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Bridging the gaps

The positive impact of third sector counselling services and the challenges they face

bacp | counselling changes lives

November 2024

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Public First is a policy, research, opinion and strategy consultancy. We work with companies, charities, professional bodies, institutions and foundations around the world to tackle major public policy and strategic challenges.

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Executive summary

Counselling can support people's mental health by providing a safe, confidential place for them to talk to a trained professional about their feelings and concerns. Those feelings and concerns could be about anxiety and bereavement, relationship difficulties, sexual, sexuality and racial issues, child abuse and trauma, or personal problem solving, and they may or may not involve a diagnosed mental health problem. In some circumstances counselling is available on the NHS, but it is also accessible, sometimes on a paid basis, through a range of other providers.

Many counselling services in England are neither part of the NHS nor in the private sector, but in the third sector: charities, social enterprises and other non-profit organisations. Some are commissioned to provide specific services by the NHS, or by other public sector bodies, and are accountable for delivering what they are paid to do. But they do more than just add additional capacity to the public sector: they add value too, with many providing additional services that are not funded by the taxpayer but nevertheless support people's mental health, to everyone's benefit.

Through our research, including interviews with representatives of third sector counselling services and others, we identified a number of sources of special **value**.

The **diverse therapeutic approaches** they offer, which in many cases go beyond what is available through the NHS.

Their **ability to reach marginalised communities** who may be reluctant to access mainstream services or who require specialist support which the NHS is unable to provide directly, although in many cases it may commission it from the third sector.

In the case of some specialist third sector services, their **understanding of trauma** which requires particular expertise and which can itself lead to a reluctance to engage with statutory services.

Linked to this, their **independence from NHS structures**, which provides them with a flexibility and freedom to innovate which is more difficult inside the NHS.

Their ability to provide their clients with **longer-term counselling**, in a more flexible way, than that which can be provided through NHS Talking Therapies.

The **broader offer** they provide alongside counselling, including stabilisation sessions before therapy, support with language and other skills, and social and wellbeing activities.

But we also found that third sector counselling services face significant **challenges** which threaten the viability of some services.

Services told us about how much work is involved in securing the **funding** they need from an extraordinarily wide range of sources, about being restricted to highly prescriptive short-term, and in some cases unreliable, contracts, and of being highly dependent on relationships with commissioners whose understanding of their value and expertise may vary.

At the same time, **demand** for the counselling services the third sector provides is rising not falling. That results in part from a greater awareness of and willingness to seek help for mental health problems, in part from increased pressure on people's mental health arising from cost of living challenges in particular, and in part from an increase in referrals to third sector counselling from the NHS – many of which do not come with any funding attached.

Given this increase, third sector counselling services have adopted a range of strategies for **managing demand**, including cutting back on promoting their services and closing waiting lists. They have also had to find ways to support staff who are impacted by heavy workloads, and to try new ways of working.

This report makes a number of **recommendations** that would support the ability of third sector counselling services to be more sustainable.

1) Funding cycles should be longer, with a presumption on the part of commissioners and grant funders in favour of three-to-five-year contracts rather than single-year contracts, alongside longer-term funding cycles for those who commission services, such as local government and ICBs, to make it easier for them to plan. Multi-year contracts should factor in the likelihood of inflation and rising wage costs.

2) Commissioning arrangements should be simplified, taking into account the administrative burden on services of securing funding from sources which have different and incompatible application processes and reporting requirements.

3) There should be better engagement between commissioners and the third sector, so that services have a better understanding of what commissioners need, and commissioners have a better understanding of the value of the third sector's offer. This should include a requirement that every ICB and ICP has at least one member drawn from the local third sector.

4) Commissioners should ensure that specialist services are available to those who need them when considering their overall commissioning requirements, so that marginalised, minoritised and "hard to reach" groups have access to services that properly meet their needs – with this requirement explicitly included in commissioning outcomes frameworks.

5) "Referrals" from the NHS and other services should be better recorded in order to enable a basis for future conversations about fair funding, including by developing accurate and consistent definitions of these "referrals", and by identifying and tackling unfunded referrals to third sector counselling services, in order to recognise and move closer to fulfilling the principle that the money should follow the patient.

Foreword

In the UK, we have a long tradition of finding community responses to recognise and bridge gaps in social support, with early charitable organisations dating back to medieval times being established to relieve poverty and illness. Today, the sector is enormously complex, made up of a large and diverse range of charities, community groups and community interest companies, with the common defining characteristic of being neither public bodies nor private enterprises – thus, a third sector – and operating on a strictly not-for-profit basis.

During the Covid-19 pandemic, community-based third sector services responded at speed and with great flexibility to the crisis, adapting quickly and adopting new technologies to continue to meet needs of communities within the restrictions of lockdown. For counselling services, this meant moving to online and telephone delivery of therapy sessions in ways that provided the same support, safety and quality of service for clients. The pandemic also highlighted another gap: deep and long-standing health inequalities that present barriers to people from marginalised and racialised community backgrounds from getting the services and support that they need.

Over the past 18 months, against the back-drop of the cost of living crisis, third sector counselling services have increasingly highlighted rapid growth in demand for therapy and rising rates of referral for their services from NHS and other statutory services, without accompanying funding and with rising overhead costs. This challenging environment has been further exacerbated by services seeing increased running costs alongside reductions in income from donations.

From our membership surveys we know that one third of BACP's 70,000 members work in the third sector. Our contact with many of our 800 organisational members provides insights and understanding of the reach and impact of community-based counselling services, as well as the gaps that they face in stretching available funding to meet growing need and demand for their work.

This report highlights the additional choice and flexibility that third sector organisations offer to meet the needs of clients. Critically, it includes a focus on the role that services specialising in working with people from marginalised and racialised community backgrounds play in bridging gaps to vital support known to persist in NHS and statutory provision. Often these specialist services are recognised for their specialisms and receive client referrals, formally and informally, from NHS services, but are still reliant on their own fundraising efforts to meet the cost of delivery.

Inevitably, in reflecting on relationships between the statutory services and the third sector, interviewees contributing to the report have identified gaps and shortfalls in

NHS provision of talking therapies. NHS Talking Therapies for Anxiety and Depression (formerly known as IAPT) has made great strides over the past two decades in increasing both the availability and awareness of psychological therapies for common mental health conditions through the NHS in England. Many of these services work closely with, or in some cases are delivered by third sector counselling services. But, as we see in this report, there are gaps in the NHS offer which are already being bridged in part by third sector services and which are set to grow if the sector is not recognised and supported to bear this extra workload. We're hearing stories of established services closing their doors, closing waiting lists and cutting back. We can't afford to lose these services – the impact on already marginalised communities, and on the public purse, of increased demand on overstretched NHS services and expensive crisis care must be offset by action.

Through this report, detailing the work of 11 third sector counselling services across England, BACP adds its voice to the calls from others in the third sector for a reset of relationships between the NHS, statutory services, and third sector organisations.

The UK's mental health is at a critical juncture. Lord Darzi's recent analysis found that "by April 2024, about 1 million people were waiting for mental health services" and that "long waits have become normalised".[1] The Darzi Report also found that at the start of 2024, 2.8 million people were economically inactive due to long-term sickness, "an 800,000 increase on pre-pandemic levels with most of the rise accounted for by mental health conditions".[2]

A strong and sustainable third sector is vital to forging a healthier population, and central to the government's ability to deliver on its stated missions for health, education, employment and the economy.

When vulnerable people hit crisis point, the third sector steps in. Now, the third sector is in crisis. We need Government to step up and bridge the gap, to ensure it is given appropriate and sustainable support. The social and economic cost of doing nothing is far too great and it risks exacerbating the mental health crisis facing our most vulnerable communities.

Dr Phil **James**

Chief Executive Officer, **British Association for Counselling and Psychotherapy**

[1] Lord Darzi, Independent Investigation of the National Health Service in England (2024), p. 3
[2] Lord Darzi, Independent Investigation of the National Health Service in England (2024), p. 7

Introduction

Third sector counselling services are a crucial, and extraordinarily diverse, part of the overall landscape of mental health support in England. The third sector is a broad term, referring to a range of non-governmental, non-profit organisations including charities and social enterprises, and the third sector counselling landscape consists of a wide number of services, large and small, with very different histories, offering different modalities of therapy to different client groups, and with different funding models. That means that it is difficult to generalise about it. But this project has identified some important common features.

Methodology

Public First worked with BACP to select 11 third sector counselling services that could demonstrate the breadth and diversity of the sector, and to interview managers and practitioners as well as asking them to complete a short survey. The organisations we focused on include a large provider of NHS Talking Therapies (NHSTT) as well as others which provide some NHS services, including but not limited to NHSTT, on a commissioned basis, some which are commissioned by other public sector organisations, and some which do not work with the public sector at all. The 11 services we focused on are listed in the Appendix of this report.

The third sector counselling services in this research include generalist services that work with clients from a broad range of backgrounds, services that specialise in work with clients from marginalised communities, and services that specialise in work with clients who have experienced trauma, including adult and child sexual and domestic abuse, clients who are refugees and/or victims of modern slavery and exploitation, and clients experiencing drug addiction or misuse. With qualified and registered counsellors (both paid and volunteers), student trainees, and other health professionals, they treat and respond to the needs of people with an extraordinarily variable and complex range of presenting problems. They include services that treat victims of complex

trauma, and people with schizophrenia, bipolar disorder, depression, anxiety, emotionally unstable personality disorder, and severe PTSD.

We are very grateful to everyone who participated in the research, and to BACP. All quotes, where not otherwise attributed, come from our interviews and we have kept the names of our participants anonymous.

