Correspondence

Encouraging dialogue for better collaboration and service improvement†

I am writing in response to the editorial by Dr Sami Timimi published in April 2015.[1]

First of all, I must declare my allegiances. I am the Clinical Lead for the London and South East Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) Learning Collaborative and a founder member of the Child Outcomes Research Consortium (CORC), so from the point of view of the original article I am doubly damned.

I feel moved to write, not to defend either CORC or CYP-IAPT specifically – there will be independent evaluations of the programme in time – but because I feel that what was portrayed in the original article does not fit with my lived experience of either CORC or CYP-IAPT and I want to give my perspective. My view will, of course, be as partial as Sami's; we all speak from a position and a certain point of understanding shaped by our past and current contexts and worldviews. As in good clinical work, progress begins to occur when a therapist and young person or family begin a dialogue to share their different perspectives, to try and understand each other and the issues at hand, and find ways to work together to move forward. It is in this spirit that I write, in the hope to create dialogue and understanding, to share learning and perspective, to build and improve.

Let me make my position clear. I believe CYP-IAPT, CORC and Outcome Orientated Child and Adolescent Mental Health Services (OO-CAMHS)/Partners for Change Outcome Management Systems (PCOMS) are entirely complementary. I think at their heart their philosophy is the same: to work to improve services for children and young people. Embedded in each is the ambition to improve the relationship between children, young people and families, and between the therapist and services. All three recommend the use of tools to facilitate better understanding and collaborative practice. All recommend the Outcomes Rating Scales (ORS) and Session Rating Scales (SRS) as useful tools to facilitate these discussions – I was one of many who fought to have the ORS and SRS included in the CYP-IAPT toolkit. CORC and CYP-IAPT produced a book dedicated to the use of feedback and outcomes tools in facilitating better collaboration: a whole chapter is dedicated to the ORS and SRS and PCOMS model, another to the cultural sensitivities of using feedback and outcomes tools. Whole modules in the CYP-IAPT training are dedicated to training therapists and supervisors in the collaborative use of feedback and outcomes tools – these core skills are drummed into trainees before they even start to specialise in a particular therapeutic modality.

Sure there are problems, and sure there is learning that has been, and still needs to be, done in what and how service improvement is implemented. None are perfect, certainly CORC and CYP-IAPT make no claims to be the answer to all the problems in children and young people's mental health services. Any large-scale, publicly funded attempt at service improvement has to strike a balance between collaborative principles and non-negotiables, to ensure some fidelity and uniformity across the country. CYP-IAPT is rolled out through five regional learning collaboratives that actively promote the discussion and sharing of practice experiences – good and bad – in an attempt to refine and improve best practice, including how feedback and outcomes tool are best used.

So to my predicament and a need to understand better. My experience does not fit with the description set out in Sami's paper, far from it: mine is of an iterative, learning collaborative that tries hard to promote personalised, evidence-based practice. To me this is not diametrically opposed to what I understand of OO-CAMHS/PCOMS. I struggle to understand why Sami and I see things so differently. Why our perceptions of the principles and practices behind CORC, CYP-IAPT and OO-CAMHS/PCOMS seem so out of step? It seems to me that there is a need for dialogue to better understand our different perspectives – that is where progress begins.

Declaration of interest: D.J.L. is Clinical Lead for the London and South East CYP-IAPT Learning Collaborative and member of the CORC steering committee.

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1 Timimi S. Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same? *BJPsych Bull* 2015; **39**: 57–60.

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Fair criticism also needs to be based on evidence†

This entire article[1] is more focused on cobbling together a damning indictment of the two Improving Access to Psychological Therapies (IAPT) programmes than approaching the facts and evaluating them fairly. In terms of adult IAPT many areas did not have the range of services described by the author, such as pre-IAPT primary care counselling services. Giving a broad section of people suffering from mild to moderate mental ill health access to cognitive–behavioural therapy (CBT) did exactly what it said on the tin: it improved access to psychological therapies. For those of us who do actually 'believe that psychological therapies help people', this is a good thing, regardless of the limitations placed by the use of limited modalities. In my area waiting lists for psychological therapies exceeded 30 weeks and were only available via secondary care, so to completely disregard the huge impact of this programme is equivalent to moaning about the limitations of a set menu when being fed for the first time in a week.

The article cites references that are twisted to purpose, for example 'Research has found that 40–60% of youth who begin treatment drop out against advice'. This research pre-dates the introduction of Children and Young People's

†See also special articles by Fonagy & Clark, pp. 248–251, this issue, and Timimi, pp. 57–60, April issue.