Conference Report

IAPT Across the Lifespan: Drawing on Experience

Friday 22nd March 2013, Leicester

We were lucky to have such an excellent chair in Mark Easton BBC Home Editor. As well as impeccable timing in keeping the day running smoothly and to time, he was entertaining and asked some thoughtful and thought-provoking questions. He kicked off the conference by talking briefly about the success of IAPT and how it has genuinely changed people’s lives – this was to be a day to share experiences and celebrate IAPT’s achievements so far.

The Future of IAPT in the New NHS: Kevin Jarman, National IAPT Operations, Delivery & Finance Lead, Department of Health

Kevin began his presentation by acknowledging the level of change and uncertainty being experienced by those working in IAPT. However he was keen to stress just what a successful and indeed world-first project IAPT has been (and continues to be), using as an illustration the fact that Norway has just set up a programme based on IAPT.

He took us through a brief history of IAPT including the rollout, progress and achievements so far, access and equalities, new areas for IAPT such as LTC/MUS, SMI, older people and PbR. He then went on to talk a bit about IAPT training and how IAPT is evolving to train therapists in new therapies other than CBT.

He finished with what could be described as a call to action – reminding us that IAPT is only two-thirds of the way there and there is still some way to go. IAPT needs to consolidate its work and continue to get finance. Regional teams are no longer going to exist going forward so it’s crucial for IAPT workers to reach out and take responsibility for forming relationships with other services. IAPT must keep working to ensure that the goal of 15% prevalence is achieved.

Innovations and Efficiencies in IAPT Services

Ruth Cocksedge, Clinical Lead, Health in Mind, North East Essex IAPT Service and IAPT Network Clinical Lead, East of England

Ruth talked a bit about how the conference came about – that it was intended as a celebration of IAPT’s achievements in the region and a chance to share experiences and learn from each other. She acknowledged that these are very challenging and changing times for IAPT, with new commissioning bodies to get one’s head around, but that we need to remember our success so far and continue the good work.

Learning from Cambridgeshire CYP IAPT: Dr Ayla Humphrey, Consultant Clinical Psychologist, and Helen Atkins, Family Therapist, Cambridgeshire & Peterborough NHS Foundation Trust

Ayla began by explaining how CYP IAPT differs in configuration to adult IAPT, being as it is a transformation of existing services rather than a new service.

She stressed just how important access and early intervention is in CYP IAPT – reaching children is reaching the adults of the future. She had some interesting data showing that early intervention works – the earlier you intervene, the better the remission rates. It’s so crucial in CYP IAPT services to help children and young people before their problems become too difficult to treat. It also means you save time in detention centres and in adult psychological services down the line. She spoke about the barriers to access for CAMHS and how they can be overcome – what facilitates help seeking?

Ayla then presented some very interesting data from their original CYP IAPT pilot which ran from 2010 – 2012, including the aims, the therapies used and the outcome data in terms of symptom improvement, functioning impact and education/employment attendance.
With two years of IAPT pilot outcomes data, Ayla had some very interesting insights to share. She spoke about the challenges of ROM in CYP IAPT, and how she had had to rethink what, why and how she measured. She spoke about the importance of integrating outcome measurement into the therapy session – in fact she said that doing so has changed the way she personally delivers therapy. She noted that young people are generally quite positive about the measures – it helps them to track their own progress through the service, and can also provide a “way in” for clients who are reluctant to talk. She has also found that outcome measurement has led to sessions becoming more collaborative and improved young people’s engagement (another key aim of CYO IAPT).

Ayla and Helen went on to present some preliminary outcome data from the 2012 project (the first wave of CYP IAPT funding), and finished by reminding us that only 10% of the health budget goes to mental health, and just 3% of that to children. Investing in children’s mental health services is investing in the future.

**Reflections on Integrating Telephone Working into IAPT Services: Sam Lane, Senior PWP, IAPT Rethink Mental Illness**

Sam gave a very interesting account of his service’s experiences with telephone working. He began by explaining the drivers for increasing telephone assessments, namely that between April and August 2010, capacity became a problem in their service. Referrals were increasing, waiting lists were growing and they simply couldn’t cope with the number of assessments required. At the time, their ration of assessments was one-third telephone and two-thirds face-to-face, but they had to start thinking differently.