The third sector's offer overlaps significantly with the NHS, including where third sector organisations are commissioned to deliver NHS services. For example, NHS Talking Therapies (NHSTT), previously known as Improving Access to Psychological Therapies (IAPT), which provides evidence-based treatment for depression and anxiety among adults, relies to a significant extent on the third sector to deliver interventions including interpersonal psychotherapy, guided self-help, behavioural activation, interpersonal therapy, cognitive behavioural therapy, counselling, and EMDR.[3] The National Audit Office estimated that in 2021/22, 17% of the NHS's total mental health funding went on "non-NHS providers, including independent and voluntary sector providers"[4] – while this figure includes third sector counselling services it is much broader than that, and also includes out-of-area secondary care, forensic psychiatry and private medical services.

The third sector offers a choice of therapeutic and counselling options, beyond what the NHS will commission, whose diversity far exceeds that of the statutory sector. As we note above, while some of these services work closely with the public sector – and are commissioned to deliver specific services – others do not formally work with the public sector at all. For this project, we spoke to services offering group, family and one-to-one therapy, reflective practice, multimodal and existential therapy, as well as person-centred, humanistic, and integrative therapy and African-centred therapy.

This choice of therapy is important: the extent to which a person believes in the approach affects the outcome of treatment, and studies have shown that giving patients choice of treatment can itself contribute to the recovery process.[5] The NHS Talking Therapies Manual itself says that "services should be commissioned so that patients can be offered a choice between the recommended treatments", and that "providing such choice is likely to enhance engagement and, consequently, improve

[3] NHS website for England, Types of Talking Therapy
[4] Progress in improving mental health services in England (National Audit Office, 2023), p. 4
[5] Lindhiem, O et al., Client preferences affect treatment satisfaction, completion, and clinical outcome: a meta-analysis. (Clinical Psychology Review, 2014)

outcomes".[6] But analysis of patient choice from IAPT assessment sessions suggests that in practice, this choice is limited.[7]

At the same time as offering a broad range of treatments, the third sector counselling organisations we spoke to engaged in therapeutic stabilisation and containment, as well as psychosocial support. From one organisation to the next, this may involve organising groups for their clients – including arts and crafts activities, talks, allotment sessions, creative writing groups, and social drop-ins – while others give their clients assistance with housing, employment, debt, and language services. As such, third sector services are often able to offer a more comprehensive support package than would typically be available from statutory health services.

This diversity can also take the form of increased practical flexibility. For example, third sector services are often able to offer more counselling sessions based on the needs of their clients than the NHS can, despite the fact that this has significant resource implications. While there is crossover between the types of clients and presenting issues that the third sector and NHS work with, there are also important differences between them. We will draw out some of these distinctions – which help to demonstrate the unique value of third sector counselling services – in more detail below. At the same time, third sector counselling services face challenges which put their staff under pressure and their viability under threat. This research brings out some of these challenges, and some of the ways in which they might be addressed and the future of these vital services made more secure.

[6] NHS Talking Therapies for anxiety and depression Manual (National Collaborating Centre for Mental Health, 2018, updated 2024), p. 70

[7] Irvine, A. et al., 'So just to go through the options…': Patient choice in the telephone delivery of the NHS Improving Access to Psychological Therapies services (Sociology of Health & Illness, 2021)

Chapter one:

The special value of third sector counselling services

The third sector is separate from the public sector but is often commissioned by it to provide a very broad range of services, in health, social care, education, crime and justice, and many more areas.

New Philanthropy Capital recently estimated that the charity sector as a whole is subsidising state services by £2.4 billion per year – that is to say, that charities are providing £6.9 billion of work to the state in return for £4.5 billion in contracts.[8] So far as counselling is concerned, we found plenty of evidence that services are both adding value and going above and beyond what they are paid to deliver in their contracts. The third sector is doing much more than simply providing additional counselling capacity to what is already available on the NHS. This is not only in the sense that it is being commissioned to provide NHS Talking Therapies services in some cases, although this is an important part of its offer. Across the services we looked at, we saw examples of innovation, of specialism, of flexibility, and of going beyond what is available elsewhere.

Commissioning

NHS services, including mental health services, are commissioned by Integrated Care Boards (ICBs), regional bodies responsible for delivering health services in their area based on the region's integrated care strategy – which is the product of many partners across the health system coming together to establish how to meet the needs of their population. NHS commissioning is complex, and will include assessing the needs of a local population, establishing priorities, planning and procuring services, and monitoring the quality of the output.[9]

[8] Clay, T. et al., State of the Sector 2024: Ready for a Reset (New Philanthropy Capital, 2024), p. 30
[9] Wenzel L, et al., What Is Commissioning And How Is It Changing? (The King's Fund, 2023)

The NHS and local authorities, as well as some other public sector organisations such as Police and Crime Commissioners, will in turn commission the third sector to deliver some specific services. Many of the services we reference in this report, for example, receive funding to deliver NHS Talking Therapies services on the NHS's behalf. These third sector organisations are specifically commissioned to deliver services that would otherwise be delivered by the NHS. They are accountable for the money they receive and required to monitor activities and outcomes.

At the same time, many third sector counselling services are also doing work that has not been commissioned by the NHS or any other public sector organisation, and for which they receive no public funding. This work may be funded by grant-making bodies, donations and fees from clients, and may also be conditional on monitoring activities and outcomes.

There are clear limits to the scope of what NHS Talking Therapies provides to patients, defined by the NHS as "treatment for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context".[10] That will be appropriate and helpful for many people, but not for everyone with mental health problems who could benefit from counselling. One of our interviewees told us that the NHS focused on a medical model – based on seeking to identify and treat specific mental illnesses, but less able to provide prevention and broader mental health support – which was not always appropriate for the clients their service supports.

> *The NHS isn't really set up to respond to this giant upswell in mental health demand, because the NHS is set up for mental illness, really.*

> *[In the NHS] provision is much less. Provision is very small and targeted. It's not always the provision that clients want.... they want to be in a room, they want to have a conversation with people. So the medicalised model is very different from the approach they might receive from an organisation like us.*

[10] NHS Talking Therapies for anxiety and depression Manual (National Collaborating Centre for Mental Health, 2018, updated 2024), p. 8

Diverse therapeutic approaches

The third sector offers a much more diverse range of therapy than can be found on the NHS. This goes beyond types of therapy, and may include combinations of therapy that can be adapted more readily to an individual client's circumstances. As one interviewee told us, in contrast to the NHS, "the third sector services are obviously a bit freer, so they can offer different modalities, different approaches, different blends of therapy". Indeed, the freedom and flexibility to experiment with different approaches, thereby offering tailored support, was frequently cited as a key benefit of the third sector.

In contrast to the NHS, this was often described as a "person-centred" model of care provision that similarly allowed for a more responsive and nimble approach to emerging problems (or gaps) in the way care is provided. A recent study of adults attending person-centred counselling found that it "was effective in reducing symptoms of anxiety and depression".[11]

One service whose clients included survivors of sexual violence and people with cancer argued that the flexibility third sector counselling services can provide is an important part of their non-statutory status, and one that provides an innovative feedback loop for the mental health system as a whole.

> *"There's a benefit that can accrue to communities or the wider system. We can just do things quicker and faster and more creatively than the NHS will do. We'll take more risks. We'll pilot something on a shoestring, we'll collate an evidence base, and then we'll work out if we can get it funded."*

It is important to stress that services are aware of NICE guidelines and the need for their interventions to have an evidence base, grounded in knowledge and experience: the flexibility of operating outside the NHS is not, and nor it is viewed as, carte blanche by third sector services to do whatever they want.

> *"Being independent means that we can make decisions ourselves without being beholden to the NHS or other services. Now, that doesn't mean we can just decide whatever we want to do because we are responsive first and foremost to our clients but equally to the Charity Commission, and also to funders. But nonetheless it gives us a certain level of freedom to decide how we want the organisation to*

[11] Young, J, et al., A practice-based exploration of therapeutic change in a charitable, community-based person-centred counselling service using routine outcome measures of anxiety and depression. I: Statistical and clinically significant change (Counselling and Psychotherapy Research, 2023)

develop, and it gives us the freedom to develop services to meet the needs of the community we serve.

It is worth reiterating the contrast this represents to NHS provision, which has often been criticised for the "narrow and prescriptive nature of the interventions offered", specifically an over-representation of cognitive behavioural therapies.[12] This is partly a result of NHS Talking Therapies having a focus on mild to moderate anxiety and depression, with specific interventions included: it does what it is designed to do, but it does not do things that are outside its scope.

The ability to provide services that are tailored to the needs of particular client groups is enormously valuable and has positive results. Research in 2018, for example, found that young people seen by counsellors in services run by charities and voluntary organisations expressed very high levels of satisfaction with their care and showed significant improvements, and that those services "may be more accessible to young people from marginalised groups, such as those from BME backgrounds, compared to statutory and school-based counselling services".[13] This greater accessibility and high quality of service was highlighted by an interviewee whose service works with young people.

> *"I would say that a lot of statutory services are aware that if they can get [a client] into us, they get a better service than CAMHS [Child and Adolescent Mental Health Services] give them because we can offer 24 weeks fully funded... and we don't end at six months if there's a clinical need for the client to continue. There are very few places that people can go and get six months fully funded professional counselling without having to pay for it."*

Reaching marginalised communities

A recent review of ethnic inequalities in the Improving Access to Psychological Therapies (IAPT) programme in England found that "people from minoritised ethnic groups (including non-British White people) experienced worse outcomes, although this has narrowed in recent years, waited longer for assessment [and] were less likely to receive a course of treatment following assessment".[14] Third sector counselling services which specifically focus on minoritised groups are in a position, depending on their specialism, to offer things which the NHS cannot offer and indeed which other third sector counselling services with different approaches also cannot offer –

[12] BACP, Understanding the cost of living crisis: Valuing our mental health (2024), p. 8
[13] Duncan C, et al., Counselling for young people and young adults in the voluntary and community sector: An overview of the demographic profile of clients and outcomes, (Psychology and Psychotherapy: Theory, Research and Practice, 2018)
[14] National Collaborating Centre for Mental Health, Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT): Executive summary and recommendations (2023), p. 1

recognising that people from marginalised and racialised community backgrounds are more likely to engage with and benefit from support that recognises, understands, and responds to their identities, culture and experience.

