.

However, some groups feel that telephone is suitable for some people, while others might prefer online (although access to the internet is also a barrier for some users). The suggestion is therefore to offer alternatives, such as face to face and online, depending on the needs of the individual user. The service should be available outside of working hours, preferably 24/7.

Self-referral is felt to be a good feature, although not everyone was aware this is an option. It needs to be well promoted so people know how to gain access to services. Likewise, staff such as primary care and VCS workers need to be well informed to support people routing into the system.

## Rapid Access Pathway (RAP)

### ***Q3. What are your views on the inclusion of a Rapid Access pathway?***

#### Focus group results

There was support for inclusion of a Rapid Access pathway, with several groups commenting that it is essential or definitely needed for those in immediate distress. Two groups observed that it can be difficult to reach the Crisis team or find out why they have not responded.

A potential issue raised was that questionnaires/thresholds will need to be carefully managed so they can't be manipulated to get access to RAP where it isn't actually needed.

#### Service user engagement meeting results

Likewise, the feedback from service user meetings was that the Rapid Access pathway is a good idea or a necessary inclusion, provided the timings are achievable and the service works as it is intended.

## Barriers to participation

### ***Q4. What are the barriers to participation in the service?***



## Focus group results

This question drew several common themes across the focus group participants, with the most commonly mentioned being:

- Stigma attached to mental health/feeling judged (mentioned by four groups);
- Long waiting times (3 groups);
- Off-putting language/terminology (3 groups);
- Lack of knowledge of the services available (3 groups);
- The method/channel of access not always being suitable for individuals (3 groups);
- Lack of consistency (2 groups);
- Poor relationship or poor match between patient and counsellor (2 groups);
- GPs having poor understanding of services (2 groups); and
- Young people need better services/can't navigate the system (2 groups).

## Service user engagement meeting results

The relationship between the patient and the counsellor was the most commonly mentioned barrier across the service user engagement groups - both in terms of having a good match and having a consistent point of contact. In addition, several groups commented that people do not like discussing their mental health in group sessions and therefore would be put off accessing such support services.

Other comments related to accessibility, such as students who live across two locations throughout the year and working people who need out-of-hours access.

## Support

### ***Q5. What support would help people to complete their course of treatment?***

## Focus group results

The most commonly mentioned aspect of support, discussed across the majority of the focus groups, related to 'filling in the gaps' between appointments and ensuring people don't feel forgotten while waiting. Some groups gave examples of ways to stay connected, such as drop-in centres/support hubs, having a number to call for a chat when needed, telephone and Skype calls, and regular text/email reminders for appointments.

A related point was ensuring good communication (leaflets, etc.) about the support available and general awareness of IAPT.

Other points that were discussed by at least two groups each included:

- Taking a holistic approach that includes both mental and physical health (also co-located services or a 'one stop shop');
- Developing a better understanding of why patients drop out of the programme, or following up on progress of those who are not treated or who don't turn up;
- Offering patients the opportunity to help others / peer programmes;
- Working around the individual / not pushing CBT for everyone;
- Ensure the practitioner (both personality and issues such as gender) matches well with the patient;
- Set out expectations clearly at the beginning of the treatment, so patients know what is likely to happen.

## Service user engagement meeting results

The service user engagement meetings focused on very similar themes, including thorough promotion of available services and access pathways, keeping in touch via a variety of channels (face to face, telephone, text, online depending on the needs of the individual and which type of communication they feel most comfortable with), general wellbeing support and the inclusion of families, and encouraging peer mentorship.

Engagement with various groups was also mentioned, for example community groups and student services, to help promote services and identify people who may need support or to offer drop-in sessions.

Accessibility of services was also discussed, particularly among groups who may experience specific issues. This includes, for example, ensuring students can stay in touch with services during both term and holiday periods; ensuring that terminology used in communication materials is easy to read and suitable for those with sight, hearing or other impairments; and ensuring services can be reached out of hours or by those using public transport.

## Related services

***Q6. What other types of services related to well-being do you think are important to link with IAPT?***

## Focus group results

There was no strong consistency across the groups, with a wide variety of services being mentioned.

Four services were mentioned by at least two groups, comprising:

- Employment support;
- Support for the wider family;
- Bereavement counselling; and
- General well-being (e.g. diet and exercise).

A variety of other services were mentioned, including support related to (although not an exhaustive list): addiction; antenatal; youth; autism; LGBT; anger; and anxiety.

## Service user engagement meeting results

A similar pattern emerged across the service user meetings, with a particular focus on general well-being services, peer support, employment and financial advice, and services that can help to keep people engaged with the system / reduce isolation.

## Targeted engagement group results

Targeted engagement groups were carried out among Voluntary and Community Organisations represented under the nine protected characteristics. These groups were conducted by:

### **Catalyst (in Stockton Borough and Hartlepool)**

Engagement with groups including:

- Mental health group – ladies
- Men's Mental Health Group
- Veterans
- Asylum Seekers
- Young People's LGBTQ
- Parents and Families support
- Blind and Visually Impaired
- Older People's Welfare
- Vulnerable Young Women
- Learning Difficulties/ Disabilities and their Carers
- Community Health Ambassadors in Stockton and Hartlepool

## **Healthwatch Darlington**

Engagement with groups including:

- Black Minority and Ethnic
- Foodbanks
- Parent and Toddler
- Learning Impairment
- Young People
- Parkinson's
- Neuro Key (Neurological conditions)
- Healthwatch Darlington volunteers
- Headway (Brain injuries)
- NECA (Substance and Gambling Misuse)

## **MVDA with Healthwatch South Tees**

Engagement with groups including:

- Refugees/Asylum Seekers
- General (women/veterans)
- Young adults who are furthest away from services
- Adults with physical and learning disabilities
- Service providers and users of mental health services

The information below is a summary of some of the key points reported by these organisations. It is not intended to replace or override the full reports provided by each organisation.

The model was broadly well received. Groups drew on their own experiences to suggest positive aspects of the model and ways in which the model could be improved. These included:

- The importance of communication, including plenty of information about how to access services and the kind of support available;
- Knowledge and understanding of the service 'IAPT' – in general people do not understand what IAPT is for and what it is,
- Awareness that different people will want to access the service in different ways (through choice or due to specific barriers) - face to face, telephone, groups, online, etc;
- Ensure groups with specific needs are well supported, e.g. specialist/experienced providers for groups such as LGBTQ, dementia, autism,

homeless people, veterans, and ensuring channels to access services are accessible and not off-putting;

- Ensure there are local IAPT providers,
- Better support during referral or self-referral;
- To have more than one provider in an area, to avoid conflict for same family members,
- No mention of drug and alcohol in the model,
- More work to be done with young people in BME groups,
- Shorter timescales, and support between treatment / appointments;
- Continuity of the therapist, with time taken to build up trust and the same therapist throughout the treatment;
- Listening to, and acting on, feedback from service users;
- Flexibility for individual requirements / those who don't fit into certain pathways;
- Ensure services are coordinated (e.g. crisis teams) and links with wider mental health provisions and VCSs.

## Online survey results

This section summarises the results from the online survey made available via CCG websites and via stakeholder groups and organisations.

In total there were 192 responses to the survey.

Results from surveys distributed during targeted engagement meetings, held with groups with protected characteristics, are reported separately.

### Referral

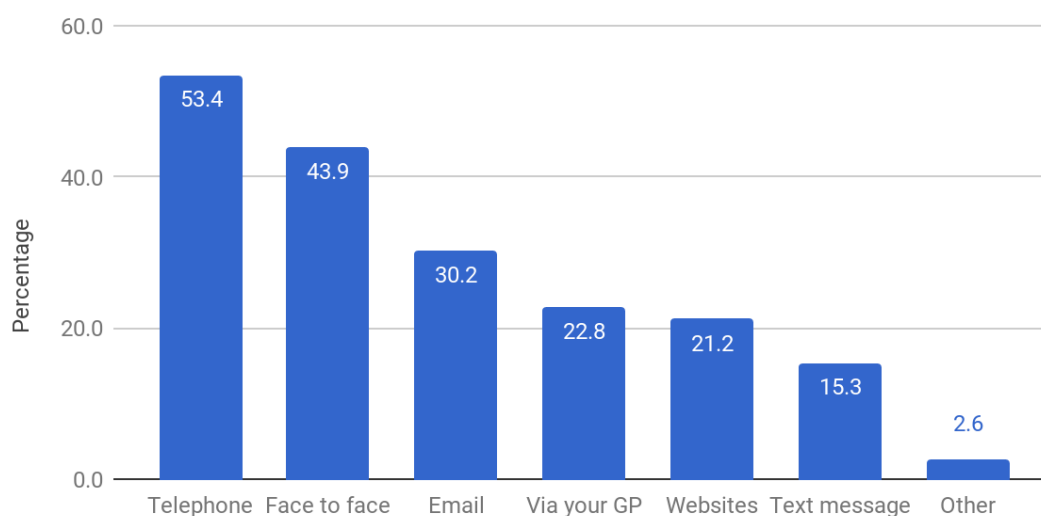
#### Accessing mental health services

Survey respondents were asked how they would like to contact mental health services. Respondents were able to choose more than one method of contact (see Figure 1).

Over half (53.4%) of respondents would like to contact mental health services by telephone. Forty-four percent (43.9%) would like to be able to access services face to face. Thirty percent (30.2%) would like to use email, 22.8% via their GP, 21.2% via websites and 15.3% by text message.

