

Fifth Annual New Savoy Conference

Psychological Therapies in the NHS

Thursday 24 and Friday 25 November 2011

Savoy Place, London

Expert Focus Group 2:

**Can we open up a window of recovery
for people with serious mental illness:
what do therapy experts say?**

What can IAPT do for SMI

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NICE Recommendations for Psychological Therapies for SMI

Table 1: NICE Recommendations for Psychological Therapies for SMI			
Schizophrenia (CG82, 2009)	Bi Polar Disorder (CG38, 2006)	Borderline Personality Disorder (CG78, 2009)	Antisocial Personality Disorder (CG 77, 2009)
<p>Manualised CBT: 16 sessions.</p> <p>Family interventions : 10 sessions over 3 months to 1 year</p> <p>Arts therapies</p>	<p>CBT: at least 16 sessions over 6-9 months.</p> <p>Family interventions for 6-9 months.</p> <p>Similar interventions for children and adolescents</p>	<p>Explicit and integrated theoretical approach used by treatment team, therapist and service user.</p> <p>Structured care</p> <p>Provision of therapist supervision</p> <p>NOT brief psychological interventions (less than 3 months).</p> <p>DBT for self harming women</p> <p>Specialist PD services</p>	<p>Group based CBT for impulsivity, interpersonal difficulties and antisocial behaviour.</p> <p>Reasoning and rehabilitation programmes for offenders</p>

What NICE Found

- Family interventions (with meds) are the best type of treatment for reducing relapse.
- They can save money
- They should be available to all who need them

The Case of Family Interventions.

- Minimal changes in recommendations for Family Interventions between 2002 and 2009 guideline.
- *“Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user”.*
- How successfully has this been implemented in the last 9 years since the first guideline was published?

Implementation in a Typical Trust (Tetley & Ordish, 2005)

- Based on 146 patients (estimated to be 2079 with schizophrenia in the Trust)
 - 64% were living with relatives.
 - 69% considered at risk of relapse.
 - Only 7% offered family interventions
 - Only half of these (5 families) were given more than 10 sessions or given an intervention that lasted more than 6 months.

So why isn't it happening?

What the evidence tells us about
successful implementation.

Few mental health staff have the competencies to implement family interventions effectively.

- What are the competencies?
 - Is training available?

Implementation of New Skills

- What hinders...
 - Competing casework demands.
 - Not enough time.
 - High caseload numbers.
 - Access to “appropriate families”
 - Lack of confidence and competence.
 - Poor staff motivation.

Implementation of New Skills

■ What Helps...

- Having appropriate competences to apply approach flexibly.
- Longer & more in-depth training.
- Supervision.
- Having a critical number of staff trained in the team / team philosophy.
- Peer Support
- Ring fenced time for family interventions
- Management support at all levels of the organisation

Problems implementing Family Work (Brooker and Brabban, 2004)

Study	Difficulty Rating		
	Not at all or a little difficult	Moderately or very difficult	Extremely Difficult /Impossible
Buckingham	44%	45%	11%
Manchester	20%	55%	25%
Sydney	30%	48%	22%
W Midlands	36%	50%	14%
Somerset	80%	20%	0%

SMI

- Ministerial commitment to the expansion of Psychological Therapies.....
- One and a half million people suffer from serious and enduring mental illnesses like schizophrenia, Bipolar Disorder and Personality Disorder.....of whom only half have been offered psychological therapies (Rethink)
- Task.....to bring together Rethink, the Royal Colleges and other professional bodies to look at existing capacity, and develop appropriate training for members and therapists.

Paul Burstow NSP conference 2/12/10

What has IAPT done for SMI to date?