This might involve the ability to reflect and embody particular cultural understandings, providing services for specific marginalised groups delivered by staff who share similar backgrounds or identities, making it easier for clients to relate to their counsellors and demonstrating that the service is a space where they can feel safe. It might include being able to speak to clients in their first language or dialect – something that is known to be particularly important for counselling, which relies on people articulating complex thoughts and having them understood. It might involve specialist subject knowledge of particular cultural communities or types of trauma. One of our interviewees, who works with women who have been victims of sexual violence, told us how this understanding differs from what clients might find elsewhere.

> *"The NHS will see the presenting symptom. They won't necessarily see the root cause of the trouble. That's why they come here, because we see the whole person. We want to help them come to terms with what happened and then move on. A non-specialist agency would probably just look at the anxiety but not necessarily understand how that is a manifestation of trauma."*

An interviewee who delivered counselling services to Black clients noted the difference it makes just to have a therapist who visibly comes from the same community.

> *"Very often clients have said they feel so relieved to see someone like them being their therapist... It's about just knowing that someone understands what it feels like to be oppressed. It is possible for therapists that don't fit that category to understand it, but there's just some things you don't have to say... It's almost like a guard comes down. Being in an organisation like this provides some ease to clients... It avoids the feeling of having to fit a round peg in a square hole."*

Another interviewee from a service that works exclusively with women told us about the benefits to clients of knowing that they are coming to a service with a specialist focus.

> *"The benefits of them coming here is A, they know it's going to be a female therapist that they're going to see, B, there's a possibility that they can also be seen by somebody who speaks the same language or dialect as them, C, there is an implicit understanding that we*

know the challenges that they may have had already before they get to us here.

Unlike the NHS, not all third sector counselling services are attempting to provide a universal service that can be accessed by everyone: many explicitly specialise in working with marginalised and racialised communities with specific needs. While universal services are vital, there are advantages to having more targeted services too, and for clients to be supported by counsellors and others who have an understanding of their lived experience.

> *People were saying that they need to feel safe when they come to a service, that it's physically safe, that they're not going to experience any harassment or discrimination, but also emotionally safe to be able to open up and talk about what's going on for them. They need to feel that they're understood as well... a lot of people feel, 'How could I go and talk about this to someone with a different experience?*

All services set out to be welcoming to clients and other visitors, and we observed that those with particular specialisms, or catering to particular client groups, take steps to make sure their decor and layout reflect that. BACP's equality, diversity and inclusion strategy states that working in a way which "recognises and values difference, is essential in providing services which are truly accessible to all, which treat our clients with the dignity and respect they deserve, and which are fit for the diverse communities within which we work as practitioners".[15]

Many of the services we spoke to in the course of this project specialise in working with clients from communities which are known to find it difficult to engage with statutory services. Factors which prevent people from ethnic minority communities from seeking mental health support include cultural stigma, senses of alienation from clinical settings, or experiencing racism.[16] The Centre for Mental Health has previously drawn attention to the effect that discrimination can have on trust in the whole mental health system.[17] As such, it is hard to overstate the importance of having services specifically designed to tackle these barriers – a point made to us by a service that delivers African-centred therapy to Black communities.

> *There is an acknowledgement that we are underrepresented within counselling and therapeutic practice, and an acknowledgement that actually the NHS Talking Therapies service does*

[15] BACP, BACP equality, diversity and inclusion strategy (2023), p. 11
[16] BACP, Race for the soul of the profession – tackling racial inequalities in the counselling professions (2022), p. 5
[17] Commission for Equality in Mental Health, Mental health for all? The final report of the Commission for Equality in Mental Health (2020), p. 15

not really work for our community, and that we should be overrepresented in terms of severe mental illness services. There is a need to engage our community... and we have accredited ways of doing that. We have all the evidence that we need that the model works and so on and so forth. That is our sole purpose.

Nor is this just the case for racialised communities. One counselling service we spoke to, for example, specialised in providing mental health services to LGBTQ+ people. In light of the poorer mental health outcomes experienced by this community, they saw a service specifically geared towards and staffed by LGBTQ+ people as an effective way to provide support.

> *Our clients have a sense that it's a service for people like them in one respect, where everybody providing that service will identify like them and have a greater understanding. That helps people's trust and confidence in the service, in perceptions of how competent we are. There's the caveat that you can't make assumptions based on one kind of affinity. But I think there is that level of trust and comfort in the service.*

Often statutory services themselves recognise these benefits and make referrals accordingly, both formally and informally. According to the BACP, "Organisations and services that specialise in working with people from marginalised community backgrounds are critical to improving access to psychological support, and often receive referrals from NHS services in recognition of their specialisms".[18] People from marginalised groups often present at NHS services – whether for physical or mental health issues – later than the general population, which can mean that when they do present, their symptoms are more acute and harder to deal with.

Understanding of trauma

Clients may require specialist support for more than one reason. Services which specialise in working with refugees, for example, may find that their clients are part of a racially marginalised group, are affected by stigma and discrimination against asylum seekers, have trauma specific to their experience, and are reluctant to engage with statutory services.

Some kinds of trauma may create a need for specialist mental health support that is distinct from membership of a particular marginalised community. We spoke to services who specialise in working with people whose mental health problems stem from sexual abuse or domestic violence, where senses of shame, embarrassment,

[18] BACP, Understanding the cost of living crisis: Valuing our mental health (2024), p. 9

self-blame, and the fear of not being believed are all common occurrences among their clients. Indeed, these can act as persistent barriers to seeking support.

> *Around sexual abuse and domestic abuse, our clients will find it harder to access services because they will feel shame around the abuse. They may blame themselves. They can understandably be embarrassed, They will often fear that they're not going to be believed, and for some of our clients, they will not recognise that this is actually abuse.*

We were told that the other side of this reluctance to engage with services, deriving in the case of sexual abuse from shame and embarrassment, can be a lack of awareness and understanding of the issues involved on the part of non-specialist services.

> *Because of the nature of sexual violence, people generally don't talk about it. There is very limited understanding, I would say even within the NHS, of sexual trauma.*

This lack of awareness and understanding can have significant consequences. A service that specialises in working with refugees told us about the risk of misdiagnosis, and consequently of going down inappropriate treatment paths, for people who have experienced trauma.

> *One of the downsides is that when people are highly traumatised, they can present with problems that look like schizophrenia or psychosis. So they often end up on very heavy medication which doesn't actually touch their symptoms, but makes them less able to function.*

Existing outside NHS structures

All of the services we spoke to are separate from the NHS, even those that are commissioned to provide services to it, and this independence was important to many of their staff and, they told us, many of their clients. Services provided outside statutory frameworks are not subject to the same requirements and assessment criteria, and can provide forms of flexibility which the NHS cannot – although the services we spoke to all recorded and evaluated outcomes in order to assess the progress of their clients and the effectiveness of their interventions, as well as to ensure adherence to regulatory guidelines and provide accountability to funders. On the other hand, where third sector services *are* being commissioned to provide counselling by the NHS or other public bodies, they are subject to whatever accountability frameworks those

public bodies require, in respect of the work being commissioned. In these situations, organisations naturally have less latitude to decide what they deliver, and how they deliver it.

Nevertheless, some of our interviewees told us that freedom from targets and from certain kinds of bureaucratic processes, enabling assessment processes to be completed in a relatively unobtrusive way, was a benefit for their clients.

> *Not being funded by the NHS gives us the flexibility to work with clients in a person-centred way. So we don't have to meet those targets, or have a client come in and do an assessment every time they meet with us which, as clients say, is not helpful for them. We can work in a way that we feel is suitable for each individual client.*

An interviewee with a background in commissioning mental health services for the NHS similarly argued that there is a real benefit here.

> *Third sector groups are not institutionalised in a very kind of cold NHS setting where you are a piece of the production line of people coming in and people coming out.*

> *The NHS is designed to treat symptoms, and that means that without intending to, people can be treated as a collection of symptoms which different parts of the NHS are responsible for treating.*

One interviewee told us that many people who go on to use non-statutory services have experienced being "knocked around" parts of the NHS before completing a diagnostic assessment.

Longer term counselling

Flexibility over the length of time clients can work with therapists is another significant advantage. Particularly where therapeutic interventions will similarly attempt to address socioeconomic factors, or where severe trauma (and the need for pre-therapy stabilisation) is involved, the ability to extend the number of sessions available to clients can be a real benefit to the most vulnerable.

> *I'm not suggesting everybody does take up to two years, but being able to say to somebody, 'You will have the same counsellor on the same day every week for as long as you need up to this*

time' does make a significant difference, and some of the feedback we get from our clients really does reflect that.

Many of the services we spoke to not only offered more options over the length of time clients can be seen, but also over the spacing of that contact. As such, clients may often have the option to pause or return to therapy at a date that suited them. This was not universally available among the services we spoke to, many of whom were conscious of either the lack of capacity to offer more flexibility in this respect, or the lost capacity from giving clients too much freedom of choice. However, increasing the length of time clients can spend with their therapists can still hugely increase the effectiveness of therapeutic interventions.