*Figure 1: Routes to access services*

Q1. How would you prefer to access mental health services? (Multiple choice)

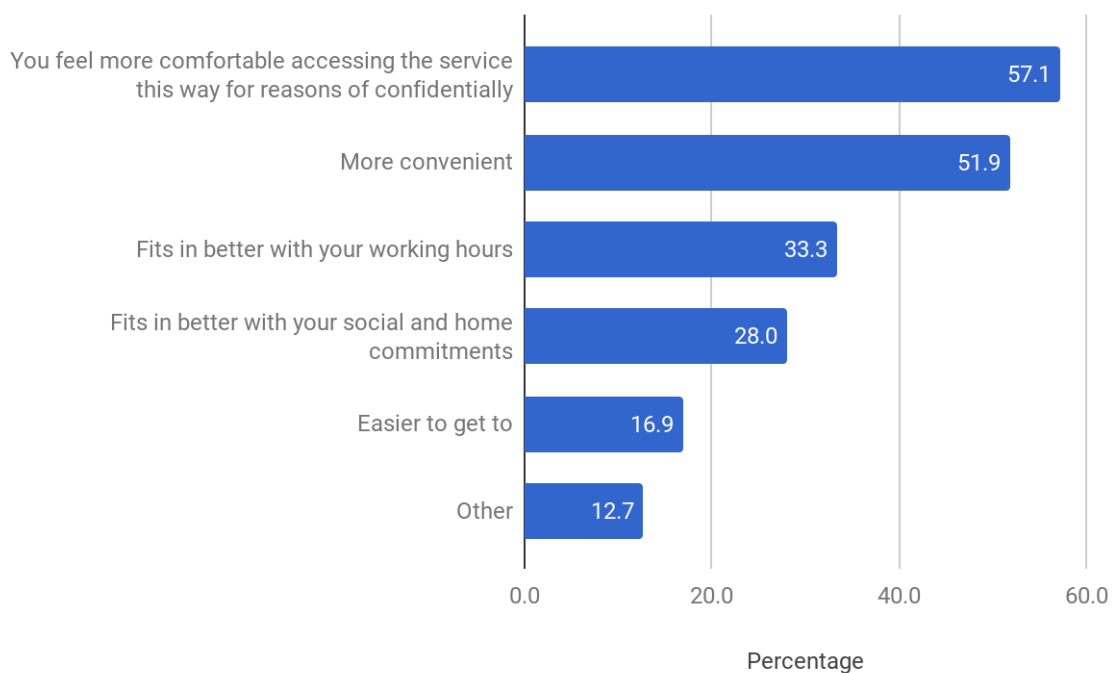


Base: 189

When respondents were asked *why* they prefer to contact services in a particular way, the most commonly mentioned reasons related to confidentiality and convenience (Figure 2). Fifty-seven percent (57.1%) of respondents chose 'You feel more comfortable accessing the service this way for reasons of confidentiality', while 51.9% chose 'More convenient'. A third (33.3%) prefer a particular kind of contact because it fits better with their working hours, while 28.0% said it fits in better with their social and home commitments.

Figure 2: *Why are certain access routes preferred?*

Q2. Why did you choose this option? (Multiple choice)



Base: 189

### Support after referral

Once referred, individuals may wait up to 10 days for assessment and six weeks for treatment. Respondents were asked what support they would like while waiting for assessment (see Figure 3).

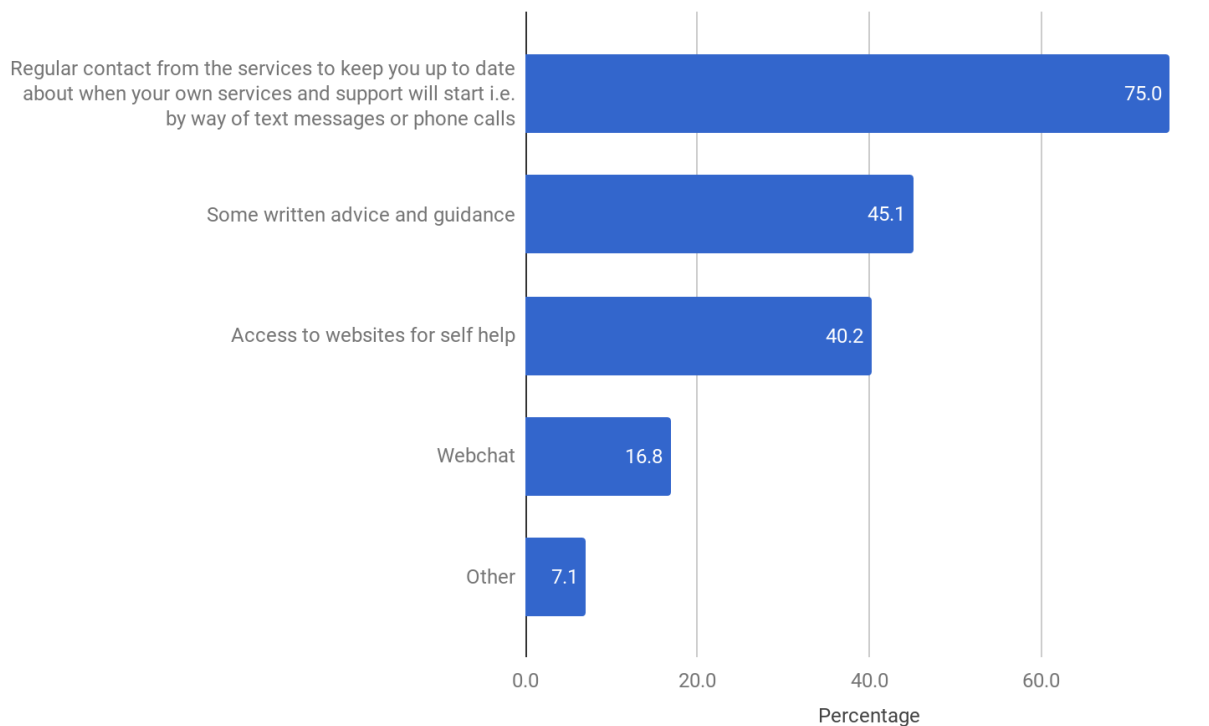
Three quarters of respondents (75.0%) would like to receive regular contact from services, to keep them up to date about when their own services and support will start (i.e. by text message or phone call). Forty-five percent (45.1%) would like written

advice and guidance; 40.2% would like access to websites for self help; and 16.8% would like support via webchat.

Respondents were given the option to suggest other types of support that would be useful: 4% of respondents commented that they would like access to support services such as in-person, telephone or group support.

*Figure 3: Support while waiting for assessment*

Q3. Once you have been referred, which could be up to 10 days for assessment and six weeks for treatment, what support would you like whilst waiting for assessment? (Multiple choice)



Base: 184



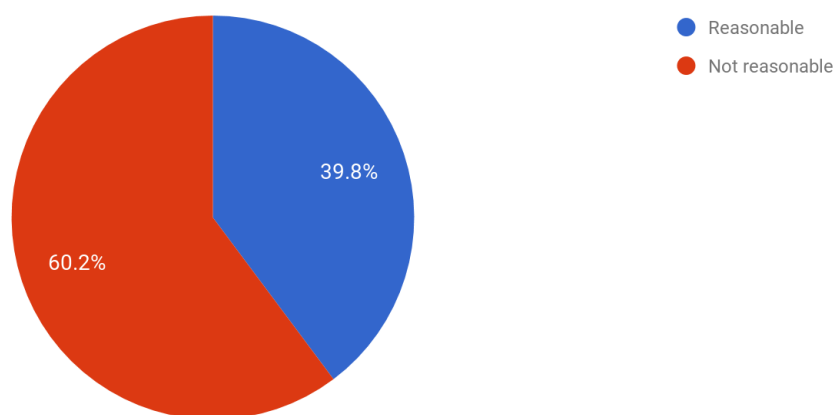
## Assessment

### Waiting times

Approximately six in ten respondents (60.2%) think that waiting times of up to 10 days for assessment and six weeks for treatment are not reasonable. Forty percent (39.8%) think these waiting times are reasonable (see Figure 4).

*Figure 4: Are waiting times reasonable?*

4. Once you have accessed mental health services and been assessed, you could be waiting for up to 10 days for assessment and six weeks for treatment. What do you feel about these waiting times? (Single choice)



Base: 176

Respondents who thought waiting times were not reasonable were asked to explain why (see Figure 5). Thirty-nine percent (39.1%) explained that people with mental health needs should be addressed quickly, particularly since they often make attempts to access services at a critical point in their condition - when they have reached crisis, or when they have spent time building up the courage to ask for help and need support straight away.

*“What if that person has hit crisis point and needs someone within 24 hours and cannot wait 10 days to be assessed, where do they go?”*

*“If you are asking for help; you need help now not in six weeks time.”*

*“When people finally ask for help and have gained the courage to make contact they need help at that moment when they are motivated. Two weeks would be a more reasonable wait”*

Thirty-two percent (31.5%) commented that these waiting times are simply too long (general comment). Almost a fifth (19.6%) observed that the suitability of waiting times depends on the circumstances and condition of the individual at the time.

*“There should be a way to ‘fast-track’ those who are more vulnerable.”*

*“Six weeks is a very long time for someone with mental health problems to wait. There should be some sort of preliminary assessment to see if it’s acceptable to leave this person that long.”*

*“Not everyone needs the same treatment. Not everyone needs CBT. Not everyone should get the same options.”*

