DRAFT Analysis of Feedback on the Future of IAPT talking therapies – March 2018

Summary of the biggest emerging themes

- The biggest overall theme that emerged was that people didn't just talk about IAPT, they talked more holistically about the gap between primary and secondary mental health services that IAPT illustrated. This tended to break down into an overt or implied request either for:
    i. IAPT to better engage with patients with more complex issues such as trauma, mainly by going beyond CBT (which it was felt by many could have a re-traumatising impact if used inappropriately)
    ii. **something else** to pick up the patients – currently ending up in IAPT – who have more complex issues such as trauma, which goes beyond CBT and offers more than six weeks.
    iii. better links and allocation between the two

- The other biggest issue was waiting times. As one respondent put it 'a lot can happen to a human in six weeks'

- Several creative models were suggested to make the service more accessible, including a satellite/core model where a geographically wide 'single point of access' – perhaps based in GP surgeries - can refer on

- There was widespread concern about the single provider model's ability to deliver the stated aims, especially:
    i. Delivering equality, and
    ii. Providing a wide range of approaches

- The view was repeatedly expressed that we should use broader qualitative and person-centred evaluation rather than rely on outcomes data

- The proportion of respondents educated to postgraduate level is around 50%, which seems exceptionally high. Without further research it would be difficult to say whether this reflects the difficulty of the survey, the difficulty of accessing IAPT, or something else.

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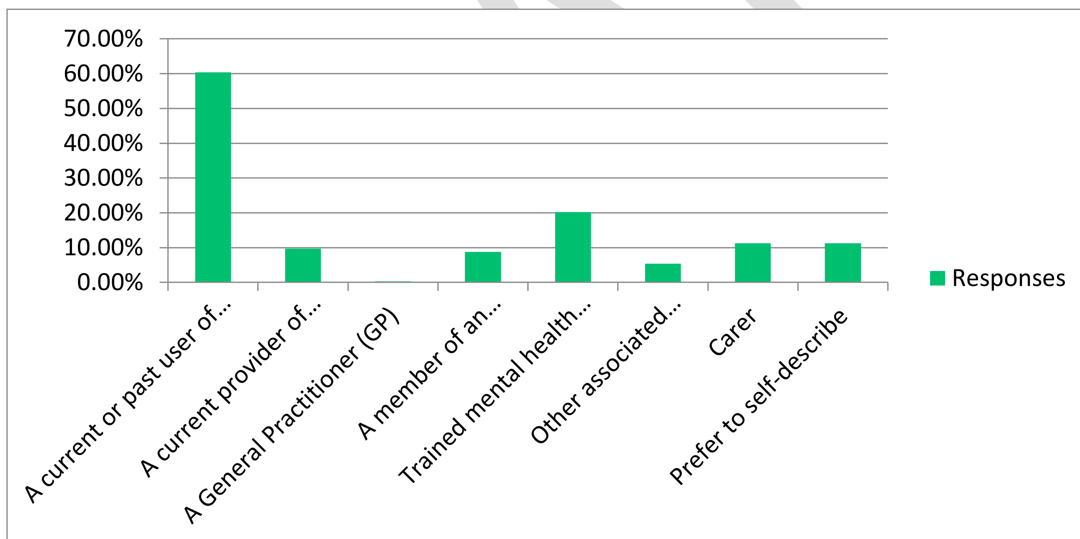
Question 1

Are you… (Tick all that apply)?

Answer Choices	Responses
A current or past user of talking therapy services	60.37%
A current provider of talking therapy services	9.65%
A General Practitioner (GP)	0.29%
A member of an organisation in the Voluntary & Community Sector	8.79%
Trained mental health practitioner	20.17%
Other associated organisation	5.33%
Carer	11.24%
Prefer to self-describe	11.24%



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Prefer to self-describe

psychotherapist	Psychology graduate
I'm on a waiting list to receive talking therapies	Mother
A surviving spouse of a past user of talking therapy services	Would have liked to receive talking therapy
Close friend of a user	Qualified counsellor, not in practice
A person living in Bristol	Also worked for NHS
Protect Our NHS	Trainee Play Therapist and Creative Arts Mentor
counsellor	Potential user of talking therapies services
Intending to contact for help. Have previously	None of the options
Waiting for therapy	Not IAPT but both inpatient and outpatient psychology services (also CPN and psychiatrist)
Also work in commissioning mental health services	Potential user of the service
A local resident	Education
NHS service user for MH. Have EUPD anxiety etc.	Suffering depression and anxiety
Student services	Solution focused clinical hypnotherapist
Someone desperately trying to get help	Student support manager in HEI
On the waiting list for CBT	Ex cater and depression sufferer
A person who suffers anxiety and depression.	In need of access to therapy
Parent of a current user of talking therapy services	Counsellor in private practice
Resident	Mental health researcher
Interested in accessing talking therapies services in the future	Someone considering using talking therapy services
I am a candidate for talking therapy	Someone who has a condition called misophonia who my Dr knows nothing about
About to join a talking therapy group	CPN Now retired. Have referred many to IAPT and long may the service continue.
Parent of a 'service user'	Also now final year counselling student