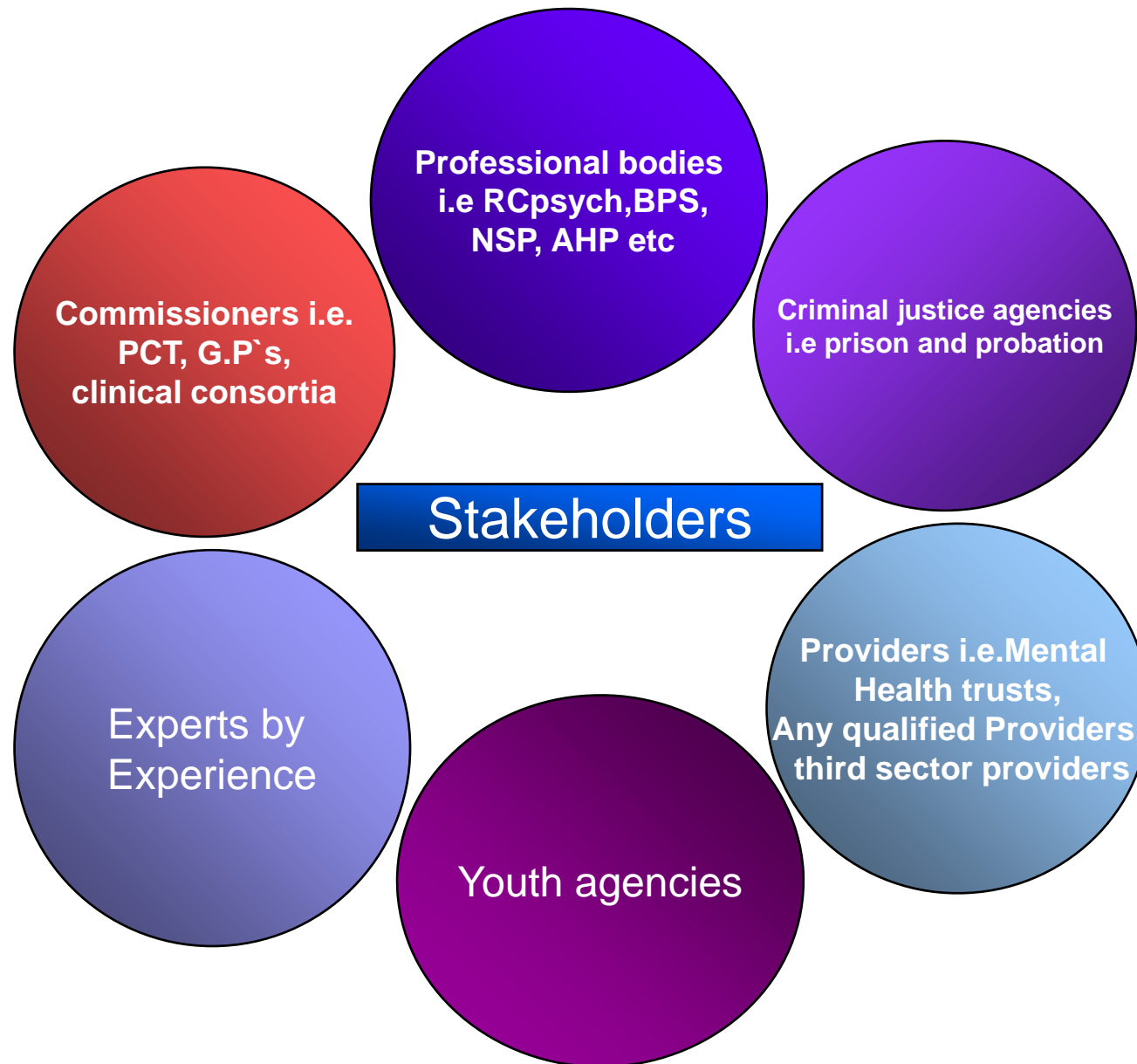
- moved skilled workforce into primary care
- Alienated secondary care practitioners
- Increasingly patchy provision
- increased exclusion/inclusion

What it needs to do?

- Understand the context of delivery
- Involve stakeholders
- Increase access for people with SEMI
- Offer choices
- Offer quality services
- Engage within a social context for patients and practitioners

How might IAPT do this?

- Identify NICE evidence based Psychological Therapies
- Identify evidence based trainings
- Develop competency frameworks
- Develop practice guidance i.e supervision, ring fenced time.
- Enable discussion across a range of stakeholder



- Improve quality
- Increase choice
- Improve outcomes
- Develop a user friendly care pathway

IAPT SMI Programme

IAPT for SMI is about *improving access to psychological therapies* NOT about fitting people with SMI into a specific IAPT service model.

It is a transformational endeavour.