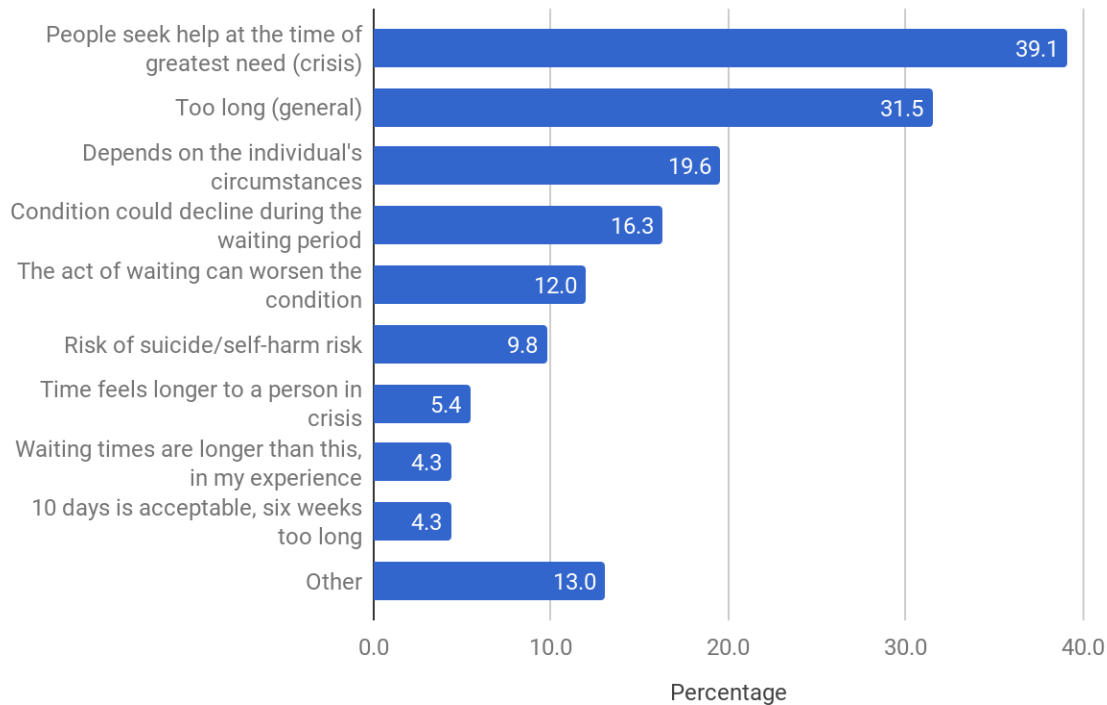
Other concerns were that the condition could worsen during the waiting period (16.3%). Twelve percent (12.0%) of respondents commented that the actual act of waiting could exacerbate a condition - by causing increased anxiety, for example. Others observed that speed is of the essence due to the potential risk of self harm or even suicide among those who have to wait for treatment (9.8%).

*“In all this time your state of mind will be getting worse and thinking no one is helping in that time.”*

*“For someone who has a mental health problem the waiting time could mean the difference between fatality and getting better.”*

*Figure 5: Why do you think waiting times are unreasonable?*

4a. If you think this is not a reasonable time to wait, please explain why (Open response)



Base: 95

## Accessing treatment

Participants were asked how or where they would like to access treatment - more than one option could be chosen (see Figure 6).

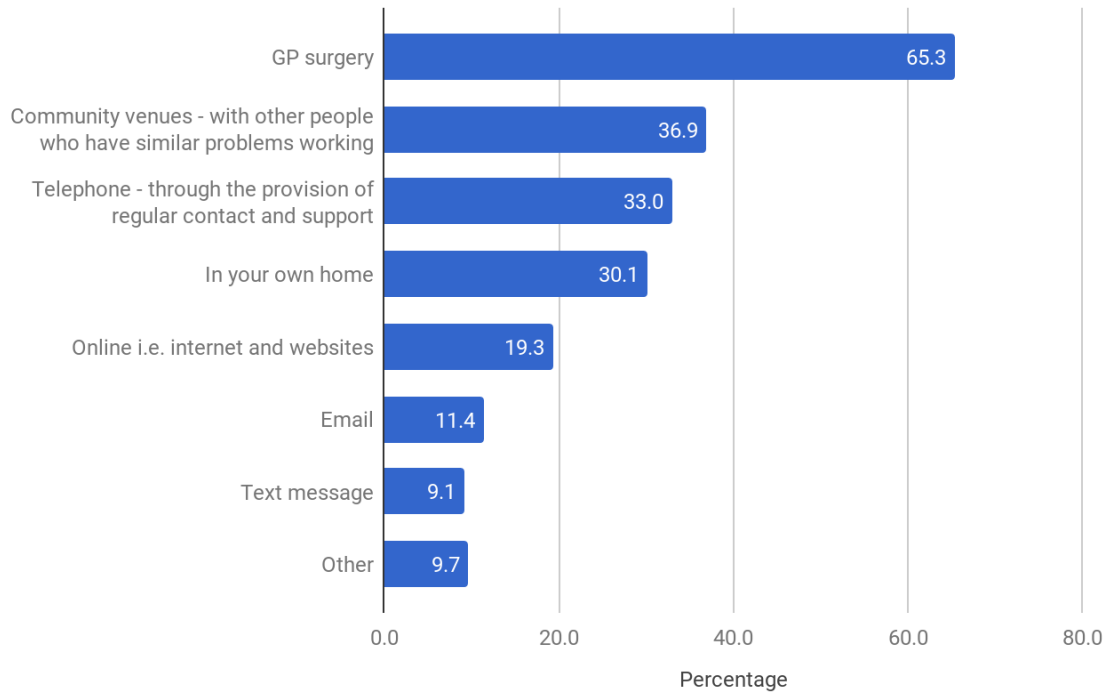
Approximately two thirds (65.3%) of respondents would like to access services through their GP surgery. Thirty-seven percent (36.9%) want to access treatment via community venues - with other people who have similar problems working together in small groups. A third (33.0%) would like to access services by telephone (through the provision of regular contact and support).

Other routes of access were 'In your own home' (30.1%), 'Online, i.e. internet and websites' (19.3%), 'Email' (11.4%) and 'Text message' (9.1%).

Respondents were able to suggest other ways they would like to access treatment: five percent (5%) of the 176 people who answered this question would like to access treatment in a community or other accessible venue but want this to be in a 1-to-1 setting rather than in groups. A further 2% would like to access treatment at the workplace of the practitioner.

*Figure 6: How would you like to access treatment?*

## Q5. How/where would you like to access treatment? (Multiple choice)



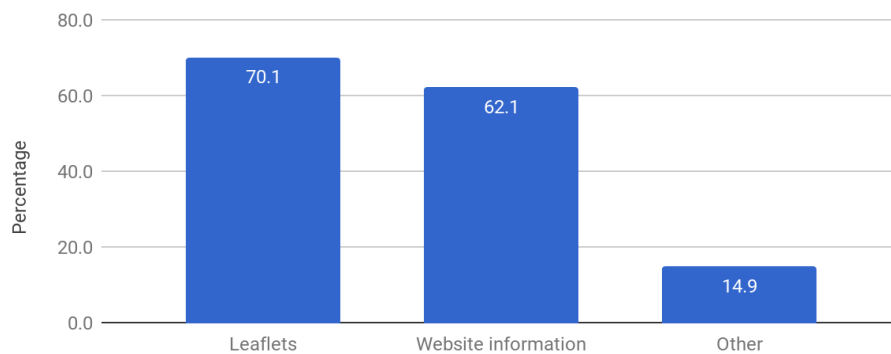
Base: 176

When asked what information they would like to receive in order to help understand their treatment, 70.1% of respondents chose leaflets and 62.1% chose website information (see Figure 7).

Respondents were able to suggest other forms of information; of the 174 people who answered this question, seven percent (7%) stated that they would like personal contact (e.g. face to face or access to a person by phone).

*Figure 7: Useful information*

## Q6. What information would you like to receive to help you understand your treatment?



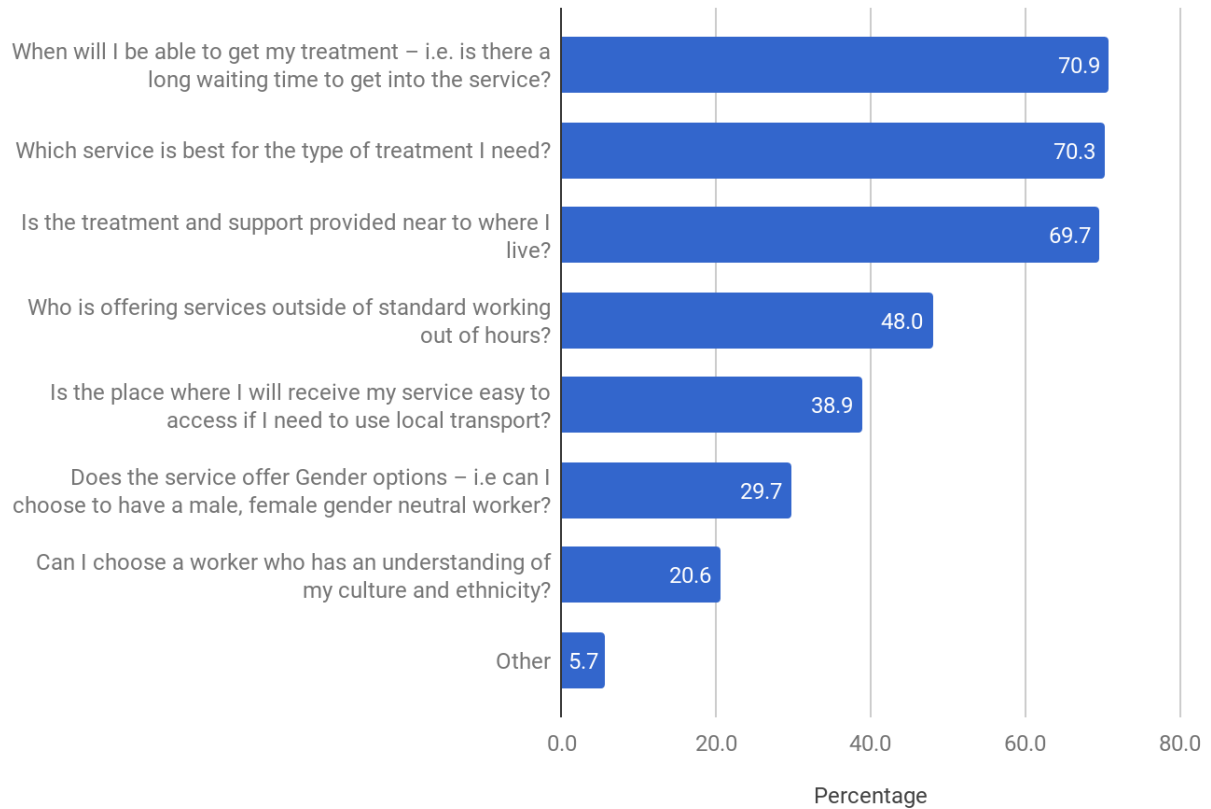
Base: 174

Respondents were asked what information is important to know when choosing who will deliver their services and treatment (Figure 8). They were provided with seven options, all of which were chosen by at least a fifth of respondents.

