Day 1: Intro to CYP-IAPT and Transformation: Core Aims and Values

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With thanks to Peter Fonagy

IAPT for Children and Young People: The Context....
Where did CYP IAPT come from?

- Adult IAPT
- Increased focus on the importance of mental health services
- The money
- Reports on CAMHS
- Service users’ dissatisfaction with services

The achievements of adult IAPT

- Outcomes achieved; 45% recovery and 60% show reliable improvement (nearly equivalent to RCTs)
- Numbers receiving EB psychological treatments (756,000 referrals a year = 12.5% of prevalence)
  - Total seen = 1.134 million people
- Savings made
  - £1050 in physical healthcare per patient, includes GP and A&E visits
  - Plus savings on benefits and lost taxes (£650 a month vs. £650 one off on a course of CBT)
  - 45,000 people back to work
Age of onset for lifetime mental disorder

At Age 14

50% of lifetime mental illness (excluding dementia) starts by age 14

By Mid Twenties

75% of lifetime mental illness (excluding dementia) starts by mid twenties


Mental health problems are the greatest health problem faced by children and young people

Figure 6 Incident YLD Rates per 1,000 Population by Age and Broad Disease Grouping, Victoria 1996

Source: NHS England

Prof Pat McGorry
ACCESS: % With anxiety or diagnosable depression not in contact with mental health services

Source:

International Perspective on CAMHS: US studies

Outcomes of usual community care

Warren et al. (2010)
International Perspective on CAMHS

- Alarms regarding the ineffectiveness and fragmentation of community-based mental health care for children and families

- majority of children receiving community-based “usual care (UC)” do not show clinical improvement

- large meta-analytic review reported few differences between UC treatment and control groups (wait list)

The context of CYP IAPT: Costs

Mental illness during childhood and adolescence in the UK:
£11,030 to £59,130 annually per child

Lifetime cost of a 1-year cohort of children with Conduct Disorder: £5.2 billion

- £60 billion in England and Wales
- £22.5 billion attributable to CD
- £37.5 billion to subthreshold CD

Evidence-based practice has substantial clinical & cost benefits

Only 6% of current spending on mental health goes to services aimed at children and young people

Kennedy, 2010
Reports on CAMHS

“children and young people are still only receiving fragmented and inconsistent support ... support is still sometimes provided too late in a crisis, and information is not easy to come by” (2008)

Outcome of the Review

An ambitious vision

“Improving the mental health and psychological well-being of all children and young people can help realise the ambition set out in the Children’s Plan “to make England the best place in the world to grow up in”.

The Review made twenty recommendations including:

Outcomes

- Develop outcome measures
- A clear strategic approach to monitoring, evaluation, service improvement, knowledge management and inspection

Workforce Development

- Basic knowledge of child development and mental health and psychological well-being
- Focus on training in evidenced based therapeutic interventions
Current service provision: a snapshot

Fragmentation of services for children and young people

Artificial structural divisions in terms of

Different lines of funding
Fragmentation of services for children & young people

Artificial structural divisions in terms of

Statutory vs voluntary providers

Fragmentation of services for children & young people

Artificial structural divisions in terms of

Separation of physical and mental health
Fragmentation of services for young people aged 12-25

Artificial structural divisions in terms of Age

Under 18

Over 18

Many service designs are not young person friendly

Many current service designs are not young person friendly

Inaccessible in terms of location, time, criteria for access
Summary of the issues facing CAMHS

- Significant shortages of sufficiently trained professionals
- Current level of CAMHS staff training is ‘poor and getting worse’
- Difficulties with access (very few services offer a self-referral route)
- Poor handling of transition between child and adult services
- Inappropriate provision of adult services to young people
- Data that could and should be used for self-critical professional practice, performance monitoring and commissioning is rarely collected
“The Government is investing around £400 million over the Spending Review period to ensure that adults with depression and anxiety in all parts of England have access to a choice of psychological therapies. This investment will also enable the expansion of psychological therapies in children and young people’s services.”