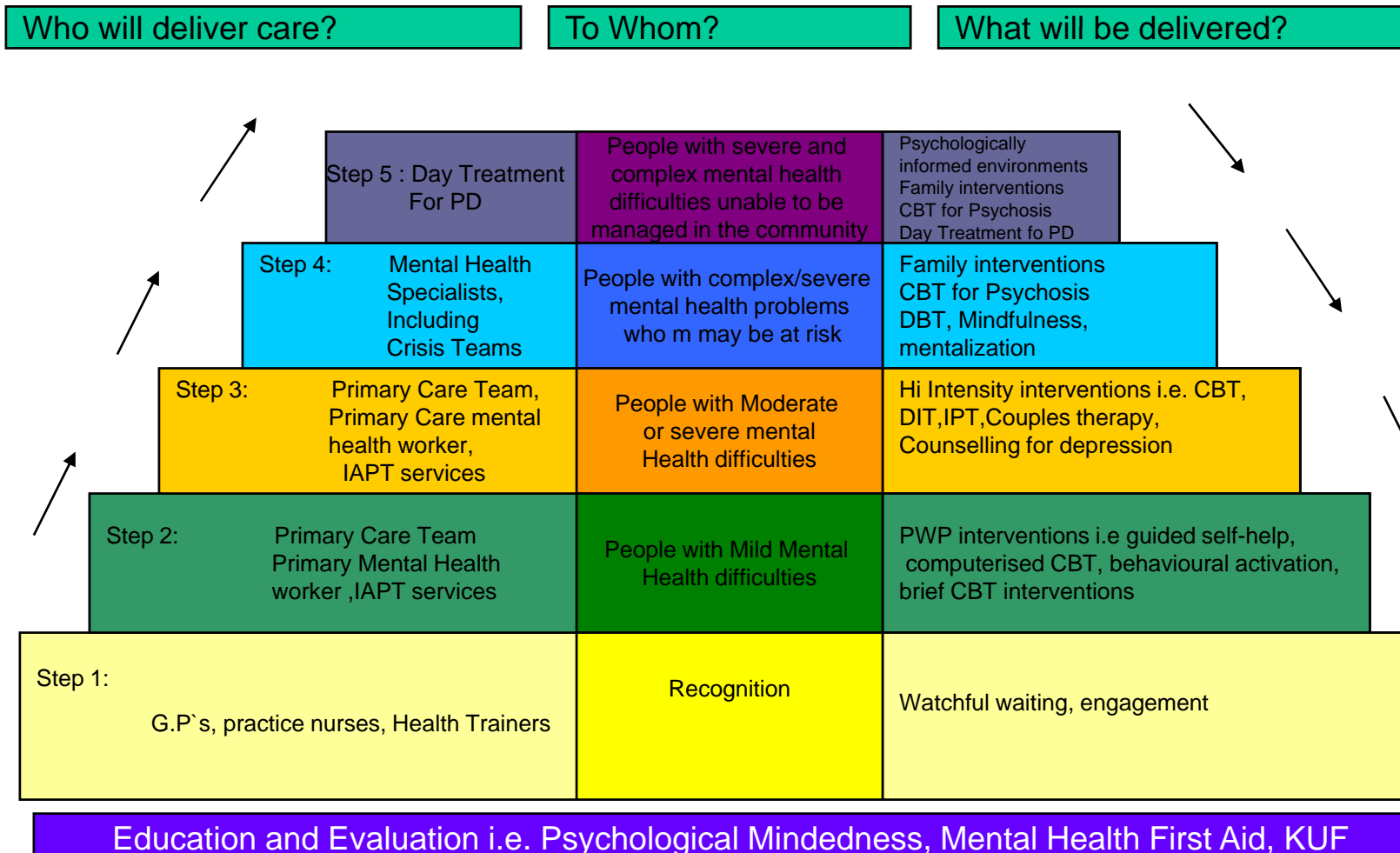
Core Features of the IAPT Programme

- Implementing evidence based therapies.
- Recognised Competencies
- High Quality Training (Accredited)
- Supervision
- Stepped Care
- Session by Session Outcome Monitoring.

IAPT for SMI: Approach

- Phased approach
- Three main areas:
 - Education and training
 - Service development and redesign
 - Outcomes and evaluation

Stepped care model



Key Challenges

- Limited capacity to deliver Psychological Therapies
- NICE Guidance not always clear
- Inconsistency in delivery
- More change in mental health
- Staff competencies low
- Staff morale low

Key Challenges cont

- Identification of appropriate outcomes
- Supervisory capacity
- Psychological therapies viewed as core business
- Involvement of service users/experts by experience

What Stakeholders Feel is Important.

(Taken from Stakeholder Event on
23rd November 2011)

Service Philosophy

- User Focused
- Psychological Mindedness Across Services.
- Early Intervention is Important.
- Not symptom based but outcome driven.
- Balance between risk and well being.
- Generic and specialist interventions available.

Key Components of a Service

- Multidisciplinary with psychological therapies embedded within.
- Bio-Psychosocial
- Recognises the complexity of an individual's needs not just symptoms.
- Evidence based practice plus need to generate practice based evidence.
- Coherent care pathways
- Accessible: self referral, web based interventions etc.