The three areas of information receiving the most mentions were each named by around seven in ten people: When will I be able to get my treatment (waiting times)? (70.9%); Which service is best for my treatment needs? (70.3%); and Is it near to where I live? (69.7%).

*Figure 8: Important information when choosing a service provider*

Q7. What are the most important things for you to know when choosing who you would like to deliver your services and treatment? (Multiple choice)



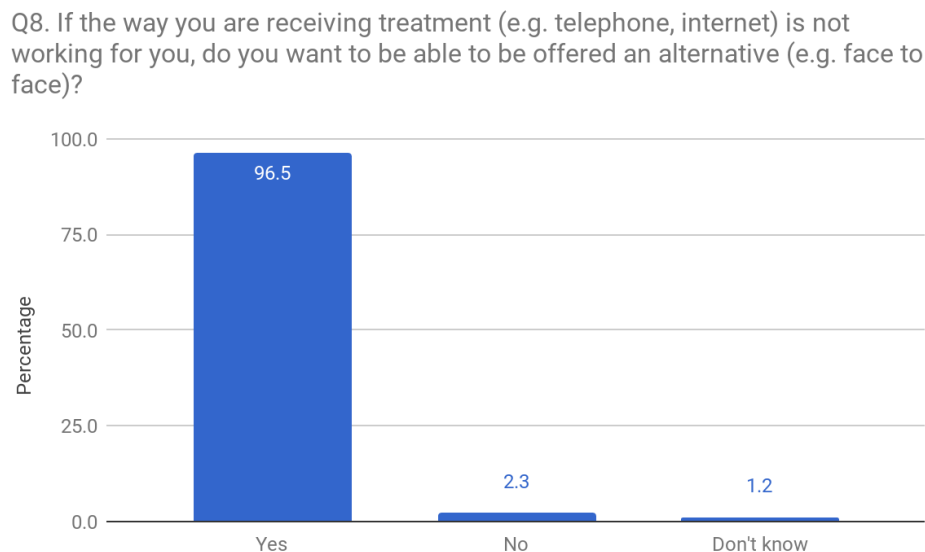
Base: 175

## Treatment

### Making changes

If the way that individuals are receiving treatment (e.g. telephone, internet) is not working for them, 96.5% of survey respondents want to be able to be offered an alternative, e.g. face to face (see Figure 9).

*Figure 9: Offering alternative methods of treatment*

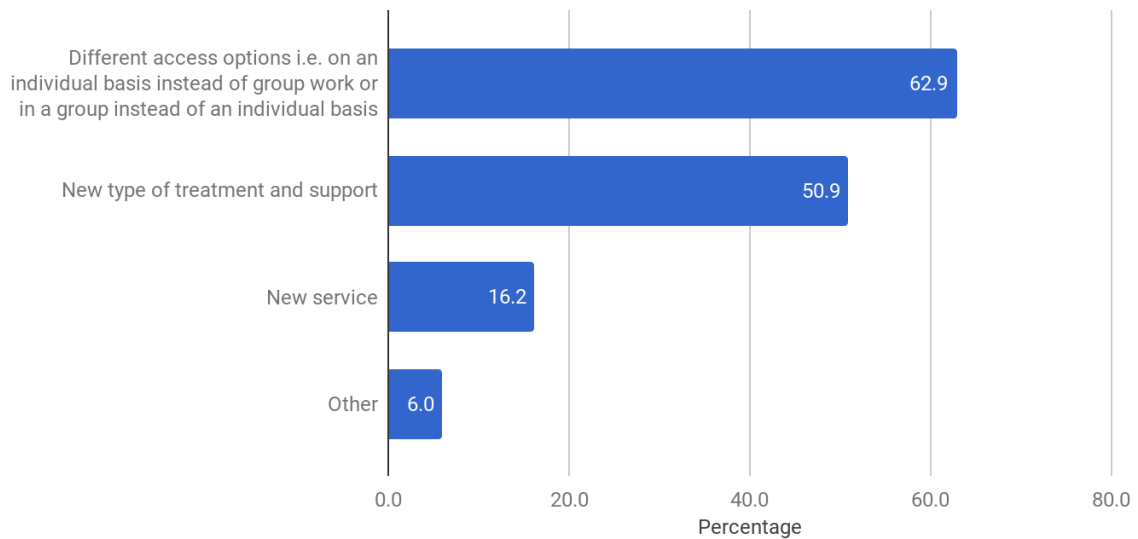


Base: 172

For those respondents who said yes, the most important things to be able to change are: 'Different access options, i.e. on an individual basis instead of group work or in a group instead of on an individual basis' (62.9%) and 'New type of treatment and support (50.9%)'. Sixteen percent (16.2%) said that a 'New service' would be an important change (see Figure 10).

*Figure 10: What would you change?*

Q9. If yes, then what is the most important thing to be able to change? (Multiple choice)



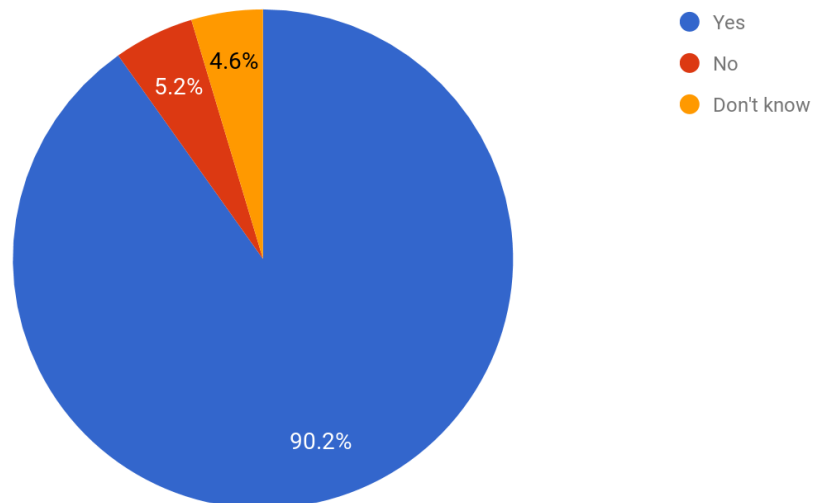
Base: 167

## Reminders about appointments

The vast majority (90.2%) of respondents feel that it would be helpful to have regular reminders about their appointment (Figure 11).

*Figure 11: Regular reminders*

Q10. Would it be helpful to have regular reminders regarding appointments?

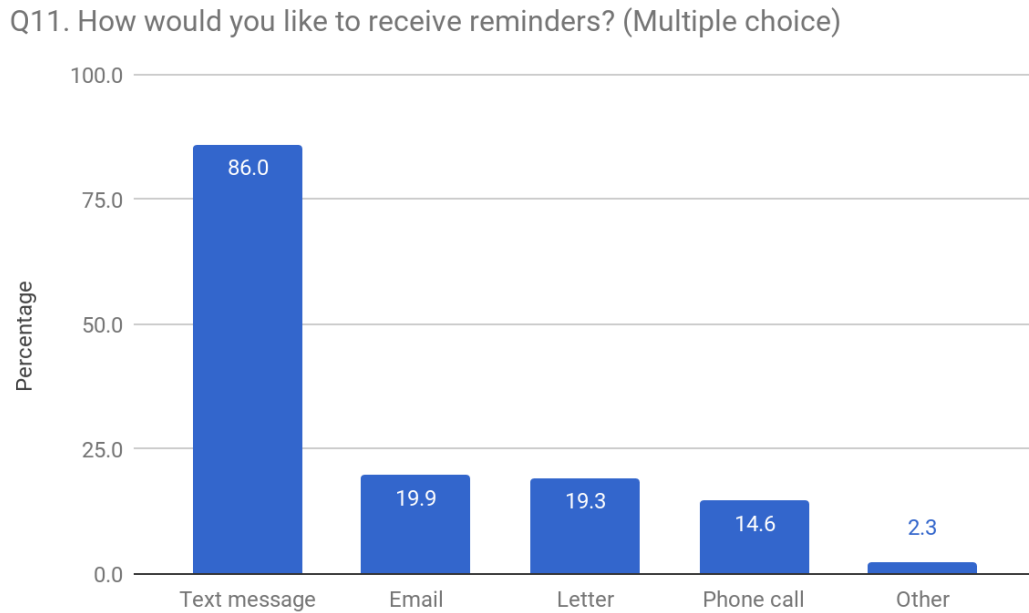


Base: 173



The preferred method for receiving such reminders is by text message, chosen by 86.0% of respondents (see Figure 12). Twenty percent (19.9%) would like to receive reminders by email, 19.3% by letter and 14.6% by phone call.

*Figure 12: Preferred format for reminders*

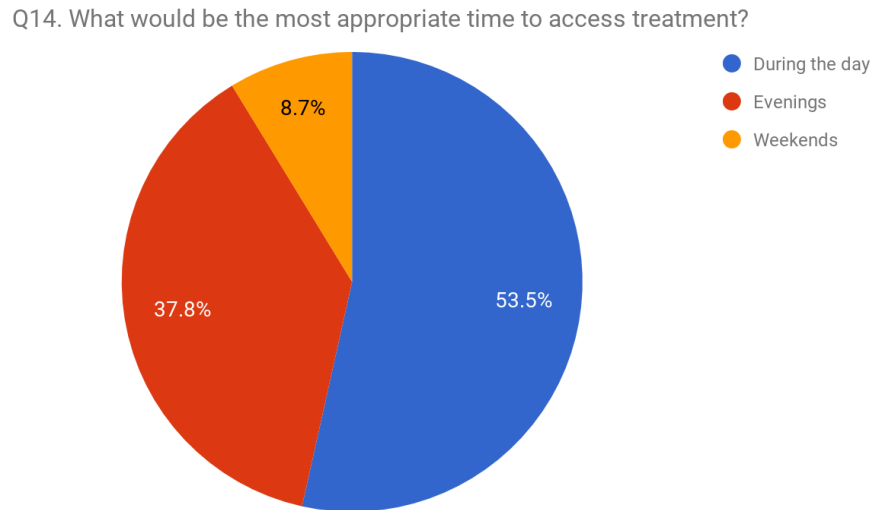


Base: 171

## Attending treatment

Respondents were asked what would be the most appropriate time to access treatment (Figure 13). Over half stated that daytime would be the most appropriate time (53.5%), while 37.8% would like to access treatment in the evening. Nine percent (8.7%) stated that weekends would be the most appropriate time.

