IAPT in Wales...are we getting nearer?

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Keeping up with the Jones'

What's happened next door ?

- Realisation of the cost of not treating depression (£26 billion to employers,£7 billion to exchequer)
- NICE 2003 /2004
- Demonstration sites 2006
- Pathfinder sites 2007
- Comprehensive Spending Review 2008 £173 m.
- Recommitment and expansion 2010 (CAMHS,SMI)

The six year plan....

- National model to implement NICE (LI and HI skill sets,principle of least burdensome intervention to meet need,sessional review to detect non improvement.)
- Aims....1) to improve choice and access 2) improve health and well being 3) achieve high levels of user satisfaction 4) help people stay employed and participate in meaningful activity
- KPI's...numbers accessing treatment,appropriate recovery rates,decreased sickness /benefit use,deliver new and effective workforce.

Meanwhile up in Scotland

- Home to LI initiatives (Glasgow)
- “Doing well by people with Depression” 2007...emphasis on reducing prescribing,developing support worker roles,third sector LI workforce
- A “Guide to Delivering Evidence Based Psychological Therapies in Scotland” 2008
- 2014 18 week access target for psychological therapy

What's emerging in Wales?

- A political pledge (“ to review access to psychological therapies..”)
- A legal requirement (part 1)
- An access target (Saff 14)
- Whole system policy guidance (in draft !)
- An intelligent target (or two)
- Frustration

IAPT agendas and Part 1 of the Measure

- Good news ?
- The draft model – five areas
- 6 – 10 session contact with range of indicative therapeutic approaches (from the CBT family)
- Reference to quality standards (including access,appropriate range of evidence based options and outcome focussed)
- In place by summer 2012

IAPT agendas and part 1 of the Measure

- But on the other hand...?
- Workforce planning mechanism as yet unclear - e.g. numbers not based on access models of unmet demand ; training plans ,integration with extant workforce etc.
- Resource (£ 3.5 m)....adequate for need ?
- Will role breadth mean role stretch ? (lifespan,omnicompetent practitioners;what will be the “therapeutic” skill set?)
- Agreement on precise mechanism to implement national vs local standards as yet unclear (e.g.

Good news really !

Whole system policy guidance

- Aims to build on IAPT principles by focussing on quality standards (without frightening the financial horses)
- Aims to recover the Saff 14 target
- Differs from English model – emphasis on the how as well as the what (relationships not just interventions),PBE (patient directed outcome focussed benchmarked care) as well as EBP, clinical networks,whole system perspective.

So if the NHS had a mental health diagnosis..

it might be a mixture of dementia (failing to learn from experience e.g. from elsewhere) and personality disorder (self defeating behaviours e.g. referral cultures,perpetual reform,anti-person centered data collection agendas).

What will contribute to successful treatment ?

- Achieve consensus within WAG and beyond (i.e. establish Welsh Collaborative across divided professions,third sector interests,SU carer perspectives)
- Effective lobbying (marketing the benefits,Savoy type declaration,annual conference)
- Close gaps between policy-practice-research in Wales
- Coherent national workforce development plan (balance central responsibilities with local ownership)
- Push where health economics evidence is strongest (health psychology,long term condition management)

More specifics..

- The Wales PMHC worker needs to be distinctively “branded” - seen as core aspirational role in Welsh mental health economy
- Early regard to modular training programme (assessment,therapeutics,PBE,organisational context skills sets)
- Buy – in to nationally agreed clinical outcome and service user experience data system
- Harness third sector energy (stabilise funding ensure complementary focus) and develop innovative service user involvement (paid SU

Practice example – North Wales

- Work in progress !
- 121 practices,445 GPs. Highest BZ prescribing
- 40 wte PMHC workers for 680,000 pop
- Pathway :- Step 0 : Foundational step (CAMHS,CCBT,upstream prevention)
- Step 1: GP – practice linked PMHC worker (intake eligibility criteria,brokerage assessment inc.psychiatric risk,6 -10 session model,use of CORE-net,portfolio of group therapy options)

Practice Example – North Wales

- Step 2 CMHT – linked psychological therapist (eligibility criteria : diagnosis+functional impairment+ability to use therapy = standard CPA ;diagnosis+functional impairment+high psychiatric risk = team invovement,enhanced CPA)
- Networks : PD,ED,EI/PSI,ASD
- “complexity” - not the same as chronicity or symptom intensity.Presence of PD,complex service use history,risk,multiple diagnoses