“The Government is now investing £32 million in psychological therapies, including talking therapies, for children and young people with mental health problems.”

“This investment in children’s mental health is vital. Talking therapies are proven to work, and so we are expanding services to treat children and young people with the tailored care that they need.

“We know psychological therapies work. Our aim is to transform existing mental health services for children so our children get the best treatment possible, from services that are more responsive to their needs.”
Children and Young People’s IAPT Implementation

Kathryn Pugh
Project Manager, NHS England

Professor Peter Fonagy
CYP IAPT National Lead

IAPT Website: www.iapt.nhs.uk

What Is CYP-IAPT?
A simple evidence based implementation of EBP

• CYP IAPT was conceived as a centrally initiated modification of CAMHS in the direction of EBP
• It is achieving remarkable degree of cultural change in terms of the acceptability of principles of EBP interpreted broadly through a modest investment in:
  • service change
  • training service leads
  • supervisors and therapists
The CYP IAPT Programme

- Using **routine outcomes** monitoring
  - To **guide therapist** and supervisor
  - To **help client monitor** and understand how treatment is progressing
  - Across **ALL professions**
- **Empowering YP** to take **control** of their care, establish treatment **goals**, choose treatment **approaches** and take **opportunities** to improve their own health
- Improving access to **evidence-based therapies**

Service Transformation Programme

- Project has reached target to work with services covering 60% of 0-19 population by 2015.
- **Learning collaboratives** made up of **universities** and **local area partnerships who** offer mutual support, problem-solving and learning networks.
• Effective and supportive service delivery models—shaped by service users—enables context for:

• Excellent supervision,
• ensuring therapy
• model fidelity and, continued collaborative practice

• Clinicians/practitioners to deliver best evidence based interventions, complemented by:

Ongoing client feedback facilitated by frequent outcome monitoring, combined with:

Clinicians/practitioners to deliver best evidence based interventions,
complemented by:

1. Closing the skills gap in CAMHS: Evidence Based Practice

Enhancing the skills of practitioners, supervisors & service managers in EBP

Appropriately skilled CAMHS workforce
Overview of CYP IAPT Training Programmes

1. Outreach Service Development to wider services
2. Outreach Supervisor Training to wider services
3. PG Certificate in Clinical Leadership and Service Transformation
4. PG Certificate in Supervising Evidenced Based Psychological Therapies
5. PG Diploma in Evidenced Based Psychological Therapies
6. PG Certificate in Enhance Evidenced Based Practice

Evidence Based Practice

- A practice that is consistently science-informed, organised around client intentions, culturally sensitive, and that continually monitors the effectiveness of interventions through reliable measures of the child and family’s response, contextualised by the events and conditions that impact on treatment.

- It is a term developed to encourage practitioners and patients to pay due respect, no more, no less, to current best evidence when making clinical decisions.

- Compatible with Practice Based Evidence = “the ability to use our clinical skills and past experience to rapidly identify each patient’s unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations” (Sackett et al., 1996)
What is evidence-based practice in child mental health?

A fundamentally participatory and co-produced (co-constructed) enterprise in which client, researcher and clinician are all fully engaged.
Evidence based practice

Research evidence + Patient preferences and values + Clinician observations

Quantifiable results
Acceptable to recipients
Utility for clinicians

Adoption and implementation of new treatments
More than a technical process, a social process

To obtain the desired outcomes, many things must be in place

EBP Organizational Social Context Practitioner Attitudes & Behaviour

Aarons, Glisson, Green, et al., 2012
Three major components of the CYP IAPT transformation

2. Routine Outcome Monitoring

- Routine Outcome Monitoring refers to measurements of clients’ progress in clinical practice and the ongoing therapeutic relationship, using **standardised instruments**, aiming to evaluate and, if necessary, **adapt** treatment.

- Clients are **invited** to fill out Routine Outcome Measures (ROMs) at the beginning of treatment, during treatment and at the end of treatment.

- Subsequently, **clinicians and clients** are provided with feedback about the response to treatment. Based on the feedback, decisions can be made regarding continuing, altering or terminating treatment.