Figure 13: When do you want to access treatment?

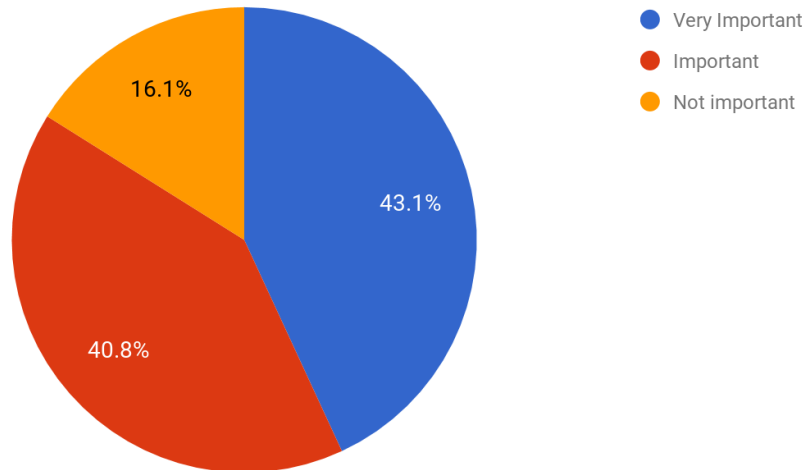


Base: 172

The ability to access support out of hours is important to the majority of respondents, with 43.1% considering it to be 'Very important' and a further 40.8% rating it 'Important'. Only 16.1% said out-of-hours access was not important (see Figure 14).

Figure 14: Importance of out-of-hours access

Q12. How important would it be to you to be able to access support out of hours?



Base: 174

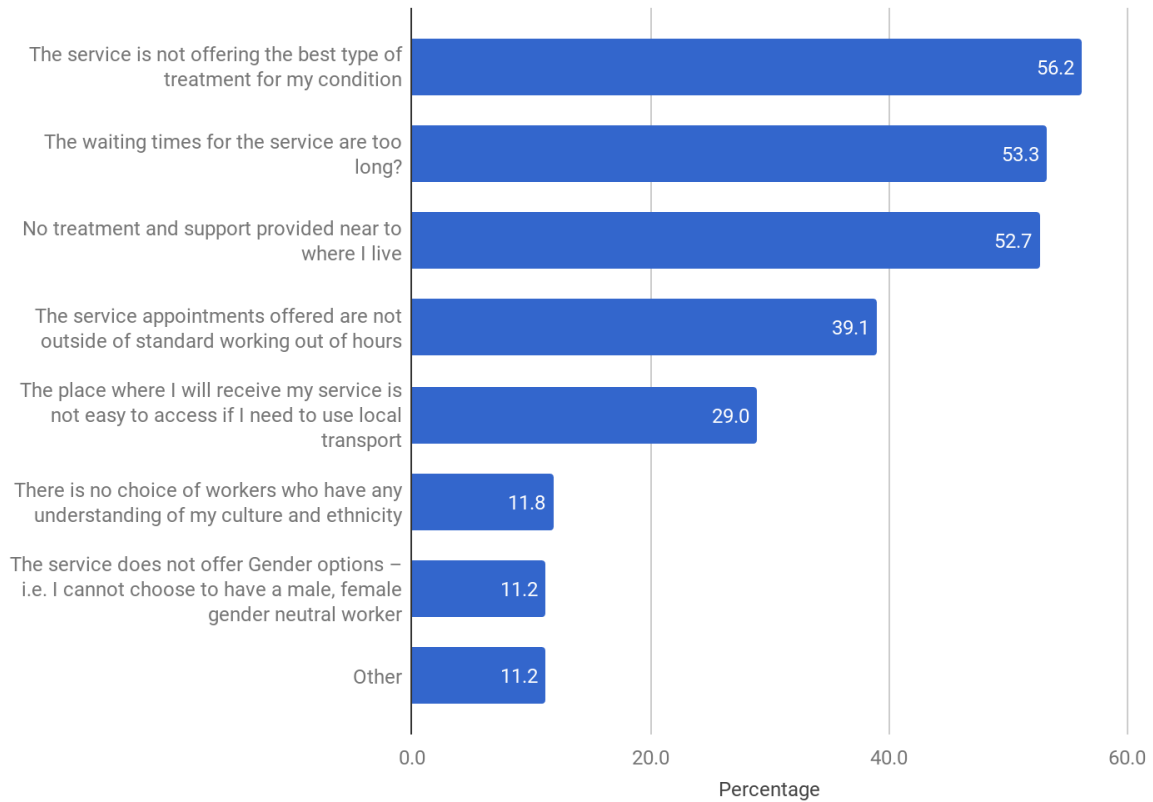
Respondents may refrain from attending appointments for a variety of reasons. When asked what issues would prevent them from attending appointments (see Figure 15), more than half of those responding selected 'The service is not offering the best type of treatment for my condition' (56.2%), 'The waiting times for the service are too long' (53.3%) and 'No treatment and support near to where I live' (52.7%).

Other issues that would prevent people from accessing appointments include a lack of appointments offered outside of working hours (39.1%), the location of the service not being easily accessible by public transport (29.0%), no choice of workers who understand the respondent's culture and ethnicity (11.8%) and a lack of ability to choose a male, female or gender neutral worker (11.2%).

Respondents were able to suggest other issues that would prevent them from attending appointments. Among the relatively small number of 'Other' factors, three received mentions by 2% of respondents overall: childcare; the quality/personality of the therapist; and a lack of disabled access/interpreter/BSL.

*Figure 15: Factors preventing attendance at appointments*

Q15. What issues would prevent you from attending appointments? (Multiple choice)



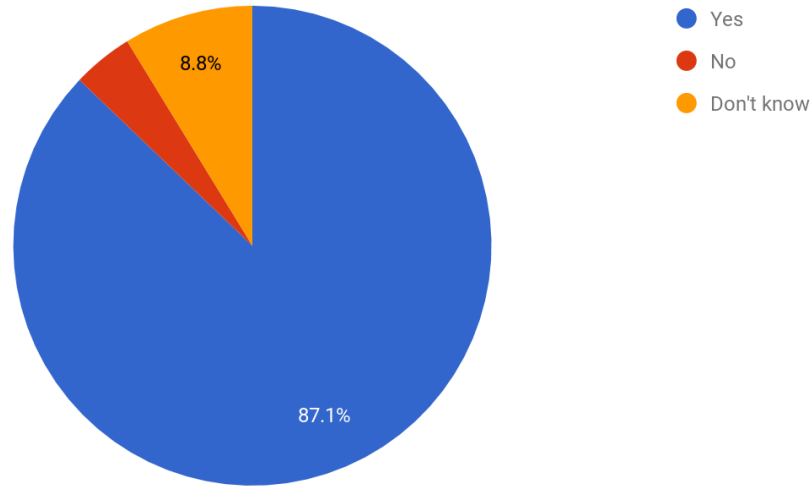
Base: 169

## Providing feedback

Most respondents (87.1%) would find it helpful to be able to provide feedback throughout the duration of their treatment, if they felt that treatment was not working for them (Figure 16).

Figure 16: Ability to provide feedback

Q13. Would it be helpful for you to give feedback throughout the duration of your treatment, if you felt it was not working for you?



Base: 171

Respondents were then asked how they would like to provide feedback - this was an open-ended question, therefore more than one method of communication could be suggested by each respondent (see Figure 17).

Thirty-eight percent (38.1%) of those who responded said they would like to fill out a feedback form or survey - some of these people specified that they would like to fill out a paper form at the end of a session and/or an online survey at another time.

*"I would be happy to complete a short questionnaire given to me by my therapist."*

*"Maybe a form I can fill at each session."*

Over a quarter (27.0%) stated that they would prefer to give feedback directly to the service provider, face to face during the session (or another suitable time). A further 15.9% said they would like to give feedback 'verbally', speaking to a person, but did not specify where or how this conversation should take place.

*“It is important to build a relationship with your therapist, so you can tell them when it isn't working.”*

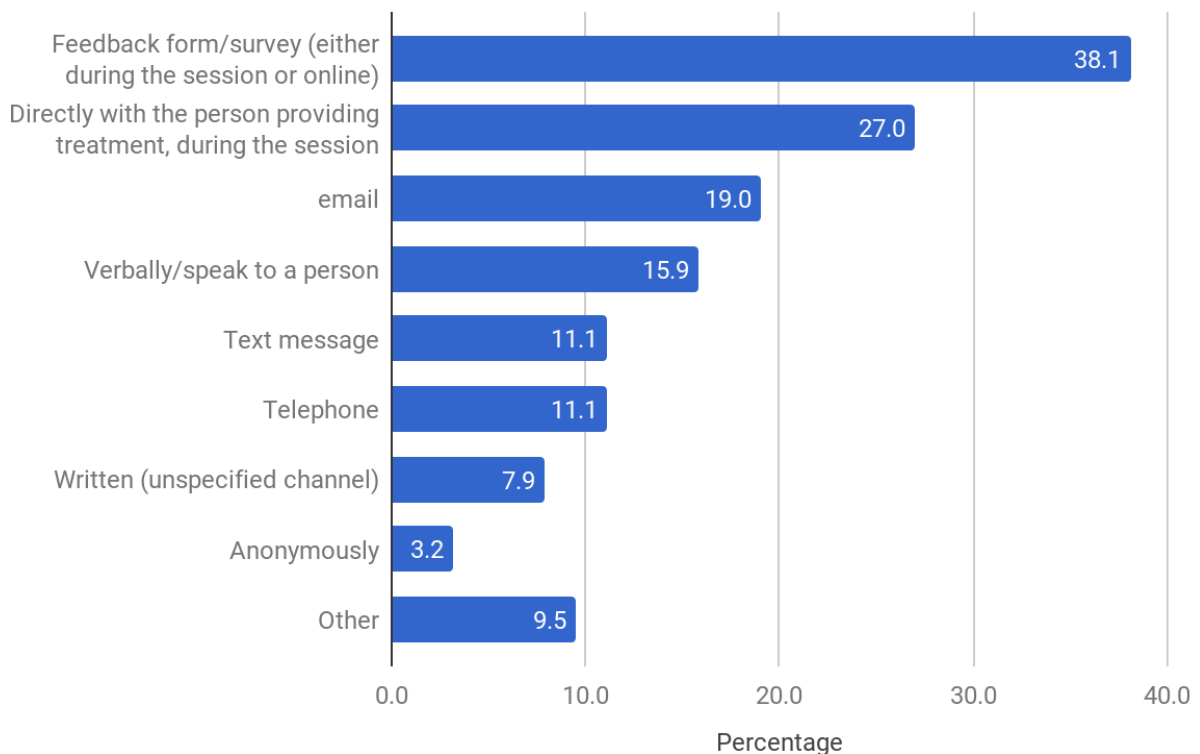
*“In negotiation with the practitioner in a blame-free environment.”*

Nineteen percent (19.0%) of people would like to give feedback by email; 11.1% by text message and 11.1% by telephone. A further 7.9% said they would like to provide ‘Written’ feedback but did not specify the method of communication.