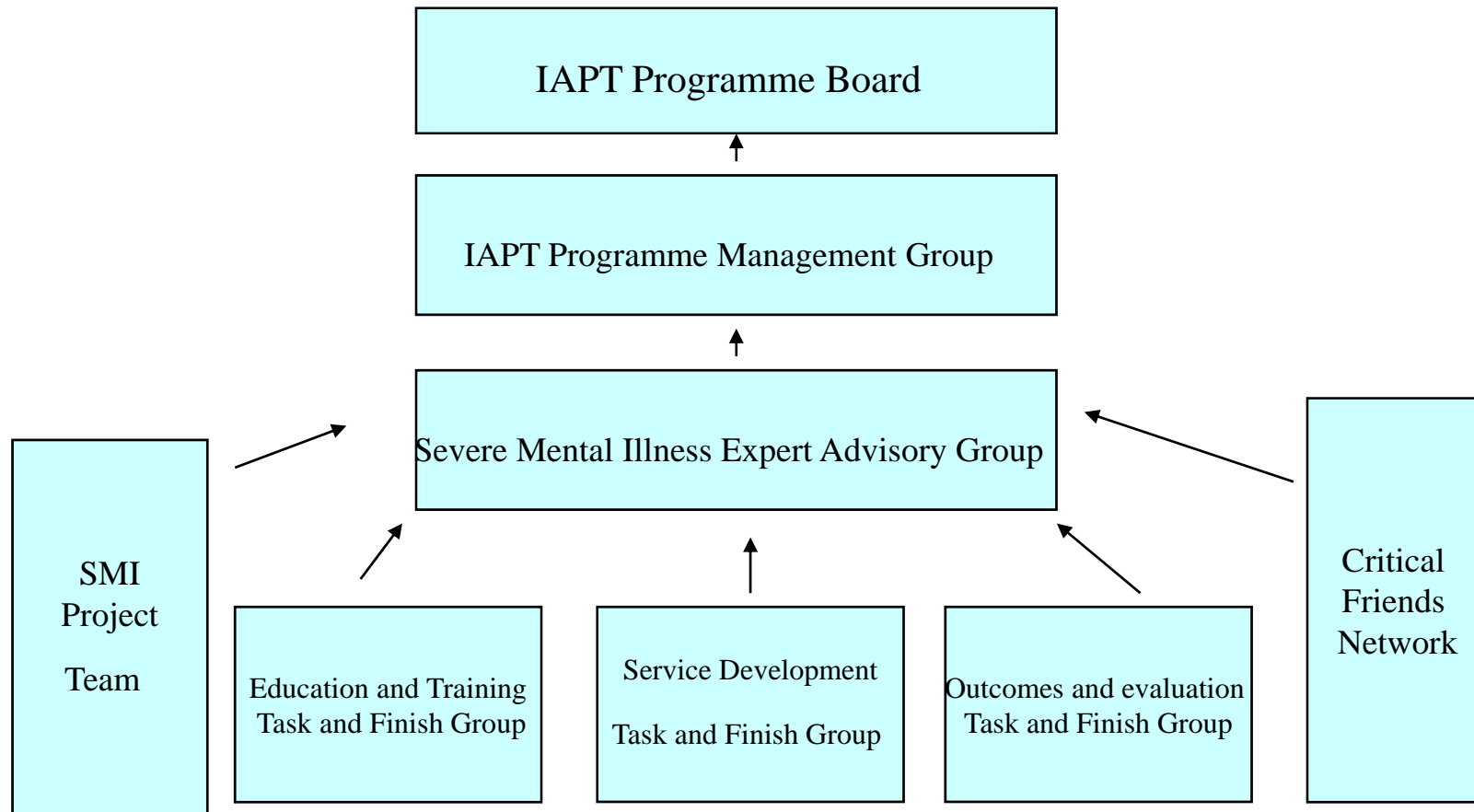
Delivering Psychological Therapies

- Wider workforce should be involved in the delivery of psychological interventions including peer support workers (will need confidence and competence).
- A range of interventions should be available (short term, long term, choice of modalities, groups vs individual).
- High quality interventions with fidelity to model (full dose, competently delivered).
- High quality clinical supervision.

Commissioning for Outcomes

- Service user defined outcomes based on collaboration.
- Less focus on symptoms e.g. Quality of life, recovery related.
- Outcome based payment vs intervention based.
- Peripheral economic gains e.g. Reduced bed days, medication usage, DLA claims.

Appendix 4: Governance Framework for the SMI Project



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