> *Particularly with any complex trauma, it can take years of work for people to begin to function. People will have 20 sessions and then get on with their lives for six months and then come back on the waiting list and can do some more. So we do pieces of work with people over time.*

This contrasts with NHS provision, through which clients can expect a relatively limited number of sessions. The NHS reported this to be an average of 8.1 sessions in 2022/23; which services we spoke to said was often insufficient. For high intensity work, NICE guidelines recommend between 12 and 20 sessions. The NHS, however, reported that the average number of sessions for high intensity cognitive behavioural therapy in 2022/23 was 6.4.[19]

The relative inability of NHS Talking Therapies to offer long term interventions was repeatedly cited as a severe limitation on the NHS's capacity to successfully address some of the mental health problems the services we spoke to regularly see in their clients. "Revolving door" patients, who finish treatment and then re-refer for more treatment, are frequently seen across mental health services including NHSTT.[20]

A broader offer

Third sector counselling services are also often in a position to offer other valuable services and packages of support that go well beyond therapeutic work – before, after and alongside counselling. A manager at one of the services we spoke to told us that in many cases they need to take steps with their clients to lay the groundwork before counselling can even begin.

[19] NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23 (NHS England)
[20] Lorimer B, et al., An investigation of treatment return after psychological therapy for depression and anxiety (Behavioural and Cognitive Psychotherapy, 2024)

> *We have a support-work service because some people are just not ready for counselling. There are too many other chaotic things going on in their life but they need some help, or they might never be suitable for counselling and therefore they can still get skills, tools, stabilisation and coping strategies. The support work can also help them understand a little bit about how they may have reacted when something happened to them, so understanding trauma responses in the body and things like that.*

One service we spoke to offered up to ten stabilisation sessions before engaging in therapy, to help survivors of particular traumas navigate the complexities of extreme emotional discord and the crippling effects of flashbacks. This is something that the NHS cannot and does not offer – but it comes at a cost.

Third sector services are also in a position to recognise that certain mental health problems are intricately tied to often complex and overlapping factors. One charity we spoke to, for example, works with refugees who have experienced modern slavery and human trafficking before arriving in the UK. In many cases, their clients have experienced torture, witnessed the deaths of family members, and traversed countries. Subject expertise and the ability to build trust are crucial if therapists are to effectively address the kaleidoscope of mental health problems these experiences can provoke. So too, however, is the capacity of services to address the range of language and institutional barriers that face refugees, particularly in terms of employment, education, and social services.

> *We discovered that we could not do counselling in isolation from offering services to help people become less isolated, to gain confidence in the community and to navigate things like poverty, debt, exploitation.*

Another service we spoke to, some of whose work involves the provision of women-only spaces, offers an extra-therapeutic service designed to provide support, preparation, and companionship for women who attend, based on the insight that counselling can often only address a small aspect of the wider array of problems contributing to poor mental health. The additional activities they provide are not counselling, but contribute to wellbeing.

> *For the women's hub, you don't have to be a client. We've got an allotment, a neurodiverse group, they do things like jewellery making, cookery classes... It helps clients to develop a psychological language and they kind of scaffold their healing. Many of*

our clients have psycho-economic issues. So you'd have people come and talk about things that you, as the therapist, cannot actively influence. We try to look at all aspects of whatever the client feels they need to progress.

Other services we spoke to offered a range of social activities and drop-ins, or organised trips and days out for their clients, all of them aimed at supporting people's mental health without being "mental health services". There is an obvious preventative side to this approach, as it tries to tackle many of the social and economic factors that contribute to the deterioration of people's mental health. The Centre for Mental Health has drawn attention to the role of the voluntary sector in "addressing the social determinants of mental health, and working across traditional clinical and disciplinary boundaries".[21]

In many cases, the ability of third sector organisations to deliver this extra-therapeutic support may be a function of their local focus. One interviewee with experience of commissioning third sector services for the NHS argued that this "grassroots understanding of local need" will increase the effectiveness of the therapy and step-down services offered by the third sector. Indeed, Integrated Care Systems (ICSs), when they were created, were expected to work with the voluntary, community and social enterprise sector to develop and deliver "plans to tackle the wider determinants of health".[22]

[21] Wilton, J and Allwood, L., A lifeline for London: How mental health services in the voluntary sector worked during the pandemic (Centre for Mental Health, 2021), p. 7

[22] Building strong integrated care systems everywhere: ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector (NHS England, 2021)

Chapter two:

Challenges facing third sector counselling services

The third sector is a vital part of the overall system of mental health provision, but it is under constant and growing pressure. Managers of third sector counselling services told us of the constant struggle of finding sufficient funding, from a range of sources, to keep their services running, the short-term nature of that funding, and the conditionality that means that they have to make compromises between the services they want to provide to their clients – and which they believe are valuable and needed – and the services their funders want to commission. And they told us of high and rising demand, demonstrating that their services were needed but adding to the pressure on them, and creating dilemmas about how to manage waiting lists including, in some cases, by temporarily shutting them down entirely.

Challenge one: Funding

The sheer range of sources from which third sector counselling providers fund their services can be daunting, and helps to illustrate just how much of some managers' time is spent finding the money to keep going.

There is no single funding model for the sector. One of the services we spoke to, a large provider, is funded entirely by providing NHS Talking Therapies commissioned by the NHS – in theory a sustainable source of significant funding, but something which nevertheless requires significant engagement with commissioners and the negotiation of changes within NHS organisations and changes to funding mechanisms. Other third sector services in our research have significant contracts with local government, with Police and Crime Commissioners and with other local or national public sector organisations. Still others avoid public funding altogether. And many rely on a broad, complicated, cumbersome and often uncertain and constantly changing mix of awards from grant-making bodies and public donations in order to keep their service functioning.

The services we focused on for this report reflect this diversity in funding sources. In the last year, of the ten who responded to our survey, two were funded almost entirely by local and regional public contracts, and the others received no funding at all from these. Three received funds from Police and Crime Commissioners. Eight received at least some level of funding from grant-making trusts and foundations. Six received public donations. Half received some money through client contributions and

payments. One of the service managers we interviewed was, at the time, in the process of organising a public fundraising event.

Funding sources

Grants and contributions from charitable trusts and grant-making bodies

Donations (for example, public fundraising or "pay what you can" models for clients)

Public contracts for providing specific services (including the NHS, local authorities, central government departments, Police and Crime Commissioners), either directly or as subcontractors for other charities

Fees from clients for sessions, or for delivering sessions to other organisations, such as Employee Assistance Programmes or offering external training on a paid basis

Miscellaneous sources (for example, letting rooms where the organisation owns its building, or collecting fees from training courses)

It is worth noting that third sector counselling services take a range of approaches to the question of whether to charge fees to clients. We spoke to very few services who routinely demanded a set fee, and more who asked for a non-specific voluntary contribution. Some felt that their services, as far as possible, should be free at the point of delivery (those who are providing commissioned services to the NHS obviously cannot charge fees for those services, but it is not unusual for services outside NHS structures to be free to clients too). Others made it clear that their service would simply be unable to stay afloat were it not for the donations they encourage their clients to make. Several expressed the view that clients paying something, even a token amount, was important not just for the financial viability of the service but as a signal of commitment from the client and an affirmation of the value of counselling, arguing that a required payment – the level of which is sometimes left to the client – leads to fewer no-shows, and increases the degree of engagement with therapeutic services.

> *We don't want to offer free counselling. We want it to be something where somebody makes a commitment to pay so*

that the relationship is a customer relationship where they feel they've got agency and control, and they're not just getting handouts.

Indeed, this was often true in cases where sessions were already funded.

> *If we get a bursary we would still ask people to contribute. We find that you get much fewer 'did not attend' situations with self-funded clients.*

To the extent that paying – even paying some way below cost – does have some positive effects on engagement and on the attitude of clients, this may represent a benefit to both some services and some clients of staying outside the NHS system, even if that is not true for everyone. Some of the organisations we spoke to have principled reasons for asking for donations or charging fees, sometimes on a sliding scale depending on income, while others have equally principled reasons for making their services free to clients at the point of delivery.

The third sector in general experiences significant funding pressures, and third sector counselling services are not unique in finding it difficult to access sufficient sustainable funding. Good quality comparable data on third sector funding are hard to come by.

This picture has, over the last few years, been in considerable flux. In response to the pandemic, many funders adopted considerably "looser" funding behaviours, demonstrating an increased willingness to respond creatively to the financial pressures facing third sector counselling organisations under pandemic conditions.[23]

As pandemic-era measures receded, however, services have faced a severely unstable economic climate that has seen costs rise precipitously while simultaneously stimulating a large increase in demand. Indeed, it goes without saying that far from increasing capacity, these pressures have threatened the very existence of many third sector services, resulting, as BACP has said, "in loss of specialisms and localism and reducing client choice".[24]

In our interviews with managers and practitioners, a number of themes around funding pressures came through repeatedly.

Funding is too prescriptive and too limited

Many services reported that funding contracts rarely contribute to the core costs associated with running a service or a particular project. This means it is much harder to find money for the day-to-day running of a service (including, for example,

[23] Wilton, J and Allwood, L., A lifeline for London: How mental health services in the voluntary sector worked during the pandemic (Centre for Mental Health, 2021), p. 18
[24] BACP, BACP's response to Labour's Review of Mental Health led by Luciana Berger (2024), p. 5

administrative or cleaning costs), or to find funding for trainees and student counsellors. This has been particularly troubling over the last few years, during which the backdrop of high inflation and cost of living pressures have limited the private donations on which many services relied while also increasing the cost of providing those services. Unsurprisingly, many have been extremely doubtful about their ability to meet basic utility costs.[25] Similarly, we heard that money is often more easily found for new projects than to continue to run services that are already in place and are valued by their users.

> *There's this trend of commissioners wanting to commission something new and shiny over things that they've already got and are existing.*

> *They all seem to want something a bit glitzy... they often want something that's innovative, something that you're not already doing. It's not the core funding you need, so project costs can sometimes be really difficult to fundraise for.*

One particular problem this causes is that prescriptive funding can create additional demand beyond the funded period which did not exist before the specific funded project was created. For example, one service specialising in working with victims of sexual assault recounted several situations in which statutory funding was strictly provided for ten therapy sessions. In many cases, these sessions demonstrated the need for more sessions – so that ten funded sessions leads to an additional 20 unfunded sessions at relatively short notice.