*“Letter, email, text, any way as long as I wasn't judged for the feedback.”*

**Figure 17: Methods of providing feedback**

Q13a. If yes, how would you like to give feedback?



Base: 172

## Other comments

Respondents to the survey were given the opportunity to record any other suggestions, comments or concerns at the end of the questionnaire.

Fifty-seven people provided an additional comment. While some of these were specific to individual cases, some key themes emerged which are shown in Figure 18. Easier access to services in general, including shorter waiting times (16.4%) and the

importance of personal/one to one interaction, rather than remote contact (16.4%) were top of the list.

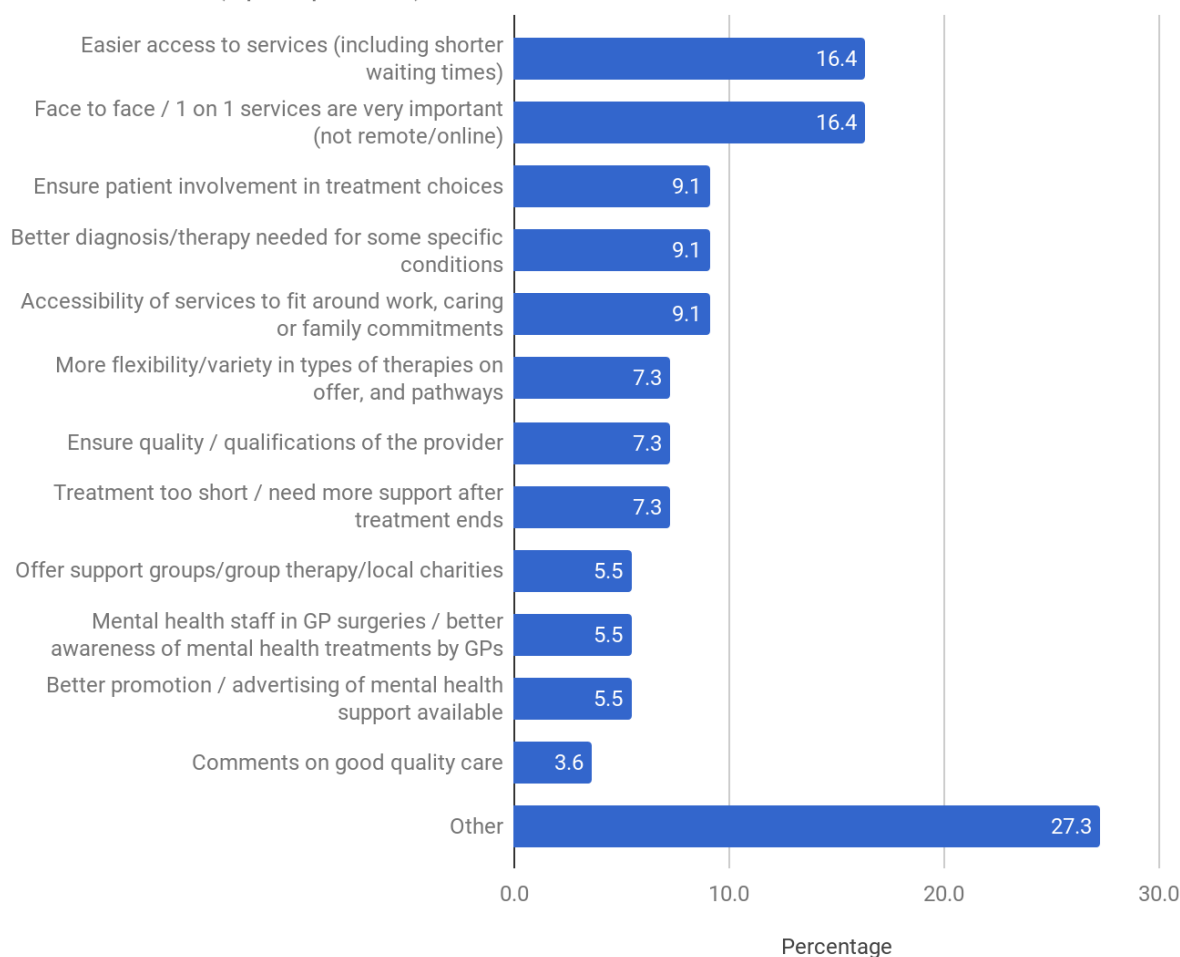
*“Telephone assessment may be cheaper, however is poor clinical practice to engage with clients and mental health needs face to face ongoing support”*

Other comments included ensuring patients are fully involved in choices made about their treatment, better diagnosis/therapy for specific conditions (such as autism), and the accessibility of services around other commitments (9.1% each).

*“There should be a better understanding of conditions such as ASD, Aspergers that have a later diagnosis which may prevent further mental health problems.”*

Figure 18: Other suggestions, comments or concerns

Q16. Do you have any other suggestions, comments or concerns you would like to share with us? (Open question)



Base: 57

## About you

The questionnaire contained a number of questions to monitor characteristics of respondents in relation to equality and diversity. These questions help the CCGs to ensure that they are engaging a cross section of people within their local communities and that they are meeting their public sector equality duty, as defined by the Equality Act 2010.

Targeted engagement activity was conducted with groups with protected characteristics, as defined by the Equality Act 2010 by VCS organisations as detailed above. DDES and ND attended groups with protected characteristics.

Q17. Are you:

Selection	Count	Percentage (%)
Person with learning disability	7	5.8%
Carer	34	28.1%
Family member	41	33.9%
Other	39	32.2%

Q18. Gender:

Selection	Count	Percentage (%)
Male	41	24.4%
Female	124	73.8%
Prefer not to say	2	1.2%
Other	1	0.6%



Q19. How old are you?

Age range	Count	Percentage (%)
Under 18	1	0.6%
18-24	8	4.8%
25-34	22	13.2%
35-44	37	22.2%
45-54	42	25.2%
55-64	34	20.4%
65-74	20	12.0%
75-84	2	1.2%
85 and over	1	0.6%

Q20. What is your marital status?

Status	Count	Percentage (%)
Married	84	52.2%
Single	38	23.6%
Divorced	15	9.3%
Widowed	4	2.5%
Separated	2	1.2%
Civil partnership	4	2.5%
Other (please specify)	14	8.7%

Q21. What is your ethnic group?

Group	Count	Percentage (%)
White	161	95.8%
Black/African/ Caribbean/Black British	1	0.6%
Asian / Asian Black	0	0.0%
Mixed / Multiple ethnic groups	0	0.0%
Prefer not to say	3	1.8%
Other (please specify)	3	1.8%

Q22. What is your religion?

Religion	Count	Percentage (%)
Church of England	57	34.3%
Roman Catholic	22	13.3%
Christian	15	9.0%
Methodist	6	3.6%
Muslim	0	0.0%
Jewish	0	0.0%
Jehovah's Witness	1	0.6%
Atheist / None	52	31.3%
Prefer not to say	10	6.0%
Other (please specify)	3	1.8%

Q23. Do you consider yourself to have a long-standing illness or disability?

Response	Count	Percentage (%)
Yes	69	42.1%
No	95	57.9%

Q24. Do you care for someone with a long standing illness or disability?

Response	Count	Percentage (%)
Yes	57	35.0%
No	106	65.0%

Q25. How would you describe your sexuality?

Sexuality	Count	Percentage (%)
Heterosexual or straight	135	83.3%
Gay or lesbian	8	4.9%
Bisexual	4	2.5%
Prefer not to say	12	7.4%
Other (please specify)	3	1.9%

Q26. Please tell us if you are pregnant or have a child under two years old

Response	Count	Percentage (%)
Yes	6	3.6%
No	156	94.0%
Prefer not to say	4	2.4%

Q27. Have you undergone gender reassignment?