The benefits of telephone assessments seemed clear: More assessments conducted, quicker / more efficient use of time, notes could be typed as you go, more accessible to patients, “DNA time” could be utilised more effectively and considerably less travel time / costs and room costs. So after discussions with staff, standardised electronic assessment forms were developed and all assessments began to be offered by telephone as standard. They also implemented a service shut-down week where they did nothing but assessments for a week, which was an effective way of clearing the backlog of assessments.

The results in terms of capacity were impressive. By August 2010, assessments were up to 72% of referrals from just 32% in the May – with no significant negative impact in terms of DNA rates, attendance at second session or PEQ outcomes.

Sam finished by saying that of course telephone assessments are not a cure-all and they cannot continue to make these efficiencies indefinitely, as increased efficiency has led to increased referrals, but it’s certainly something many of the delegates in the audience seemed to be very interested in for their own services.

**Challenges of Extending IAPT into a Broader Wellbeing Service: Nesta Reeve, Consultant Clinical Psychologist/Clinical Lead, Norfolk and Suffolk Wellbeing Service**

Nesta started by comparing the challenging journey she’d had to get to the conference (a flat tyre, the AA, traffic and snow all featured!) to the challenging journey IAPT has gone on. She went on to talk consider what IAPT is, what wellbeing is, and how/whether you can do both.

Nesta went on to stress that she didn’t want to be misunderstood as being critical of IAPT, as she thinks it has been a great success in treating mild-moderate depression, and is a great service for the right people. However there are some challenges, including questions around whether the medical model, symptom focus and outcome-based approach is too rigid, and whether the 15% access target was discouraging access for all. She feels that there are people who might benefit from other more wellbeing-focused services.

She went on to describe wellbeing as something which was an aim for the whole population, not just those with a diagnosed mental health problem. It goes beyond measures such as moving from caseness to non-caseness, or improvement in symptoms – although it’s still important to demonstrate that services are improving wellbeing, which brings challenges of its own.

At Nesta’s service they have been working on developing integrated service models, which has brought with it its own challenges – what’s IAPT and what’s not? How can we make our systems more flexible in order to report both IAPT, and also what we want to report from our wellbeing approaches? This more integrated approach is reflected in
commissioning – commissioners are beginning to move beyond IAPT to include a wellbeing approach. Nesta concluded by sharing some more of her fears about the impact of targets in IAPT – in particular whether the 50% recovery target is encouraging services to bar certain people from entering the service.

Innovations and Efficiencies in IAPT Services: Question Session

Mark Easton kicked off by asking whether the 50% target means that IAPT services are in danger of only accepting people who are likely to recover. Kevin Jarman responded first to this, talking about how PbR hopes to tackle this exact issue. He stated that IAPT does not just want to take people who are just below caseness, but that PbR is in fact looking at statistically reliable improvement, rather than relying on disorder specific measures.

There was then a further question about whether IAPT is in danger of taking an overly medical model to psychological problems, and of treating symptoms, not people. Why can’t treatment also include a wellbeing approach? This evolved into a discussion about the tension, perceived or otherwise, between a wellness/whole person approach versus a data/outcomes/measurement approach. The question is, how can we tie these things together to help people? One of the suggestions was the idea of trying to develop a goal-based outcome measure, and another idea mentioned was a greater use of the Work and Social Adjustment scale.

Participants mentioned that IAPT was brought in to try and stop a medicate-only approach and it’s been very successful in this. Nobody denied that IAPT may need to change and adapt as it matures – it’s a young service after all. And indeed it is evolving – the Warwick-Edinburgh Mental Well-being Scale will be used as a measure in the IAPT SMI pilots. Kevin Jarman concluded this debate by reminding us that he feels the real issue is driving up investment and improving access to services.
There were also questions for Sam Lane about the impact of increased telephone assessments on recovery rates, and whether there was any resistance from staff and patients. Sam was able to answer these fully and it seemed that many people in the audience were inspired to try and replicate the success of Sam’s service in this area.

