Department of Health & Social Care

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention

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Your Ref: 10727/CH
Our Ref: PFD-1169006

Ms Alison Patricia Mutch OBE
HM Senior Coroner, Manchester South
HM Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

20th May 2019

Dear Ms Mutch,

Thank you for your correspondence of 26 February to Matt Hancock about the death of Mr Danyon Robert Chesters. I am responding as Minister with responsibility for mental health and I am grateful for the additional time in which to do so.

I was very sorry to read of the circumstances of Mr Chesters death. I appreciate his loss must be extremely distressing for his family and loved ones and I offer my sincerest condolences.

I have noted carefully the matters of concern raised. It is essential that we look to make improvements where we can to ensure the safety of healthcare and prevent future deaths and I am grateful to you for bringing these matters to my attention.

My officials have made enquiries with NHS England, the Royal College of Psychiatrists and the British Association for Counselling and Psychotherapy in advising me about this response.

Firstly, I note that Mr Chesters chose to access private mental health therapy after being advised of a significant waiting time for NHS treatment. The decision to access private treatment is, of course, a personal one, and one that can be made for many reasons. However, it is regrettable if such a decision is influenced by difficulties in accessing NHS treatment.

It is the responsibility of the local NHS to commission services to meet the needs of their local populations. With regard to access to psychological therapies, one of the stated targets of the Improving Access to Psychological Therapies (IAPT) programme is that for new referrals, 75 per cent of people referred will enter treatment within six weeks, and 95 per cent within 18 weeks.

Published figures for February 2019[1] show that, for those who completed a course of IAPT treatment, a national average of 88.6 per cent had waited less than six weeks to enter treatment, and 98.8 per cent of people had waited less than 18 weeks, from the point of referral, both figures above target.

The IAPT programme began in 2008 and has transformed treatment of adult anxiety disorders and depression in England. IAPT services offer a range of therapies recommended by the National Institute for Health and Care Excellence (NICE) for depression and anxiety disorders, in line with a stepped care model, when appropriately indicated.

The *Five Year Forward View for Mental Health*[2] set out a commitment to expand IAPT services and improve quality further, with an ambition to increase access to psychological therapies for an additional 600,000 people with common mental health problems each year.

As well as investing more in IAPT, we are supporting the NHS with an additional £2.3billion investment in real terms by 2023-24 in a comprehensive expansion of mental health services. Outlined in the NHS Long Term Plan[3] published in January 2019, this includes an expansion of community services and better access to psychological interventions in the community and primary care.

Turning to the concerns about the co-ordination of care when a patient accesses private mental health therapy, I am advised that private therapists, such as counsellors and psychotherapists, will often take GP details from a client in order to be able to contact them should they have concerns, for example, around risk of suicide or serious harm. However, counsellors and psychotherapists in general are not medically trained and would not become involved with any medication that a client may have been prescribed.

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[1] https://files.digital.nhs.uk/81/65A540/iapt-month-feb-2019-exec-sum.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[3] https://www.longtermplan.nhs.uk/

As you will know, private therapy is an unregulated occupation and can encompass a range of practitioners, from those who may have undertaken correspondence courses with educational institutions to highly qualified psychotherapists. Clients wishing to access private therapy are advised to enquire about a potential therapists' qualifications and experience.

The UK Council for Psychotherapy, the British Psychoanalytical Council and the British Association of Counselling and Psychotherapy provide accredited registers of practitioners who have met their standards and voluntarily signed up to their respective codes of practice and ethical conduct.

The British Association of Counselling and Psychotherapy for example, provides an ethical framework within which all its members are expected to operate, underpinned by good practice resources. This includes guidance on managing confidentiality and identifying situations where confidentiality may need to be breached[4].

Your report does not indicate if Mr Chesters' therapist had concerns about suicidal ideation or intention. However, it may be useful to note that specific advice is given where a client is identified at risk of suicide or serious self-harm.

The guidance acknowledges that '*...this is one of the most challenging situations encountered by counsellors, with the ethical management of confidentiality inextricably linked to decisions about when to act in order to attempt to preserve life and when to remain silent out of respect for a client's autonomy'.*

The guidance advises counsellors to be explicit about reserving the power to breach confidentiality for a suicidal adult client, for example building an appropriate agreement in a counselling contract at the start of therapy, which can also include agreement on who might be contacted should a client present at high risk, such as the clients' GP or crisis team. In addition:

'*Referral may be defensible in the public interest where the therapist holds a reasonable belief that the client or others are at immediate risk of serious harm. However, careful consideration needs to be given to the seriousness and immediacy of the risk, the ethics of the situation, consent issues, and the appropriate action to be taken'.*

Furthermore, counsellors are advised to act within the scope of their personal expertise, and to consider their own limitations, giving consideration to onward

[4] https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/confidentiality/

referral with the client's consent. It might be appropriate for example, to contact the client's GP to express specific concerns about the nature of the risk and to discuss how to respond to the client. Alternatively, and if appropriate, it might be possible to contact a mental health crisis team who could consider a range of responses with the practitioner and the client. Where a client does not consent to referral, and if the client or others may be at risk of harm, the therapist should seek professional advice.

Suicide prevention is a key priority for this Government and we have set out clear recommendations to the NHS on suicide prevention and reduction in the National Suicide Prevention Strategy[5] (2012), and the Cross-Government suicide prevention plan (2019)[6]. However, suicide prevention and reduction should be a priority for all who work with people with mental health problems, including counselling professionals. I am pleased to note that the British Association of Counselling and Psychotherapy has issued guidance to its members on '*Working with Suicidal Clients in the Counselling professions*'[7].

I hope this information is helpful.

JACKIE DOYLE-PRICE

[5] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

[6] https://www.gov.uk/government/publications/suicide-prevention-cross-government-plan

[7] https://www.bacp.co.uk/media/2157/bacp-working-with-suicidal-clients-fact-sheet-gpia042.pdf