Response	Count	Percentage (%)
Yes	0	0.0%
No	159	98.2%
Prefer not to say	3	1.9%

Q28. Postcode

CCG	Postcodes	Count	Percentage (%)
South Tees CCG	TS7 8, TS5 8, TS7, TS3 7, TS12, TS7 0, TS14, TS12 1, TS4 2, TS6, TS5, TS3, TS10, WA1 3, TS7 8, TS12.	23	18.2%
HAST CCG	TS23, TS19, TS20, TS18, TS17, TS23, TS8, TS26, TS25, TS25 2, TS18 1, TS18 3, TS15, TS17 5,	56	44.4%
Darlington CCG	DL3 0, DL3 6, DL3 7, DL1 1, DL1 2, DL1 3, DL1 4, DL2 1, DL2 2, DL2 3, DL3 0, DL98 1, DL3 7, DL3 8, DL3 9, DL8 9, DL5 6, DL4 2, TS11 6, TS21 1, DL1 5	18	14.2%
DDES CCG	DL17 9, TS21 3, TS22 5, TS21 4, SR8 1, SR8 2, SR8 3, SR8 4, SR8 5, SR8 9, SR88 1, DL17 9, DL16 6, DL16 7, DH8 9, DL17 0, DL17 8, DL16 9, TS21 2, TS21 1, TS21 3, DL5 6, DL5 7, DL4 2, DL5 4, DL5 5, DL12 8, DL12 0, DL12 9, DL13 1, DL13 2, DL13 3, DL13 4, DL5 4, DL4 2, DL11 7, DL12 0, DL12 2, DL12 8, DL4 1, DH8 9, DH6 2, DL14 8, DL10 4, DL14 9, DL14 7, DL14 9, DL15 0, DL15 8, DL15 9, DL16 6, TS27 4, TS28 5, TS29 6, DL13 5, DL14 0, DL14 4, DL14 6, DL5 9, DH6 2, DH6 1, DH6 3, DH6 5,	17	13.4%
North Durham CCG	DH99, DH4 5, DH1 5, DH2, DH9, DH3, DH9 7, DH1 2, DH3 3, DH1 3, DH1 1,	12	9.5%

## Survey results: Targeted engagement with protected characteristics groups in Darlington

During targeted meetings held with groups with protected characteristics in Darlington, the survey was distributed and completed by attendees. These groups were facilitated and reported by Healthwatch Darlington. HWD gathered the views of 161 people during two weeks of focus groups in community settings as follows:

- St Andrew's Foodbank - 5
- Parent and Toddler Groups x 2 - 24
- Learning Impairment - 12
- Young People x 2 - 50
- Parkinson's - 40
- Neuro Key - 1 Executive Representative on behalf of Darlington members
- Healthwatch Darlington - 4
- Black, Minority & Ethnic (BME) - 7
- NECA - 8 (2 professionals and 6 clients)
- Headway - 10

The data below is a summary of key points from the survey and 'About you' results.

### Survey results

Q1. How would you prefer to contact mental health services?

- Telephone - 75
- Face to Face - 51
- Websites - 10
- Email - 21
- Text Message - 29
- Via your GP - 69
- Other (please state) - 2

Q2. Please state why you chose this option

- More convenient - 16
- Easier to get to - 7
- You feel more comfortable accessing the service this way for reasons of confidentiality - 31
- Other (please state) - 6

3. Once you have been referred, which could take up to 10 days for an assessment and 6 weeks for treatment, what support would you like whilst waiting for an assessment?

- Some written advice and guidance - 20
- Access to website for self-help - 15
- Regular contact from the services to keep you up to date about when your own support and services will start - 123
- Webchat - 2
- Other (please state) -1

4. Once you have accessed mental health services and been assessed you could be waiting up to 10 days for an assessment and 6 weeks, what do you feel about these waiting times?

- Reasonable - 32
- Not reasonable - 56

5. How and where would you like to access treatment?

- GP surgery - 70
- Telephone – through the provision of regular contact and support - 13
- Online; internet and websites - 11
- Text message - 5
- Email - 4
- Community venues together in small groups - 28
- In your own home - 68
- Other (please state) -1

6. What information would you like to help you understand your treatment?

- Leaflets - 102
- Website information 49
- Other – (Please state) - 2

7. What are the most important things to you when choosing who delivers your service and treatment?

- Is the treatment and support provide near where you live? - 102
- Who's offering the service outside of standard working hours - 104
- Is the place that I receive my service, easy to get to if I used local transport - 88
- Does the service offer gender options - 46
- Can I choose a worker who is understanding of my culture and ethnicity - 59

- When will I be able to get my treatment - 53
- Which service is best for the type of treatment that I need? - 61

8. If they were you were receiving treatment is not working for you, do you want to be able to be offered another alternative treatment?

- Yes - 88
- No - 3
- Don't know - 3

9. If yes what was the most important thing to be able to change?

- New service - 28
- New type of treatment and support - 66
- Different access options - 38
- Other (Please state) - 2

10. Would it be helpful to receive regular reminders regarding appointments?

- Yes - 97

11. How would you like to receive reminders?

- Letter - 19
- Email - 7
- Phone call - 11
- Text message - 86

12. How important would it be to you to be able to access support out of hours?

- Very Important - 65
- Important - 23
- Not important - 3

13. Would it be helpful for you to give feedback throughout the duration of your treatment, if you felt it was not working for you?

- Yes - 85
- No - 4
- Don't know - 8

14. What would be the most appropriate time to access treatment?

- During the day - 55
- Evenings - 65
- Weekends - 39
- Other (please state) - 3

15. What issues with prevent you from attending an appointment?

- The service appointments offered are not outside of standard working out of hours? - 40
- No treatment and support provided to near where I live - 39
- The place where I will receive my service is not easy to access if I need local transport - 41
- The service does not offer gender options - 24
- The waiting times for the service are too long - 35
- There is no choice of workers that would be understanding of my ethnicity or culture - 19
- The service is not offering the best type of treatment for my condition - 29
- Other (please state) - 6

## About you

Although everyone was given an Equality and Diversity questionnaire, not everyone wanted to complete it. The results are as follows:

Q18. Gender

- Female - 61
- Male - 45

Q19. Age:

- 16 – 17 - 34
- 18 – 24 - 17
- 25 – 34 - 2
- 35 – 44 - 10
- 45 – 54 - 8
- 55 – 64 - 11
- 65 – 74 - 11
- 75 years old or older - 10

Q20. Marital Status :

- Single - 55
- Civil Partnership - 1
- Married - 19
- Separated - 2
- Cohabiting - 7
- Divorced or civil partnership dissolved - 3
- Widowed - 5



- Prefer not say - 4

Q21. Ethnicity?

- White British - 104
- White European - 1
- Mixed race Asian & white - 1
- Pakistani - 2
- Black African - 1
- Indian - 1
- Bangladeshi - 1
- Rohingya - 1

Q22. Religion :

- No religion - 52
- Christianity - 42
- Muslim - 5
- Hindu - 1
- Jewish - 1
- Other religion - 5
- Prefer not to say - 1

Q23. Disability or long term health condition?

- Yes - 48
- No - 67

Disability or long term condition type?

- A mental health difficulty - 15
- A long standing illness or health condition - 6
- A physical impairment or mobility issues - 10
- A social/communication impairment - 3
- A specific learning disability - 7
- A hearing Impairment - 2
- A blind or visual impairment - 1
- An impairment or health condition not listed - 8

Q24. Caring responsibility?

- Primary Carer of a child or children under the age of 2 years old - 4
- Primary carer of a child or children between the ages of 2 and 18 years old - 16
- Primary carer for disabled adult 18 years - 1
- Primary Carer for older person over 65 years old - 7

- Secondary Carer - 2
- None - 38
- Prefer not to say - 11

Q25. Sexual Orientation:

- Heterosexual or straight - 96
- Bisexual - 7
- Gay woman or lesbian - 1
- Asexual - 1
- Prefer not to say or other - 7

Q26. Are you currently pregnant or have you had a baby in the last year?

- Yes - 4
- No - 96
- N/A - 15
- No response - 1

Q27. Gender match at birth

- Yes – 116

Served in the armed forces?

- Yes - 3
- No - 98

## Survey results: Targeted engagement with protected characteristics groups in Durham and Tees.

During targeted meetings held with groups with protected characteristics in Durham and Tees, the survey was distributed and completed by attendees. These groups were facilitated and reported by Catalyst. They gathered the views of 61 people across groups / discussions including:

- Mental health group – ladies
- Men's Mental Health Group
- Veterans
- Asylum Seekers
- Young People's LGBTQ
- Parents and Families support
- Blind and Visually Impaired
- Older People's Welfare
- Vulnerable Young Women
- Learning Difficulties/ Disabilities and their Carers
- Community Health Ambassadors in Stockton and Hartlepool

The data below is a summary of key points from the survey and 'About you' results.

### Survey results

Q1. How would you prefer to contact mental health services?

- Telephone - 22
- Face to face - 32
- Websites - 9
- Email - 9
- Text Message - 11
- Via your GP - 25

Q2. Please state why you chose this option. If there is more than one reason please tick all which apply.

- More convenient - 30
- Easier to get to - 12
- You feel more comfortable accessing the service this way for reasons of confidentiality - 36
- Fits in better with your working hours - 12

- Fits in better with your social and home commitments - 7
- Other (please specify) - 3

Q3. Once you have been referred, which could be up to 10 days for assessment and 6 weeks for treatment, what support would you like whilst waiting for assessment?

- Some written advice and guidance - 23
- Access to websites for self help - 14
- Regular contact from the services to keep you up to date about when your own services and support will start i.e. by way of text messages or phone calls - 36
- Webchat - 2
- Other (please specify) - 5

Q4. Once you have accessed mental health services and been assessed, you could be waiting for up to 10 days for assessment and 6 weeks for treatment, what do you feel about these waiting times?

- Reasonable - 30
- Not reasonable - 26

Q5. How/where would you like to access treatment?

- GP Surgery - 35
- Telephone - through the provision of regular contact and support - 11
- Online i.e. internet and websites - 6
- Text message - 12
- Email - 8
- Community venues - with other people who have similar problems working together in small groups - 28
- In your own home - 15
- Other (please specify) - 3

Q6. What information would you like to receive to help you understand your treatment?

- Leaflets - 39
- Website information - 18
- Other (please specify) - 12

Q7. What are the most important things for you to know when choosing who you would like to deliver your services and treatment?

- Who is offering service outside of standard working out of hours? - 22
- Is the treatment and support near where I live? - 44

- Is the place where I will receive my service easy to access if I need to use local transport? - 29
- Does the service offer gender options - i.e can I choose to have a male, female gender neutral worker? - 16
- Can I choose a worker who has an understanding of my culture and ethnicity? - 14
- When will I be able to get my treatment - i.e. is there a long waiting time to get into the service? - 27
- Which service is best for the type of treatment I need? - 29
- Other (please specify) - 8

Q8. If the way you are receiving treatment (e.g. telephone, internet) is not working for you, do you want to be able to be offered an alternative (e.g. face to face)?