> *The contract brings people that ultimately means we have to go and find the money to pay for the other 20 sessions that we knew they were going to need when they first came to us.*

At the same time, these contracts tend to be limited, rarely building in contingencies to deal with rising cost pressures and help services stay afloat. As such, services may struggle to fulfil contractual obligations without finding new funding in the event of, say, inflationary pressures or increases in the National Living Wage. Indeed, this is particularly concerning in the case of longer contracts, rare as they are.

> *With much longer contracts, one of the problems is that when we have to tender for them, there is not an opportunity to build in any inflationary costs. So the costs that you put in for year one are the same in year five, and we know how much things increase in terms*

[25] BACP, Understanding the cost of living crisis: Valuing our mental health (2024), p. 11

of costs, in terms of staffing costs. That's a real problem when we have to run the building, people need a desk, they need a laptop.

This is a problem not just for third sector counselling services, but across the charity sector where it is delivering public services. Sarah Elliott, chief executive of the National Council for Voluntary Organisations, recently said that "We are seeing more closures, and it does tend to be at the smaller end [of the sector]... Charities delivering public sector contracts are [particularly] struggling because their contracts are not keeping up with inflation".[26] Many of the services we spoke to suggested that statutory funders perceived the third sector as a means of getting things done at the lowest possible cost.

> *Statutory services will have a very limited budget, and an expectation that far exceeds what they can pay for. So what they'll do is go to the voluntary sector to get it, and I would argue that the majority of time it's to the lowest bidder.*

At the same time, third sector services did recognise that they needed to be accountable and able to justify their contracts to funders.

> *I don't believe that the voluntary sector has a God-given right to be funded or to exist just because it's the voluntary sector. I think as the sector we have to demonstrate the value of what we do and we have to demonstrate the stuff that we can do that nobody else can do... that's our responsibility, it's not the NHS's responsibility to come to us and give us free rein.*

Since the interviews for this report were conducted, the October 2024 Budget increased employer National Insurance Contributions. The NHS and local authorities have been protected from the impact of this rise but voluntary sector providers of public services have not. This will increase staffing costs, and therefore the cost of delivering contracts, for many third sector counselling services – adding to the pressures discussed in this chapter.

Contracts are too short

Short-term contracts force services to work to short time horizons, making it hard to invest in improvements to service provision and efficiency, increase the frequency with which services have to rely on more expensive agency staff, and sink a lot of staff time into contingency preparations in the face of fiscal cliff edges.

[26] Robert Booth, Lisa Nandy announces plan to restore charities to 'centre of national life' (Guardian, 18 October 2024)

> *We need an increase in multi-year funding, because a large part of the work taken up by my CEO and the fundraising and communications manager is this constant hunt for funding. I think they need to do away with one- and two-year funding, I think it should be three years and above, because you can plan with that.*

The crippling inability to plan service delivery due to the demands of short-term funding was frequently cited by our interviewees, who regularly drew attention to the difficulties it causes for workforce planning and the administrative burden incumbent upon having to regularly find new money. This was particularly the case for smaller organisations. Workforce planning, for example, is an essential corollary of short-term contracts which inevitably causes disruption – even when new funding is in fact secured and staff can be kept on. With services often required to give notice before funding expires, many counsellors will seek, and find, work elsewhere before new funding is secured.[27] In this way, short term funding can lock in a destabilising degree of attrition.

> *The pressures are the short term funding cycles that charities are facing. They're basically having to re-tender every year, so they're not able to plan, they're not able to do any workforce planning. The staff are receiving redundancy notices year in year out because they've got to wait until the funding comes.*

One interviewee with longer experience in the sector told us that this is a problem that has grown in the last ten years in particular, with long-term funding increasingly replaced by cumbersome short-term processes.

> *It used to be, many many years ago, that you'd be funded, say, for three or five or ten years. But in the last ten years or so it's been an annual renewal because they've not really known what they're doing. So we've only known what we're doing year-to-year.*

There is evidence that those who commission services are aware that this short-termism can be a problem too. In a 2023 report, the National Audit Office noted that 68% of ICBs surveyed "said that use of short-term contracts for voluntary and community sector providers was a significant barrier to service improvement".[28] That is not to say that short-term contracts do not have a place in the system, for short-term, reactive or pilot projects – but services that are seen by both commissioners and providers as "core" need sustainable long-term funding.

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[27] Wilton, J and Allwood, L., A lifeline for London: How mental health services in the voluntary sector worked during the pandemic (Centre for Mental Health, 2021), p. 18

[28] Comptroller and Auditor General, Progress in improving mental health services in England (National Audit Office, 2023), p. 57

Contract break clauses make funding less predictable

Several services highlighted that even when contracts are in place, there is a risk that they can be broken. Local authority budgets in particular are in a financially precarious position, having seen significant cuts over the last decade and a half along with increases in demand for some key services.

> *Another pressure of course is local authorities, they've got no money, we've seen a couple go bankrupt, and that has had a massive effect on third sector commissioned services.*

With local authorities increasingly focused on delivering services for which they are statutorily responsible, such as adult social care, contracts with providers of a wide range of other services, including third sector counselling organisations, have been increasingly deprioritised, with contract breaks derailing the funds on which some services rely.

> *We've also noticed that funders have increased the number of breaks, and one of our local authorities has ended their funding. Three months after the contract started, we'd been informed that one of the partners was withdrawing from that contract and ending their funding, because a lot of the local authorities are at risk of bankruptcy and they are going back to look at funding their statutory requirements, which is really concerning.*

This means that much statutory funding is seen by third sector counselling services as increasingly unstable, leading them to sink a lot of time into contingency planning.

> *At any point funding could be pulled and that in itself is quite interesting because it can be quite political, especially if it's statutory funding, and it can be on a whim... We have for several years lived on a knife edge.*

Finding funding can be resource-intensive

The process of securing and retaining funding for third sector counselling projects can be a resource-intensive one. Applying for funding is a very time-consuming process, particularly when there can be multiple funders for a single project, even more funders for the overall service within which that project sits, and an even larger number of potential funders – and after all, just as much work has to go into an unsuccessful bid

as a successful one. Once funding has been secured, that often carries with it ongoing requirements not just to do the work but to account for it – which is perfectly reasonable but nevertheless time-consuming. As one interviewee put it, "Quite simply, more funders means more reports to write". That can have a knock-on effect on service provision, and also on a service's ability to secure other funding.

> *I think there is quite a lot of funding we could have gone after, but we haven't had the managerial time or resources to spend a lot of time writing big funding bids for very specific client cohorts.*

Different funders can require different data to be gathered by their funded services as part of the financial accountability process. Sometimes, this data is different from the kinds of data third sector organisations would prefer to collect (for example, regarding the progress of their clients), causing administrative burdens on services, or even affecting client sessions themselves. One service we spoke to reported that providing NHS Talking Therapy services in particular entails a number of assessments per session (covering the clients' functioning, well-being, psychological thinking, and risk) on top of the more bespoke monitoring in which the service engages.

> There are internal systems that need to adapt to be able to gather information around specific indicators. So I think sometimes the demands are quite high on getting that information.

This can be starkly contrasted to the approach taken by many funders during the pandemic. As the Centre for Mental Health has reported, "many funders [took] a more flexible, pragmatic and supportive approach, providing extra funds, loosening targets and extending contracts"[29] to allow services to focus solely on service delivery.

Data collection can be particularly cumbersome for services when the source of funding is in flux, meaning that monitoring systems frequently have to change, or when services rely on several different funders at once. Previous research has found inconsistencies in the way data is collected in third sector counselling services, which is partly a result of resource and staff challenges, and partly because they are independent organisations with no standardised national management.[30]

> *The difficulty with having lots of smaller funders is that they all have very different ways of wanting to measure and monitor things. And actually what we would like in the sexual violence*

[29] Wilton, J and Allwood, L., A lifeline for London: How mental health services in the voluntary sector worked during the pandemic (Centre for Mental Health, 2021), p. 18

[30] O'Donnell, J et al., Counselling in the third sector: to what extent are older adults accessing these services and how complete are the data third sector services collect measuring client psychological distress? (Counselling and Psychotherapy Research, 2021), p. 389

sector is to be able to say 'This is the way we measure and monitor our outcomes for this particular client group' and not have to keep changing.

But the services we spoke to did make clear that they recognise the need to demonstrate how well funders' money has been spent, and that collecting data, even data that are not what the services themselves would prioritise, is an important part of this. The issue is not that many funders demand onerous monitoring as a matter of course, so much as the lack of consistency and the administrative burden of dealing with several funders at once, or changing funders – and reporting requirements – frequently.

Commissioner relationships are vital

Some interviewees noted that the question of whether or not a third sector counselling project receives grant funding from the NHS is highly dependent on how creative and supportive a commissioner is willing to be. Commissioners have some leeway in determining the process by which contracted services are selected, and they have to be confident that the money they spend will be used well, and so far as their willingness to commission from third sector counselling services is concerned this often means that they need to understand and appreciate the value of a more diverse offer and choice of therapy. This builds more variability and uncertainty to an already unstable funding situation.

> *"I do think the presumption to procurement and competitive tender is unhelpful, but obviously the provider selection regime potentially mitigates against that if you've got a commissioner who's minded to use it, and if the commissioner doesn't want to go to competitive tender, they have got mechanisms around it. So maybe it's just a case of getting your commissioner on side."*

One interviewee told us that it makes a big difference when commissioners appreciate the value of specialised counselling services, and when the commissioning process does not put up barriers to smaller organisations that work with hard-to-reach groups. Another, with significant experience in both third sector counselling services and the NHS argued that the former's "person-centred" approach can often grate against the NHS's more "diagnostic" commissioning model.