**Long Term Conditions**

**Long Term Conditions Pathfinder Project: Dr Mike Scanlan, Nurse Consultant, Changing Minds IAPT Service, Northamptonshire**

Mike gave us an extremely interesting insight into an LTC IAPT project he has been working on, using group work which included teleconferencing and video conferencing. He kicked off his talk by showing an excerpt from a film about a patient who had had a stroke. Chris, the patient, spoke about his apprehension about and experience of attending the group sessions. This film forms part of a group of films of patients talking about their experiences that Mike and his team use to get discussion going in their LTC group work. Mike noted that often people find watching a film easier than reading something, and that it’s a great way to get people talking about how they feel. He said that we tend to assume that people with an LTC will have a good level of health education about their condition, but that this is often not the case.

He finished by talking about the lessons learned during the project, in particular around the pathway. They actually found themselves having to chase around for referrals, which as we all know is a fairly unusual state of affairs for IAPT. He talked about how the use of these films could be evolved – linking them to manuals, expanding the use of technology such as Say Page, and also widening their usage from LTC to other areas of IAPT.

**Mindfulness for Long term Conditions and Cancer: Peter Caunt, Service Director, Good Thinking Therapy, Leicestershire County & Rutland**

Peter’s talk revolved around mindfulness, the aim of which he described as helping someone to move from being someone overwhelmed by their own thoughts to someone who was able to take a more structured approach to their own thoughts. He introduced a project led by his service which took a group approach to mindfulness for people with LTC, with the desire of increasing equitable access and facilitate high volumes of patients into treatment.

Peter then introduced a practical exercise by leading the audience in a hand mindfulness exercise. The exercise was a simple but effective one designed to get participants to simply be in the moment. As well as talking through the implementation and expected outcomes of his project in Leicestershire, Peter stressed the importance of doing mindfulness work with staff – if healthcare professionals have experienced mindfulness they are more likely to be able to “sell” the idea of it to patients, and get that all-important (for LTC) buy-in from physical health professionals. He added that this can also have a secondary effect of healthcare professionals having less time off for stress as a result of mindfulness work.

**East Midlands Project on Mindfulness and Managing Pain: Norman Finlayson, Service Lead, Open Mind Service, Leicester City IAPT**

Norman spoke about the pain pilot he is involved in which is due to start in May/June 2013. He began by reminding us of the drivers for these services - medically unexplained physical symptoms (MUPS) are the main reason for between 15% and 19% of GP consultations in the UK, and furthermore up to 70% of people suffering with MUPS will also suffer from depression and/or anxiety disorders. The majority of people with MUPS have chronic or persistent pain as part of their symptom spectrum.

Norman recommended an integrated approach for MUS where pain is the main symptom – using both a mindfulness approach and a Pain Management Programme. Psychological approaches to unexplained or resistant pain have been shown to improve reported well-being and function by between 25%-45% - although Norman did raise the question of what the best pain outcome measures are.
Dr Rob Hampton, GP & Clinical Lead, Leicester: Norman then handed over to Rob, who spoke about Pain Management Programmes vs Mindfulness-based Cognitive Therapy (MBCT) for people with MUPS. He looked at issues including research evidence for Pain Management Programme and MBCT, and identifying the best intervention for the individual person.

Long Term Conditions: Q&A / Discussion Session

One of the questions discussed in this session was how to combat reticence and scepticism amongst medical professionals in secondary and primary care with regard to psychological approaches to LTC/MUS. How can we engage GPs in particular, and convince them of the value of a psychological approach?

There were a couple of possible suggestions to answer this – one is better training for GPs and other HCPs. The other was taking a more pragmatic approach and using available data to demonstrate the impact of psychological approaches on surgery and A&E attendance rates.