- Yes - 56
- No - 0
- Don't know - 4

Q9. If yes, then what is the most important thing to be able to change?

- New Service - 14
- New type of treatment and support - 35
- Different access options i.e. on an individual basis instead of group work or in a group instead of individual basis - 20
- Other (please specify) - 10

Q10. Would it be helpful to have regular reminders regarding appointments?

- Yes - 59
- No - 1
- Don't know - 0

Q11. How would you like to receive reminders?

- Letter - 21
- Text message - 32
- Phone call - 24
- Email - 11
- Other (please specify) - 4

Q12. How important would it be to you to be able to access support out of hours?

- Very important - 37
- Important - 16
- Not important - 6

Q13. Would it be helpful for you to give feedback throughout the duration of your treatment, if you felt it was not working for you?

- Yes - 37
- No - 0
- Don't know - 6
- If yes how would you like to give feedback? - 0
- Other (please specify) - 18

Q14. What would be the most appropriate time to access treatment

- During the day - 45
- Evenings - 13
- Weekends - 3

Q15. What issues would prevent you from attending appointments?

- The service appointments offered are not outside standard working out of hours - 11
- No treatment or support provided near to where I live - 26
- The place where I will receive my service is not easy to access if I need to use local transport - 23
- The service does not offer gender options - i.e. I cannot choose to have a male, female gender neutral worker - 8
- There is no choice of worker who have any understanding of my culture and ethnicity - 8
- The waiting times for the services are too long - 29
- The service is not offering the best type of treatment for my condition - 27
- Other (please specify) - 4

## About you

Q17. Are you:

- Person with Learning Disability - 6
- Carer - 8
- Family member - 23

- Other (please specify) - 18

Q18. Please state your gender:

- Male - 31
- Female - 20
- Prefer not to say - 9
- Other (please specify) - 1

Q19. How old are you?

- 18 - 24 - 9
- 25 - 34 - 4
- 35 - 44 - 5
- 45 - 54 - 5
- 55 - 64 - 11
- 14.75% 9
- 65 - 74 - 11
- 75 - 84 - 5
- 85 and over - 2

Q20. What is your marital status ?

- Married - 12
- Single - 19
- Divorced - 10
- Widowed -11
- Separated - 5
- Civil partnership - 3
- Other (please specify) - 1

Q21. What is your ethnic group?

- White - 54
- Black/African/Caribbean/Black British - 1
- Asian/Asian Black - 1
- Mixed/Multiple ethnic group - 2
- Prefer not to say - 1
- Other (please specify) - 1

Q22. What is your religion?

- Church of England - 22
- Roman Catholic - 8

- Christian - 4
- Methodist - 2
- Jewish - 0
- Jehovah Witness - 0
- Jehovah Witness - 0
- Other (please specify) - 5

Q23. Do you consider yourself to have a long standing illness or disability?

- No - 33
- Yes - 27

Q24. Do you care for someone with a long standing illness or disability?

- No - 11
- Yes - 50

Q25. How would you describe your sexuality?

- Heterosexual or Straight - 48
- Gay or Lesbian - 1
- Bisexual - 3
- Prefer not to say - 5
- Other (please specify) - 2

Q26. Please tell us if you are pregnant or have a child under two years old

- Yes - 1
- No - 59
- Prefer not to say - 0

Q27. Have you undergone gender reassignment?

- Yes - 1
- No - 59
- Prefer not to say - 0



# Appendix 1: Online questionnaire

## Improving Access to Psychological Therapies (IAPT) 2018

### Introduction

Clinical Commissioning Groups (CCGs) in Durham and Tees are working together to deliver an enhanced IAPT service that it is consistent and equitable across the region with a single point of access. This will mean changing the way that the service is delivered currently, and we are at the stage where we would like to gain views on the proposed model from past and current services users.

We would therefore be grateful if you could spare a few minutes to complete this survey, to provide us with your thoughts and opinions. Your feedback is extremely important us.

If you need any assistance completing this survey, please contact the Communications and Engagement team at [NECSU.engagement@nhs.net](mailto:NECSU.engagement@nhs.net) or 0191 3742795.

The deadline for completed surveys is Sunday 22 April 2018.

### Referral

1. How would you prefer to contact mental health services?

- ☐ Telephone
- ☐ Face to face
- ☐ Websites
- ☐ Email
- ☐ Text message
- ☐ Via your GP
- ☐ Other (please specify)

2. Please state why you chose this option. If there is more than one reason, please tick all which apply.

- ☐ More convenient
- ☐ Easier to get to
- ☐ You feel more comfortable accessing the service this way for reasons of confidentiality
- ☐ Fits in better with your working hours
- ☐ Fits in better with your social and home commitments
- ☐ Other (please specify)

3. Once you have been referred, which could be up to 10 days for assessment and 6 weeks for treatment, what support would you like whilst waiting for assessment?

- ☐ Some written advice and guidance
- ☐ Access to websites for self help
- ☐ Regular contact from the services to keep you up to date about when your own services and support will start i.e. by way of
- ☐ text messages or phone calls
- ☐ Webchat
- ☐ Other (please specify)

4. Once you have accessed mental health services and been assessed, you could be waiting for up to 10 days for assessment and 6 weeks for treatment, what do you feel about these waiting times?

- ☐ Reasonable
- ☐ Not reasonable

4a. If you think this is NOT a reasonable time to wait, please explain why?

5. How/where would you like to access treatment?

- ☐ GP Surgery
- ☐ Telephone - through the provision of regular contact and support
- ☐ Online i.e. internet and websites
- ☐ Text message
- ☐ Email
- ☐ Community venues - with other people who have similar problems working together in small groups
- ☐ In your own home
- ☐ Other (please specify)

## Assessment

6. What information would you like to receive to help you understand your treatment?

- ☐ Leaflets
- ☐ Website information
- ☐ Other (please specify)

7. What are the most important things for you to know when choosing who you would like to deliver your services and treatment?

- ☐ Who is offering services outside of standard working out of hours?

- ☐ Is the treatment and support provided near to where I live?
- ☐ Is the place where I will receive my service easy to access if I need to use local transport?
- ☐ Does the service offer Gender options – i.e. can I choose to have a male, female gender neutral worker?
- ☐ Can I choose a worker who has an understanding of my culture and ethnicity?
- ☐ When will I be able to get my treatment – i.e. is there a long waiting time to get into the service?
- ☐ Which service is best for the type of treatment I need?
- ☐ Other (please specify)

### Treatment

8. If the way you are receiving treatment (e.g. telephone, internet) is not working for you, do you want to be able to be offered an alternative (e.g. face to face)?

- ☐ Yes
- ☐ No
- ☐ Don't know

9. If yes, then what is the most important thing to be able to change?

- ☐ New service
- ☐ New type of treatment and support
- ☐ Different access options i.e. on an individual basis instead of group work or in a group instead of an individual basis
- ☐ Other (please specify)

10. Would it be helpful to have regular reminders regarding appointments?

- ☐ Yes
- ☐ No
- ☐ Don't know

11. How would you like to receive reminders?

- ☐ Letter
- ☐ Text message
- ☐ Phone call
- ☐ Email
- ☐ Other (please specify)

12. How important would it be to you to be able to access support out of hours?

- ☐ Very Important
- ☐ Important

- Not important

13. Would it be helpful for you to give feedback throughout the duration of your treatment, if you felt it was not working for you?

- Yes
- No
- Don't know

13a. If yes, how would you like to give feedback?

14. What would be the most appropriate time to access treatment?

- During the day
- Evenings
- Weekends

15. What issues would prevent you from attending appointments?

- ☐ The service appointments offered are not outside of standard working out of hours
- ☐ No treatment and support provided near to where I live
- ☐ The place where I will receive my service is not easy to access if I need to use local transport
- ☐ The service does not offer Gender options – i.e. I cannot choose to have a male, female gender neutral worker
- ☐ There is no choice of workers who have any understanding of my culture and ethnicity
- ☐ The waiting times for the service are too long?
- ☐ The service is not offering the best type of treatment for my condition
- ☐ Other (please specify)

### Feedback

16. Do you have any other suggestions, comments or concerns you would like to share with us?

### About you

The CCGs have a duty to ask for data monitoring information, so we can meet our equality duties. You do not have to answer all the questions if you do not want to.

17. Are you:

- Person with Learning Disability
- Carer
- Family Member

- ☐ Other (please state)

18. Please state your gender:

- ☐ Male
- ☐ Female
- ☐ Prefer not to say
- ☐ Other (please specify)

19. How old are you?

- ☐ Under 18
- ☐ 18 – 24
- ☐ 25 – 34
- ☐ 35 – 44
- ☐ 45 - 54
- ☐ 55 - 64
- ☐ 65 - 74
- ☐ 75 - 84
- ☐ 85 and over

20. What is your marital status?

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Civil partnership
- ☐ Other (please specify)

21. What is your ethnic group?

- ☐ White
- ☐ Black/African/Caribbean/Black British
- ☐ Asian / Asian Black
- ☐ Mixed / Multiple ethnic groups
- ☐ Prefer not to say
- ☐ Other (please specify)

22. What is your religion?

- ☐ Church of England
- ☐ Roman Catholic
- ☐ Christian
- ☐ Methodist
- ☐ Muslim
- ☐ Jewish

- ☐ Jehovah Witness
- ☐ Atheist / None
- ☐ Prefer not to say
- ☐ Other (please specify)

23. Do you consider yourself to have a long standing illness or disability?

- ☐ Yes
- ☐ No

24. Do you care for someone with a long standing illness or disability?

- ☐ Yes
- ☐ No

25. How would you describe your sexuality?

- ☐ Heterosexual or Straight
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Prefer not to say
- ☐ Other (please specify)

26. Please tell us if you are pregnant or have a child under two years old

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

27. Have you undergone gender reassignment?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

28. Please tell us the first 4 or 5 characters of your postcode (please note this does not identify a street or house) e.g. TS18 1 or TS4 2.