> *"A person-centred approach works brilliantly for people, but this also limits the ability of many counselling services to get funding, because the only way they will get funding is if that particular commissioner can understand what the person-centred model really is."*

The frequent need for clinical leads to approve a commissioner's funding decisions above a certain value has the potential to add another layer of misunderstanding.

In recent years, another layer of difficulty has been added thanks to the restructuring of the NHS into Integrated Care Systems (ICSs). Neither the Integrated Care Boards (ICBs) which manage ICSs, nor the Integrated Care Partnerships (ICPs), which are responsible for developing a health and care strategy for their area, are required to include local third sector representatives, although they may do so. As a recent Public First/Institute for Government report observed, "it is concerning that ICS accountability is so muddled".[31] The restructure has, at least from the point of view of some of the third sector counselling providers we spoke to, blurred and confused lines of communication, making consistent conversations with NHS representatives hard even for larger third sector providers.

> *The whole point of that ICS restructuring, as it was explained to us, was so that the NHS could work collaboratively with the voluntary sector as equal partners… I have seen no evidence of them treating the third sector as equal partners. I think they talk down to us when we actually have more skills and expertise. They said it would also release funds, and it hasn't done.*

> *It's proving very, very tricky at the moment to even have sensible conversations with NHS colleagues. I don't know if this is a national thing, but our Integrated Care Board is going through a pretty chunky restructure, so personnel have changed, remits and portfolios have changed, so actually trying to work out who's got responsibility for a particular project or service line or geographical area is really, really tricky.*

It is important to emphasise that this is not only considered a problem for the third sector. The National Audit Office has reported that "complex or uncoordinated contracting arrangements" were found to be a "significant barrier to service improvement" for many NHS trusts too.[32]

Challenge two: High and growing demand

The adequacy of funding is a function of the level of demand: the higher the demand, the more funding is required to meet it. Over the last few years, the third sector counselling services we spoke to told us that demand has risen, leaving many of them

[31] Freedman S, Wolf R, The NHS productivity puzzle: Why has hospital activity not increased in line with funding and staffing? (Institute for Government/Public First, 2023), p. 58
[32] Progress in improving mental health services in England (National Audit Office, 2023), p. 57

oversubscribed and with long waiting lists. Eight of the ten services we surveyed reported that the number of client referrals they received last year was greater than five years before. The other two reported that the level of referrals was about the same; none had seen a decline in referrals. This is reflected in wider research. In a survey of London-based services delivering frontline or ancillary mental health support conducted by the Centre for Mental Health in 2021, for example, 90% of respondents "agreed or strongly agreed that their organisation had seen an increase in the number of people seeking help for their mental health over the course of the pandemic".[33] Public First's previous work with BACP on the case for counselling in schools and colleges found a significant increase in probable mental health conditions among 8-16 year olds in 2023 compared to 2017.[34]

The services we spoke to in the course of this research identified a broad range of factors behind increases in demand, some of which are system-wide and some of which reflect issues that affect their particular communities and client groups.

Increased awareness of and comfort with discussing mental health

Many of our interviewees argued that shifts in societal attitudes towards mental health, while positive in themselves, had contributed to increased demand on mental health services in general and their own services in particular, with people feeling more comfortable about the idea of seeking support and counselling than they might have done in previous decades.

> *I think there is perhaps a generational shift in terms of health seeking behaviours. We see this with particularly our clients in their 70s and 80s who will say 'you wouldn't have talked about this when I was a child, there was nowhere to go'.*

As well as a greater willingness to seek mental health support, interviewees noted greater awareness of some of the reasons people might recognise a need for such support, such as media coverage of historic sexual abuse helping people to realise that they have experienced this themselves and that they need support to process it, and making them more confident in coming forward to contact services who offer that support.

> *The independent inquiry into child sexual abuse drove an increase in referrals, which then has just remained fairly*

[33] Wilton, J and Allwood, L., A lifeline for London: How mental health services in the voluntary sector worked during the pandemic (Centre for Mental Health, 2021), p. 18
[34] Public First, The case for counselling in schools and colleges: A socioeconomic impact assessment (2024), p. 8

static. Going back a long way, all of the Jimmy Savile stuff also created a significant increase in referrals, which then didn't dip and pretty much plateaued. So I think there's something there about society: in the last 10 to 15 years the issue around childhood sexual abuse has become more prominent, more known.

Government action on these issues is part of the increased awareness, for example on sexual violence and trauma, with several strategies and inquiries drawing attention to both the pervasiveness of the issue and the need to dramatically improve how government and public services respond to it. One counselling service manager specialising in violence against women and girls applauded these strategies, but noted that they have dramatically increased demand for their services without doing anything to increase their funding or capacity.

While increased awareness of the need for mental health support and willingness to seek it is welcome, it increases both the number of people asking for counselling and other services and, within that, the number of complex cases those services are being asked to deal with.

The increased complexity of cases was cited by almost everyone we spoke to as a major cause of increased demand. Put simply, this makes individual cases more difficult, which effectively adds to overall demand on the service even if the absolute number of clients stays the same – and in fact, the absolute number of clients is, for most services, rising.

One interviewee told us that the assessment process alone was becoming more complex due to the change in help-seeking attitudes. More people are aware of and willing to consider counselling, but that means that more people come to counselling with a less clear idea of what it is and of what they want from it. Another interviewee told us about the complexity of working with people who present with more deep-seated, long-standing traumas which they have only recently felt able to come forward and seek help.

> *If an individual has a very resilient and robust life and an event happens that traumatises them, there are a lot of protective factors that give them a level of resilience. That means that the therapeutic intervention might be quite short term, or it's worked through and the individual bounces back. But when you have somebody who has had various things happen to them throughout their life and the same traumatic event, their response to it is necessarily different. So what I think we're noticing is that individuals' protective factors or resilience isn't necessarily what it was.*

Cost of living pressures and the pandemic

Both the cost of living crisis and the pandemic were repeatedly cited by our interviewees as causing increased demand for third sector counselling services, in both cases because they have put pressure on people's mental health.

> *The psychological profile of people hasn't changed. It's the same traumas. But what's changed is that people are increasingly in poverty, in debt, homeless or very insecurely housed. The things that have made people have more difficulty, or to do with cuts to frontline public services generally.*

We were told that cost of living pressures also had the effect of deterring people from seeking help as early as they might have done, leading to more complex problems later on.

> *Things like the cost of living crisis have created problems for people where they're dealing with their immediate issues and their mental health is in the background. So when they're actually coming forward for help, they've got some more serious, complex needs.*

> *Some people don't have good coping strategies or defence systems in place. Things have got a lot harder for most people with all the things that we're all experiencing. So therefore it puts a much tighter squeeze on them, so if your coping strategies are not particularly positive ones, it generally just impacts other areas, your relationship with work, your social life, your health, your fitness... they all start spiralling in a direction that gets really hard.*

So far as the pandemic is concerned, lockdown made accessing health support in general more difficult, while isolating people and creating additional pressure on their mental health, which led to increases in those seeking help once the pandemic was over. The pandemic was associated with a rise in reported moderate to severe depression,[35] and BACP has noted that in particular there were "higher rates of anxiety and mental distress among racialised communities as a consequence of the pandemic".[36] Long periods of isolation played a big role in harming young people's social development, while adding another layer of complexity to adult presentations.

[35] Office for National Statistics, Cost of living and depression in adults, Great Britain: 29 September to 23 October 2022 (December 2022), Figure 1

[36] BACP, Race for the soul of the profession – tackling racial inequalities in the counselling professions (2022), p. 4

> *On the back of Covid, we had huge anxiety and more existential presentations.*

Referrals from the NHS

As more people seek help with mental health challenges in general, more cases are passed on from the NHS to third sector counselling services – and this includes many of the most complex cases. Many of the services we spoke to said they had seen an increase in referrals from the NHS.

> *A lot of NHS funding says it won't fund what the NHS delivers, but the NHS often refers clients into third sector services it doesn't fund.*

However, care must be taken when we talk about "referrals" in this context. In general, when we talk about "referrals" in the health system we mean a patient being directed from one part of the system to another – for example, from a GP appointment about a particular complaint to a hospital where tests or a procedure can be carried out – with, crucially, funding following the patient. This is the case with some referrals to some of the services we spoke to, although it is worth pointing out that where these arrangements were in place, the funding often did not cover the entire cost.

This is not always what "referral" means, in the case of referral to a third sector counselling service. In many cases, it amounts to a GP, for example, informally recommending a service they are aware of and think might be helpful to a patient. In this way, a "referral" may be nothing more than signposting, without any funding attached. This is a problem so far as demand – and the ability to meet that demand – is concerned.

> *'Referral' is the giving of a leaflet and saying 'You should call these people.' Sometimes there's a lack of buy-in whereby 'This is the next thing the doctors told me to do', rather than clients really wanting counselling. But also there's a real mismatch of what is achievable. GPs are throwing massively complex clients to what is a group of volunteers.*

These volunteers, on whom many third sector services rely (different third sector services will have different balances of paid and voluntary staff), are skilled, qualified and registered – but they are still working on a voluntary basis, doing work that the NHS is not able to do and does not fund.

This creates the perverse situation that relatively straightforward cases get referred by GPs to NHS Talking Therapies, with money following them through the system, while more complex cases which the NHS is unable to cope with get passed to specialist services outside the NHS, and either coming off or never even going onto NHS waiting lists, with no money following them at all – and with the word "referral" being used, misleadingly and confusingly, in both cases.

Third sector counselling services, especially those that specialise in complex trauma or work with client groups with specific needs, will as a matter of course pick up cases that are too complex for NHS Talking Therapies, as we were told by a service working with people who have experienced sexual abuse.