Making IAPT more Accessible to Older People

Amanda Gatherer, Workstream Clinical Lead, NHS West Midlands

Amanda introduced the topic of treating older adults in IAPT. When IAPT first started it was focussed on adults of working age, but there is now an increasing focus on treating older adults. There is no specific funding for this stream of work in IAPT, so Amanda stressed the importance of being able to get together at events such as this one to learn from others’ experiences and network.
How Older Adult Friendly is Your Service? Roslyn Hope, National Workforce Adviser, IAPT

Roslyn gave a very interesting presentation on workforce training for Older People’s IAPT, and how improving training, in particular for PWPs and High Intensity therapists, can ensure that IAPT as a programme embraces older people. She talked more about the basic stance on and knowledge about older people – what values and attitudes do we have about older people? Can they benefit from psychological therapies?

Roslyn went on to discuss the screening and assessment tools and set of competencies that have been put in place, and the 2-day training programmes that has been introduced for PWPs and High Intensity therapists. She spoke about the possibilities of asking certain staff to take a lead on older people, and how that 2-day training could be built on to offer further training for these staff. She talked a bit about audit tools to see how accessible your service is to older people (she recommends looking at Steve Boddington’s audit to see how you can use it). She also noted that as older people’s services do not have funding within IAPT, a good way to keep an eye on how you’re doing is through your LTC work (which does have funding) as a good proportion of people with LTC are older people.

She then concluded by looking at what is still to do in this area, including extending the campaign, ensuring 2-day training is rolled out, introducing additional 3-day training for some IAPT staff with a special interest, piloting IAPT in Memory Clinics and monitoring of % older people accessing IAPT.

Debbie Howard, PWP, Westminster IAPT

Debbie gave a fascinating insight into her work with older people at her IAPT service in Westminster. She told us that one of the strategies they have used to try to get away from the stigma of mental health is using different language to describe their work, so rather than mental health or therapy, they use words such as wellbeing and stress management. This gives older people a way into the service without the stigma.
Making IAPT more Accessible to Older People: Q&A/Discussion Session

There was a discussion around the benefits of IAPT for older people in terms of reducing healthcare bills in other areas. As there is no extra investment for older people’s services, the only way to advance practice is by sharing experiences and best practice with other services, so this event was very valuable in that respect.

A question was asked regarding psychopharmacology in older adults’ services - there has traditionally been a strong emphasis on medication – how can we redress that balance? Amanda Gatherer responded by talking about some work she has done with GPs in Warwickshire on alternatives to medication, which focussed on putting older adults in as peer support workers, as well as holding workshops for people who had been on anti-depressants for more than two years. The GPs welcomed these approaches and were very open to them.

Another question was asked about managing liaison with secondary care as regards older adults. Discussion ensued about the possibility of collaboration between IAPT and specialist older adult services. It was felt that unless they were part of the same foundation trust, this could get very complicated and difficult.

Discussion then moved on from older adults to a more general discussion of what IAPT is and what it should be. A question was asked about whether IAPT should be doing something more radical, rather than following a traditional medical model based on symptoms and outcome measurement. An answer was given that suggested that no, IAPT is meeting an unmet need, and engaging a range of organisations that can help clients. It’s not just NHS-specific, it involves 3rd sector organisations and accesses the resources available in the communities it serves.

The discussion moved on to discuss exactly what IAPT is and how it is evolving. At first, GPs just referred everyone to the service, but they are now being more careful about understanding and promoting the idea that distress can be normal and not everyone needs the service. IAPT started as a very CBT focussed service but is beginning to recognise that CBT is not the “only show in town” and that other evidence-based therapies can be used.

Mark Easton summed up by sharing his thoughts on a fantastic day. He picked out in particular the use of telephone, internet and film, and how new technologies are being used to improve lives. He also mentioned the presentations on mindfulness and suggested that IAPT may be moving away from tick-box medicalization of mental health treatment.

He concluded by saying that he felt that the day showed that IAPT is a maturing service, self-confident and optimistic enough to challenge the status quo. So a day for celebration indeed – everyone present has been part of something that has achieved great things, and that will continue to do so.