IAPT at the younger end

Sara Barnes is the CYP IAPT Service Transformation Lead for Pennine Care. We spoke to her about what is happening in the world of IAPT for young people, and how it looks in her own collaborative

Can you bring us up to date about where we've got to in this project nationwide? What's happening on the ground so far?

When the money was rolled out last year, Higher Education Institutions were invited to apply to become collaboratives with partner trusts in their geographical areas. They weren't clear about how many would be set up, but from the 13 that bid, three pilot sites were chosen and our collaborative was one of those. Two new collaboratives have been announced recently[1]. For bidding purposes, Pennine Care, here in the north west collaborative, was divided into Pennine North and Pennine South because the area is big and diverse, and luckily we both got through. We view ourselves as one – but for the purposes of the programme there are two funding streams, and for reporting we are clearly Pennine North and Pennine South, which works more effectively. My understanding of this process is that, over the next four years, the collaboratives will gather in more trusts and that by 2015 every CAMHS service should have some IAPT funding. So it's gradual exposure.

For illustration purposes only; posed by models

That's good news. So what's been happening in your own area?

A tremendous amount. The funding was to cover a broad range of activities. The first one, which is the one everyone focuses on, is the delivery of CBT training and parenting training to diploma level. We're three-quarters of the way through that now. Within Pennine, we have 18 staff receiving this training on a full-time basis – they've come out of their posts completely, and they're using their secondment time to build their clinical hours. To cover their absence, we were given what's called backfill money – a pot of money to provide temporary replacement staff.

There's also a huge amount of work going into improving participation and engaging young people and families in how our services are delivered. As I see it, there are four pillars to IAPT: service transformation, user participation, evidence-based psychological therapies and routine outcome measurement. The last three were going on already but not in a way that's robust enough and embedded enough in routine practice.

So will this be merely a replica of the adult IAPT for young people?

The basic principles I mentioned are key, as is the stepped-care model, and they're part of the basic structure for CYP IAPT too. But the way it's used in adult IAPT is very different from how it operates in CAMHS. What we need particularly are links and an interface with Tier 2 services. We already have robust links with Tier 4, but we really need to work hard with commissioners over our links with Tier 2 and Tier 1 services so that young people can be very smoothly moved on. It's a difficult economic climate in which to have that aspiration, with so many of the Tier 2 services being cut and Tier 3 services across the country having seen an increase in referrals in the last six months of around 25 per cent. This means we're faced with having to screen and identify those young people who could be appropriately helped by our service and those who would benefit from a community intervention. In other words, make informed choices about managing our front door in a way that doesn't alienate families yet also manages their needs. That's challenging when there's been such a huge increase in referrals. But establishing those links is important.

The key difference from the adult programme is that they're embedding this training and transformation in existing CAMHS services. They're using the expertise that's already there to build on and develop the high quality and effective services that are more user focused, rather than setting up standalone services that deliver a particular intervention in isolation. Children, especially, exist in a really complex system of other people and agencies, and key to our role is linking with all of these and understanding the child in context. So it would be quite hard to set up an IAPT service for children that stood alone and didn't have those connections. We have, and use, a broad range of expertise, such as Dialectical Behaviour Therapy (DBT) skills, parenting skills, family therapy etc, and my understanding is that the new adult IAPT services for serious mental illness will follow the same embedded model.

Above: Poster presenting the pledge to the young people's panel

One of your roles is to manage this change process in your area. How is that going for you?

It's really exciting because all of these things are what we've been aspiring to implement in the face of huge workloads and poor resources, and it's been a drip-drip change process. IAPT has allowed us to have some energy and the resources to move this through. And a timeframe – the plane is leaving *now* and we're definitely all going to be on it! That's really exciting for me. I've been involved in a lot of change processes over the years and it's been frustrating, but this has come with sign-up from everyone: chief executives, local authority and PCT, commissioners and in particular our Divisional and Directorate Manager. And it's come with deliverables that we have to achieve. So it's just given us a little bit of impetus and motivation and energy to achieve what we were trying to achieve anyway.

What's the most difficult thing about transforming an existing service in this way? What kind of teething problems have you come up against?

I think the first challenge we encountered was a sense of people externalising IAPT and saying oh it's just something that's out there and it's nothing to do with me. I'm not going to be one of the trainees, so it doesn't matter to me. I think that CYP IAPT is not so much about training as about transforming services to deliver better high quality ones that are user focused. Getting over the message that everyone in this organisation has a role in that was difficult. What we did was write a presentation summarising what CYP IAPT was and present it in exactly the same way to the trust board, the consultants, to every single team, to commissioners etc, so that everybody got the same message and we weren't differentiating, saying your bit is there, and your bit is there, although everyone does have a different role of course, but the message was that we all have a responsibility in driving this forward. It was challenging, because in the NHS there is a lot of change fatigue and daily firefighting.

The other thing has been practicalities. The pace of this implementation has been phenomenal. We were notified our bid had been successful in September 2011 but couldn't announce it until November. So we had to interview trainees in November and they started their courses in January this year! And if I'm honest, it's been a struggle to find 12 new members of staff to backfill those trainees – staff who've got the appropriate competencies to come and work in CAMHS for a year. The timeframe to find these people was challenging to say the least!

What kind of skills do you look for in that role?

We look for people who can manage very acute presentations and who can do risk assessments, as well as people who can deliver therapeutic interventions. The key thing is about managing risk and recognising mental illness so we can identify this early. That doesn't form the bulk of our work, but if people have those skills, we can support them in learning about children's development, because we do need to see children in a developmental framework: is what they're doing appropriate for their chronological age?

Your prioritising does make sense in a CAMHS service. But turning to the young people themselves: in which ways do *they* get a say in shaping their services?