> *If [NHS Talking Therapies] see they're allowed six sessions but a client's problems are to do with child sexual abuse, they're going to say I can't do anything with you because you're too complex and that's not what this six week space is for. But equally, they then can't have them waiting, and it's a way of closing some of their lists, so they will just say no at the earliest opportunity. That's somebody got rid of straight away from their waiting list.*

This interviewee told us that the NHS accounted for 25% of nearly 1,000 annual referrals, compared to 11% of roughly 650 referrals two years ago. Another told us that a retreat by the NHS from community care had a knock-on effect on demand for their services.

> *We just can't keep up with demand, but I do know that the NHS has sort of stopped working with people in the community in the same way. When I say complex, I'm talking about dissociative disorders, particularly where people just don't function very well. In the past there would have been a mental health nurse or support workers to help them go to appointments and things like that. Those people have been discharged and there isn't that support in the community any more.*

Another interviewee highlighted the issue of inappropriate referrals, where clients do need NHS care but are referred to the third sector instead.

Services also receive clients who have self-referred. Many interviewees told us that long-term referral trends are hard to establish, given the mixed provenance of self-referrals in particular. Self-referral can be the result of a client's own research, word of mouth, publicity, or being signposted informally by a statutory service that a third sector service may then record as a self-referral. As such, two similar cases with the

same "underlying pathway", as one interviewee put it, may appear as different referral processes. Sometimes, encouraging self-referral through informal signposting can be a positive process of empowerment for certain clients.

> *It's difficult to track exactly how many of our self-referrals have actually come via an agency. We have a domestic abuse helpline locally and we introduced quite a simple card with the details on. We noticed a huge reduction in referrals from children's services but then an increase in self-referrals. We think this was because the social workers thought that if the client is able to make a referral themselves, why shouldn't they be empowered to do that?*

Another person we spoke to observed that self-referrals of any kind increase the likelihood of clients engaging with the counselling. But nevertheless, they make it harder for third sector services – or anyone else, including the NHS – to fully understand the scale of the demand they are taking off statutory services, particularly when it comes to the most complex cases. As one interviewee put it, "It sometimes feels like they're knocking on the responsibility of it to us".

> *If you were to talk to our clinical team, they would tell you that the presentations have become increasingly complex. What we used to call the everyday bread and butter stuff, the low-level to moderate depression and anxiety, that stuff gets processed by IAPT and then whatever's left over tends to come our way.*

> *[We are receiving complex cases] because the provision in the NHS is significantly reduced. Their threshold for accepting clients is much higher now than it was. Complex clients just don't get the support that they need through the NHS or specialist providers.*

An increasingly complex caseload increases the demand services face, posing particularly acute problems for services which rely on student counsellors.

> *Because the majority of our therapists are students, we can't give them the more complex presentations, so that has a huge impact on our waiting list.*

The problem of unfunded referrals is by no means universal: there are plenty of examples of third sector counselling services which have been commissioned to provide specialist services that are not linked to NHS Talking Therapies. For example,

one of the services we spoke to is funded by Sexual Assault Referral Centres to provide counselling to victims of sexual violence. They told us that they had done a lot of work themselves to ensure that they are part of the pathway for non-NHS services including the police, receiving funded referrals in recognition of their expertise.

Hostile environments

Some services which specialise in working with marginalised groups told us that an increasingly hostile political and social environment was a contributory factor to some of the demand they faced, directly impacting the wellbeing of already vulnerable people. One service working with refugees told us that they saw a direct link between the rhetoric of politicians, amplified through the media, and the trauma experienced by their clients.

> *I think the external environment and the politics within the environment does have an impact on how people respond or how people are dealing with their day-to-day life, but also their wellbeing as well. And the last government's 'stop the boats' thing, which deliberately portrayed people fleeing and seeking asylum as criminals, has really upset the people that we see because they feel misunderstood, unseen, unheard.*

Another service we spoke to, which provides mental health support for the LGBTQ+ community specifically, argued that a "golden thread" runs through the demand they see for their services, encompassing internalised and societal homophobia as well as cultural pressure. They identified a worsening social climate for LGBTQ+ people which they told us has an outsized impact on the mental health of their clients. Indeed, they said that specific statements made by senior politicians had a direct effect.

> *A lot more people feel far more comfortable coming out now, but even though we've made a lot of progress, the social climate for LGBTQ+ people has worsened significantly over the past few years.*

Challenge three: Managing demand

Given these pressures, third sector services have had to manage demand. In some cases, managing demand simply means offering less, as one interviewee told us.

> *We used to deliver much longer therapy. But the demand and the funding dictates that we offer less.*

But interviewees also told us about other measures and strategies they use to deal with increased pressure on their services.

Reducing visibility

Facing the prospect of increased waiting lists for their clients, many services have reduced their visibility to the public. One interviewee, the head of a sexual violence support centre, said they had been forced to stop advertising their service due to demand pressures.

> *We don't advertise because we struggle to keep pace with demand.*

Another told us that advertising would increase the amount of time clients would be waiting on their list, rather than being incentivised to seek help elsewhere.

> *We don't tend to do too much advertising for the counselling service because of capacity issues. If we opened up to try to attract a lot more people, they would just be on the waiting list for an inappropriate amount of time really.*

Closing waiting lists

Some services told us that high demand had forced them on occasion to close their waiting lists entirely. In some cases, this has simply been a technique to reduce waiting times for future clients. In others, however, closing the waiting list for future clients is a vital way of taking pressure off the service. This is because certain services have safeguarding responsibilities for clients on their waiting lists.

For example, one service had to close their waiting list even after establishing a group dedicated to managing risk on their waiting list.

> *This is where the issue of safeguarding and the clinical governance group came in to manage women on the waiting list who were in real need, complex, and high risk, because they were waiting so long. I had to make a case to close the waiting list. You can't always have a waiting list open because once the client refers, even if they're just waiting, they are still your client.*

Even where safeguarding responsibilities are not a concern, keeping waiting lists open can still sap resources from third sector organisations because of what an assessment

entails. One interviewee detailed this cumbersome process, consisting of an initial screening assessing whether a client fits their funder criteria and can be helped by the service. This is followed by a second screening to ascertain the risk factors and complexities with which the client is presenting (for example, suicidal ideation, drug abuse, or the use of medication). Even then, complex clients often require rejections to be handled very carefully, adding another layer of complication.

Where communication between agencies is poor, there can be cases in which people have been referred without themselves knowing why, causing a significant knock-on impact for the service.

> *If I put it in terms of hours, it's two days for one client.*

Supporting staff

High demand puts pressure on therapists, support staff and managers, and so services need to have effective methods in place for managing those pressures and supporting their people. Many services, for example, highlighted the need to address problems related to vicarious trauma and burnout.

> *We are really alive to the idea of vicarious trauma. So everybody has to have clinical supervision as well as their one-to-one management, and those clinical supervisors will report back to us about general themes. We have to be aware of things like compassion fatigue and burnout, and we have to just make sure that there's enough places for them to get help and support. So we have a benefit scheme, and recognise that counsellors might need a break from the complexities by giving them easier clients.*

This is an important set of responses to keep staff healthy and effective during periods of heightened demand, but it places a drain on already thin resources.

Other staffing problems flow directly from the mismatch between funding and demand. Many services told us that their staff would be able to work more hours, and meet demand better, if more funding were available, and that this lack of funding incentivises counsellors to seek work elsewhere even if they would rather stay where they are. The cost of living also compounds this problem, making it less likely that counsellors are willing to offer voluntary work.

> *Our organisation is reliant on people like myself who can give up time, which in this present climate is getting harder*

and harder for people to do, and you have to come from a certain socioeconomic background because most people can't actually afford to give up three hours of their time a week.

New ways of working

Many third sector organisations have found ways to change the way they run their services to make their funding go further. The enforced shift to remote working during the pandemic has led to changes in practice compared to the pre-pandemic environment, with remote counselling sessions remaining part of the offer many services make to clients.

The greater use of remote working has, in some instances, allowed services to make better use of their staff. Many told us that some of the mismatch between supply and demand was due to the difficulties some clients had attending sessions during the day, which can be difficult for clients with jobs, leading to greater pressure on whatever evening appointments were available. Increased remote working might partly solve this problem by cutting out travel time.

> *If you came to me tomorrow and said 'I really want counselling, I've got open availability', we probably could get you seen within a month, so very quickly. If you come and say to me I can only do a Thursday at 7, you could be waiting up to two years.*

> *Working online has meant that we are accessible to people that otherwise we wouldn't have been accessible to. So we might see more of a diverse client group, but certainly clients who wanted to access counselling but couldn't leave their home, for example, can now access counselling.*

This may also allow some services to expand the geographical distribution of their trainees, and work with clients who do not live locally. So changes in working practices can have real advantages.

> *Charities innovate to survive, they don't innovate to thrive. We don't have the space and the luxury to sit back and draw up long, detailed plans of what we might do in 12 months' time. We have to kind of learn and improve and amend our services on the hop.*

Chapter three:

Recommendations

Third sector counselling services are carrying out vital work which makes a real difference to the mental health and wellbeing of clients and supports and supplements statutory services – and it is clear that this work is highly valued by funders, commissioners and, crucially, clients themselves. But increasing demand, funding that cannot keep up with demand, and the challenge for service managers of securing and retaining what funding is available while dealing with an increasingly complex caseload, are putting the sector under significant pressure. We heard about, and have described in this report, some of the strategies third sector counselling services use to deal with this pressure.

There is no easy solution to any of this, especially at a time when additional funding is unlikely to be forthcoming – although additional funding would make a real difference. But in the course of our interviews and research we have identified some changes that would support the sustainability and viability of third sector counselling services and make it easier for them to focus on the work they are trained to do, that they want to do, and that we all need them to do.

Recommendation one:

Longer funding cycles

Short funding cycles make it harder for third sector counselling services to operate effectively, and mean that funders' money and/or taxpayers' money is spent less efficiently. **Service commissioners and grant funders should operate on the basis of three-to-five-year contracts rather than single year contracts**, to support continuity of service, reduce the administrative burden on services in applying for funding, and enable better workforce planning.