**Why should we?**

- Our clients want us to!

- The data can help us grow as clinicians

- The data helps us provide better CAMHS provisions that are targeted to the needs of our client population

- Commissioning – the need to show that what we are doing is helping children, young people and families

- The use of ROMs improves treatment outcomes for clients; evidence-based practice.....
Measurement for a purpose: Guiding treatment to better outcomes


Three major components of the CYP IAPT transformation

3. Shift to collaborative practice

- Patient-reported outcomes
- Clinical decision-making
- Practitioner
Redressing the balance of expertise

Collaborative Practice

- involves the child, young person or parent and the mental health professional jointly identifying problems and agreeing goals for treatment
- partnership expertise
- shared decision making
- provision of a range of evidence-based approaches
Shared Decision Making aims to empower children and young people (and their families) to play an active part in decisions about their care by focusing on the detail of interactions between individual practitioners and the children and young people they work with.

linked to:
• Better treatment adherence
• Better treatment outcomes
• Increased knowledge and understanding of condition and treatment
• Greater reductions in medication prescriptions
• Greater satisfaction with care

Empowering young people

Understand and modify treatment progress via PROMs

Participate in service design

Participate in training of practitioners & managers
Empowering and working collaboratively with young people enables them to:

1. Take control of their care
2. Establish treatment goals
3. Choose the treatment that’s best for them
4. Improve their own health
Participation is at the heart of CYP IAPT

- At the event held by Young Minds in March 2011, children and young people gave detailed evidence of services received, narrow assessment and prescription, and limited opportunity for being active participants in their own care and recovery

CYPs were asked the following:

1. What do good mental health outcomes (results) look like for you?
2. What do successful talking therapies look like?
3. What range of therapies do you think should be offered?
4. How should these therapies be delivered (length, place, times and so on)?
5. How do you know they are being delivered well and to a high standard?
6. What knowledge and skills do workers need to deliver the therapies well?
7. What should these workers be taught, how and by whom?
8. What backing is needed from supervisors and managers?
9. Who is best to train these workers?
10. How should these therapies be commissioned and evaluated?
Feeling good

Feeling good is about all aspects of one’s life and good mental health is fundamental to that. Mental health assessments need to show interest in the whole person, not narrowing on the presenting problem. These should include:

- Initial assessment
- Session by session monitoring
- Complaints and independent advocacy

“When I was bulimic it hurt more than my anorexia. The doctor wouldn’t take me seriously because there was nothing I could show him….I wasn’t told that I wasn’t sick enough - I was told I wasn’t the right kind of sick.”

Doing the job right

Doing the job right is about having clear beliefs and values underpinning sound knowledge and competent practice. This should include:

- Training the worker
- Recruiting the worker
- Supervision and appraisal of the worker

“Service users should be involved in interview process for jobs. I heard someone say, ‘the service users pick the same person as us.’ This may be true but it doesn’t make having them on the panel redundant as it gives them a voice and makes them feel they have a say in the service they receive.”
Their reply = 9 CYP IAPT participation priorities

Running the service well

Running the service well is about commitment and leadership for a whole change process across the service and organisation. This should include:

- Commissioning (design, procurement and evaluation)
- Influencing senior managers
- Mission statement of intent on involving children and young people

“Style and cultural change: treat treating service users like part of a business – treat them like people who need care”

The outcomes of participation:
implicit benefits to the CYP involved

- increased self-esteem and self-confidence
- increased sense of empowerment and self-efficacy
- improved peer relationships
- improved relationships with adults involved in their care
- improved access and engagement with services
- self-awareness and self-reflection
- group presentation skills
- social skills and peer networking
- knowledge of mental health
- pro-social behavior
- tolerance of others
The outcomes of participation: explicit benefits to services

- Making services easier to access
- Making services better designed to meet the need of the children and young people that they support
- Improving services users’ experience of using services
- More enthusiastic and motivated practitioners
- The development of more information about services and treatment which is relevant and useful for children/young person
- New services and initiatives
- Research priorities identified