During the bidding process, we were interviewed by a young people's panel and we were asked to make a pledge to them. What we did, as a collaborative, was to use the letters of the word 'pledge' to give them some key short-and-snappy messages to be the bedrock of our involvement with them. These were: Participation, Listen and learn, Engagement, Deliver best treatment at right time and place, Gather and give feedback, and Empower children and young people. They interviewed us about how we would deliver this pledge.

And presumably found your plans satisfactory! How else can they participate?

We already have a whole range of things that we do. We have a participation strategy in place and we have some pieces of work that really demonstrate positive participation. For instance, we did a piece of work with Streetwise in Bury and created a resource book about issues young people have and contacts where they can seek help, not only about mental health but around things like pregnancy and diet as well – it's called *With U in Mind* and you can find it on the Pennine Care website[2]. It's a fantastic resource. The young people also created a branding which is now our CAMHS branding. So we already have some very good examples in Pennine. Obviously you can never stand still, so we've recruited a participation worker who is going to standardise this across all the boroughs, because one borough may be less able to deliver, and another have a strong participation element. In one borough, for example, some young people have actually written training for others to use on how to set up a panel to include young people when interviewing staff, how to keep them interested, how to train them. But we mustn't forget parents and young children. It's more of a challenge to find creative ways to include them.

Talking about parents and younger children, a lot of CYP IAPT money seems to be for parenting classes and CBT. How do you envisage the service developing, if at all?

In February, Nick Clegg announced a further £22m investment in IAPT for Systemic Family Therapy and Interpersonal Therapy and that's the next thing there's going to be training for. The issue for me is that this is a service *transformation* programme, not just a training programme, and it's important we don't leave out the modalities that are already being skilfully used by our staff. We have a really wide range – DBT, family therapy, play therapy, mindfulness approaches, psychodynamic psychotherapy and an early attachment service working with newborn babies. What we want to do is really celebrate that diversity but make it more robust so that these modalities are protected, if you like, rather than them just being used and people anecdotally saying, 'Yes, they work and that's what I like to do.' That means actually incorporating them into care pathways so that people can make informed choices about which path they take. That's ultimately what we want – for families to come in, have an informed choice about what might be the most helpful, and be able to access that pathway with a very clear focus. We don't want to say, well you can only do CBT. But we do want any therapy that's delivered to be evidence based, to have a clear goal about why you're doing it, to have review points, and to be measured as it's happening, to see whether it's effective.

It seems harder to apply that to play therapy. How would you do that?

This is a big challenge. A lot of the non-verbal therapies can be very hard to measure. In fact, there's a group working across the region at the moment, based in Manchester, who are looking at how to measure that in a way that doesn't

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interfere with the process of therapy. There are core outcome measures we're expected to do, but they're going to have to look at particular things such as family therapy – for instance, who do you ask for feedback in this situation? All of these things are in development and they're not there yet. And it wouldn't be appropriate to do it every single session because the trajectory of change is so small. So I think there's an understanding about that and a sense that, yes, we do need to be able to reflect on whether the therapy is being effective, if it needs to be changed, what the young person's experience of it is, and whether it's something they are finding useful. But it's a tricky one.

Many of our members are counsellors. If you deliver lots of different modalities and you hope to have them incorporated more robustly, how come you've no counsellors on the teams? Is it all about psychotherapists?

Not exactly. We do have psychotherapy trainees in a four-year training programme, but we don't have any dedicated psychotherapy posts. I think what's happened is that all these other people who deliver these different modalities are mental health practitioners (MHPs) who have expanded their training. Counselling skills are an essential component of everyone's skill base and we do have some people who also have counselling qualifications to a higher level, and that supports them delivering other therapies, but they don't say, 'I'm going to have this specialist time ring-fenced for counselling.' Certainly not at Tier 3. So play therapists, most of the people in family therapy teams and most of the CBT therapists are actually employed as MHPs. This needs to be different in the future so that we have a more focused and balanced workforce.

I'm only asking because you have spoken about families coming in and having a choice. But without counselling, it's not a full choice is it?

No, but in all the boroughs at Tier 2, there are excellent counselling services that are very well used and have very robust governance and clear pathways and which do a lot of very effective work. And they're also working with the harder-to-engage young people, who wouldn't come to a medically run service or be seen in a hospital where you have to attend at a particular time. These services do seem to be more the remit of voluntary sector organisations or the local authority Tier 2 providers. It's an interesting one and something I'm just starting to get my head around.

Finally, can you say something about the use of regular outcome monitoring with young people? Is there any evidence that they like or don't like session-by-session forms to fill in?

At a national level, before the programme was initiated, young people were involved through YoungMinds in thinking about this, and their very clear message was that they wanted outcome measures, and they wanted them regularly – although 'session by session' is a Department of Health translation! But monitoring mirrors so many aspects of everybody's life now – you go to a gym, you go to Weight Watchers or wherever and you get a chart of how you're doing. Certainly we're getting a lot of feedback about it. Over the years, we've always done a few measures at critical points – beginning, middle and end – but young people say they feel it's more clinically relevant and more helpful to have it as they go along. I'm aiming to develop tablet technology so that we can do it then and there in the room along with the young person and show them a visual representation of where they're up to. If you show them a graph of their scores as they've gone along, well, maybe they were feeling really awful when they started, and often, when they start to feel better, it's quite hard to remember what that was like, so seeing where they've come from is really positive for them. They like it.

I guess that's our answer then, if we're really serious about listening to what the young people themselves want. ●

Interview by **Eleanor Patrick**

References
1 www.iapt.nhs.uk/cyp-iapt/
2 www.penninecare.nhs.uk/services/withuinmind/flash/downloads.html