Some of the current problems with short-term contracts stem from funders themselves, especially in local government, also being subject to

short-term funding. Given this, **the current UK Government's commitment to move to multi-year funding settlements for councils is welcome, and should apply to NHS Integrated Care Boards and Integrated Care Systems (ICBs and ICSs)**.

This does not mean that short-term contracts are *never* needed – for crises and emergencies, and for pilot projects, for example – but they should not be used for services that are regarded as "core" and which commissioners would, all things being equal, want to be provided on an ongoing basis.

In addition, **multi-year contracts should reflect the likelihood of inflation and rising wage costs, and factor this into their contract value at the start**.

Recommendation two:

Simplified commissioning

Our interviewees complained about overly complex commissioning arrangements, something also found by the National Audit Office in a recent survey of mental health trusts and ICBs.

All funders should **consider the administrative burden on services both when designing processes for applying for funding and when setting reporting requirements**; for example, by working together to create standardised data returns that reflect best practice, or finding ways for multiple funders of the same project to accept standardised applications. The flexible approach taken by many funders during the pandemic should be a model of best practice here.

Recommendation three:

Better engagement between commissioners and the third sector

Many of the services we spoke to told us that there is significant variation in the willingness of commissioners to commission third sector counselling services, particularly specialist services or those which use less standard forms of therapy. This partly stems, according to some of our interviewees, from a lack of understanding on the part of some commissioners of the value of third sector counselling services.

That points to the need for better engagement between the third sector and commissioners so that services have a better understanding of what commissioners need, and commissioners have a better understanding of the special value the third sector brings – as set out in chapter one of this report.

As part of this, in addition to the requirement for every ICB to include at least one member with knowledge and expertise in mental health services, **every ICB and ICP should include at least one member drawn from the local third sector**.

Recommendation four:

Commissioning specialist services

Specialist services which work with particular marginalised and minoritised communities, or which provide services for people with specific needs arising from issues including (but not limited to) sexual abuse, domestic violence or drug or alcohol misuse are vital, and so **commissioners should ensure that specialist services are available to those who need them when considering their overall commissioning requirements**. That means that those responsible for commissioning, and for designing commissioning processes, should appreciate the value of these specialist services and not put up barriers to smaller organisations that work with "hard to reach" groups.

We know that clients from marginalised and minoritised communities place great value on having access to services that are specific to them: where they feel physically and emotionally safe, where they feel better understood, and where they perceive that their needs are met better than they would be in mainstream services.

For example, in 2019 the House of Commons Women and Equalities Committee found that LGBT-specific services are needed but often overlooked in commissioning, and recommended that **this should be explicitly included in commissioning outcome frameworks**.[37] The same should go for other specialist services which work with specific groups and communities, as well as on specialist issues. If commissioners are serving their whole community, some of the counselling services they commission need to be specialist.

[37] House of Commons Women and Equalities Committee, Health and Social Care and LGBT Communities (2019), p. 63

Recommendation five:

Better recording of NHS "referrals"

We were consistently told about the problem of clients being "referred" to third sector counselling services by the NHS with no funding attached, but as we noted much of this is not technically "referral" so much as informal signposting towards something which unquestionably meets an otherwise unmet need and reduces the burden on the NHS.

"[We need] just basic better recognition of the contribution that these services are making and the fact that they are taking pressure away from statutory and NHS services. It's about making sure that referrals are followed by appropriate funding because if you don't fund these services they disappear. That creates even more pressure on the NHS in the long term."

Third sector counselling services should work together to **develop accurate and consistent definition and measurement of these "referrals"**, as the basis for future conversations with NHS bodies about fair funding.

In addition, ICBs should work to **identify and tackle unfunded referrals to third sector counselling services from the NHS and other organisations** which have been commissioned to deliver services by those ICBs.

Appendix:

Participating services

We worked with BACP to identify and interview staff from 11 services which reflected the diversity of the third sector counselling landscape: large and small services; services which deliver NHS Talking Therapies and services which are not commissioned by the NHS at all; services that are open to all and specialist services which aim to serve a specific community or client group; services which charge fees to clients and services that are free at the point of use; and services from different regions of England.

We are very grateful to everyone from the participating services who took the time to speak to us and respond to our survey, and to a number of other interviewees who contributed to this research.

DAWN Charitable Trust

Based in Harrow in North West London, DAWN provides culturally sensitive counselling delivered in 25 languages (including Hindi, Gujarati, Punjabi, Marathi, Urdu, Dari, Farsi, Pashto, Cantonese, Tamil, Bengali, Sylheti, Somali, Romanian and Polish).

DAWN has a particular focus on reaching out to women and girls from all backgrounds who may be socially isolated and hard to reach, and who face multiple barriers in accessing mental health services. The service sets aside time to offer counselling in a women-only space at specific times five days a week, as well as specific times for gender neutral spaces and times that are reserved for family and relational therapy.

It also offers non-counselling services, including women's English classes, dance workshops for young people, a film club, meditation and mindfulness classes and women-only social wellbeing opportunities.

www.dawncharitabletrust.org.uk

Horsham & Crawley Counselling Group

A not-for-profit community interest company (CIC), Horsham & Crawley Counselling Group offers counselling sessions for adults, children and young people in its area of West Sussex. Sessions are delivered by a mix of trained counsellors and experienced trainees.

It offers a relational service, and offers humanistic, psychodynamic, integrative and transactional therapy, among others. The group also offers mental health workshops and talks, as well as delivering employee assistance programmes.

www.hccounselling.org.uk

London Friend

London Friend specialises in supporting the health and wellbeing of the capital's LGBTQ+ community, and recently celebrated its 50th anniversary. It delivers one to one and group counselling.

Its services are delivered by members of the LGBTQ+ community, who help clients with a range of problems including coming out, friends and family concerns, domestic abuse and chemsex.

It is home to the LGBTQ+ run and targeted drug and alcohol support service Antidote, as well as offering social and support groups, and training for professionals. It also provides volunteering opportunities for members of the LGBTQ+ community.

londonfriend.org.uk

The Maya Centre

The Maya Centre is a community-based charity in North London providing free counselling to low income women. In particular, it works to tackle depression and anxiety, and problems stemming from violence against women and girls, inequality, racism, and discrimination.

It can deliver support in 13 languages to help them provide culturally sensitive therapy. For this, it also delivers special services including an Irish Women's Service and Turkish Women's Therapy.

The Maya Centre provides not only counselling, but also group and art therapy, psychoeducational and community workshops and complementary therapies.

www.mayacentre.org.uk

Network Counselling and Training

Network is a generalist counselling and training service based in Bristol, delivering therapy to clients suitable for student counsellors. Founded in 1985 by local churches, Network offers a diverse and inclusive service based on a person-centred model.

Network is also a Counselling Training provider, delivering a range of counselling sessions from short evening courses to professional qualifications and continuing professional development.

network.org.uk

Pattigift

Pattigift is a Birmingham-based community-focused provider of African-centred therapy and accredited courses in African psychological skills, knowledge, and awareness, working on the impact of race on mental health and wellbeing. It is supported by the Association of Black Psychologists.

It does this through the principles of collective responsibility, co-operation, creativity, self-determination, purpose, unity, and faith. As such, Pattigift seeks to promote self-knowledge while delivering holistic, culturally congruent psychological and physical therapies for underserved communities.

www.pattigifttherapy.com

Refugee Resource

Refugee Resource is a therapeutic charity based in Oxford, offering services to asylum seekers, victims of modern slavery and other vulnerable migrants, and refugees. Its services are aimed at relieving emotional distress, enabling people to build new lives and integrate into their communities.

Its core service is a counselling team. It also offers mentoring support, groups for men and women, and a social inclusion service to help people with problems like debt, poverty, access to rights, and help accessing work and study, as well as clinical supervision and training for professionals working with refugees and asylum seekers.

www.refugeeresource.org.uk

Renew Counselling and Training

Renew's services are based in Chelmsford, Basildon, Brentwood and in schools across Essex and East London. Renew is a multi-modal counselling service, offering a range of therapeutic types including, but not limited to, CBT and person-centred, psychodynamic, existential, and humanistic therapy.

Renew is open access, catering to those with any presenting issues and working with children and young people, adults, schools, and couples.

renew.org.uk

Sunderland Counselling Service

Sunderland Counselling Service is based in the north east of England. The service works to relieve suffering and distress through counselling and psychological therapy services, informed by a person-centred philosophy.

It is involved in the provision of several NHS Talking Therapies services for anxiety and depression in the region, delivering both low intensity and high intensity interventions. SCS provides generic and more specialist counselling services, including for bereavement, children and

young people, cancer patients and survivors of sexual violence and abuse.

The service aso works to promote emotional wellbeing and mental health among adults and children and young people, through the delivery of support groups and social prescribing interventions.

sunderlandcounselling.org.uk

Survive

Survive delivers specialist trauma-informed services and interventions to adult survivors of sexual violence and abuse in York and North Yorkshire.

It aims to help its clients discuss their trauma, make sense of traumatic symptoms, recognise the need for emotional self-regulation, and take back control of their lives. It also offers other support work to survivors, including a helpline and book loaning service.

www.survive-northyorks.org.uk

Yellow Door

Yellow Door is a domestic and sexual abuse charity that offers a range of specialist therapeutic support, advocacy, and prevention services.

Yellow Door delivers services across Hampshire and works with all ages and genders. The services include one-to-one and group therapy, art therapy, play therapy, a trauma intervention service, family therapy and EMDR. It also has an Independent Sexual Violence Advisory service, Domestic Abuse Group programmes, a Diversity & Inclusion Service, and education/community outreach projects.

yellowdoor.org.uk