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none of these	Someone who felt to uncomfortable getting past front door telephone call - because first thing that was said was only got 15 mins to complete telephone assessment
Interested community member	Considering my need to have therapy
I have worked as a mental health practitioner but not for 9 years now. I have used counselling services as a client.	M.I sufferer
Occupational therapist	Health visitor
Parent of son with multiple mental health problems.	Speech and language therapist
I received CBT therapy	Person with mental health difficulties
On the waiting list for CBT in Bristol	A potential service user with 3 complex mental health diagnoses, yet has always been told I am too complex for services (a sorry excuse) and therefore has never been offered any psychological or talking therapy intervention and told to go private (I can't afford that)
Individual	Parent
Mental health nursing student	Someone who is repeatedly refused access to therapy services on the grounds that my needs are 'too complex'.
Interested in the community and the help they are given.	Private therapist
None of the above	Student physiotherapist
BIMHN is a disablist organisation and a front for bccg	Trainee counsellor
Retired GP	Has depression.
Body oriented therapist	Counsellor
Patient trying to get access to services!	Supervisor of counsellors therapist providing IAPT services
Service user but not of IAPT	IAPT Service User & Carer Representative

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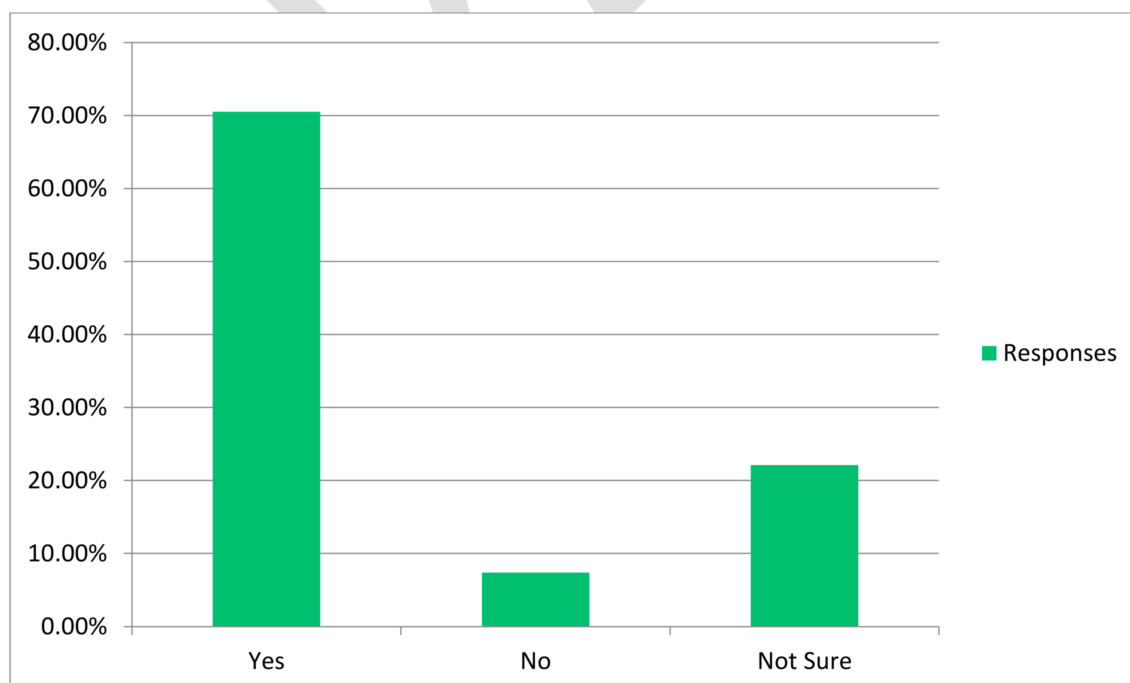
Question 2

BNSSG CGG is aiming to commission a single service (through one contract) with one lead provider and an outcomes-based specification, which places IAPT treatments into a wider social, cultural and economic context, by:

- embedding equality, diversity and inclusion
- taking a holistic approach
- offering a flexible and responsive service
- deploying a wide range of approaches
- providing a timely service
- improving access to the service
- improving recovery rates
- communicating strongly

Based on your experiences of IAPT, do you think that these are the right principles and approaches?

Answer Choices	Responses
Yes	70.51%
No	7.37%
Not Sure	22.12%



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Key themes regarding these approaches

General comments

- There is widespread agreement with the principles**,** but there was concern from others that they were mere buzzwords and that aspirations needed to be more concrete.
- For example, rather than 'communicating strongly', respondents wanted more sensitive communication, including:
    - Appropriate use of phone
    - Returning calls
    - More tactful written communication rather than just a 'questionnaire in the post'

One agency

- There was widespread concern among respondents that one lead provider means:
    - exclusion of smaller organisations that cater for minority needs;
    - hitting macro targets such as speed rather than quality;
    - adopting 'one size fits all approach';
    - depleted richness and diversity of provision;
    - all eggs in one basket – risk not spread;
    - a monopoly will by definition not help the end user
    - people 'slipping through the net' as currently suggested happens in North Somerset
- On the other hand, the view was put forward that:
    - One agency means less complexity, which would be a good thing.
    - There are too many providers currently and they don't all join up.
    - The current system is very segregated

Clinical approaches

- There is widespread antipathy to dominance of group work
- There is concern with current dominance of CBT and perpetuating this – especially its weakness in regard to complex issues, trauma and young people
- Another angle here is that CBT is potentially valid but not necessarily the best initial point of contact and a more listening-oriented therapist may be better at first assessment
- The point is also made that IAPT as a national concept is not really intended to be holistic but to get people back into work, hence emphasis on CBT
- 'Evidence based' was felt to be an important principle

Equality

- 'Cultural sensitivity' comes up repeatedly, as follows: 'The point is made that we can't just say 'we have a policy for that' – we need to think about implicit barriers for example expecting black people to come for treatment in a building staffed only by white people'.

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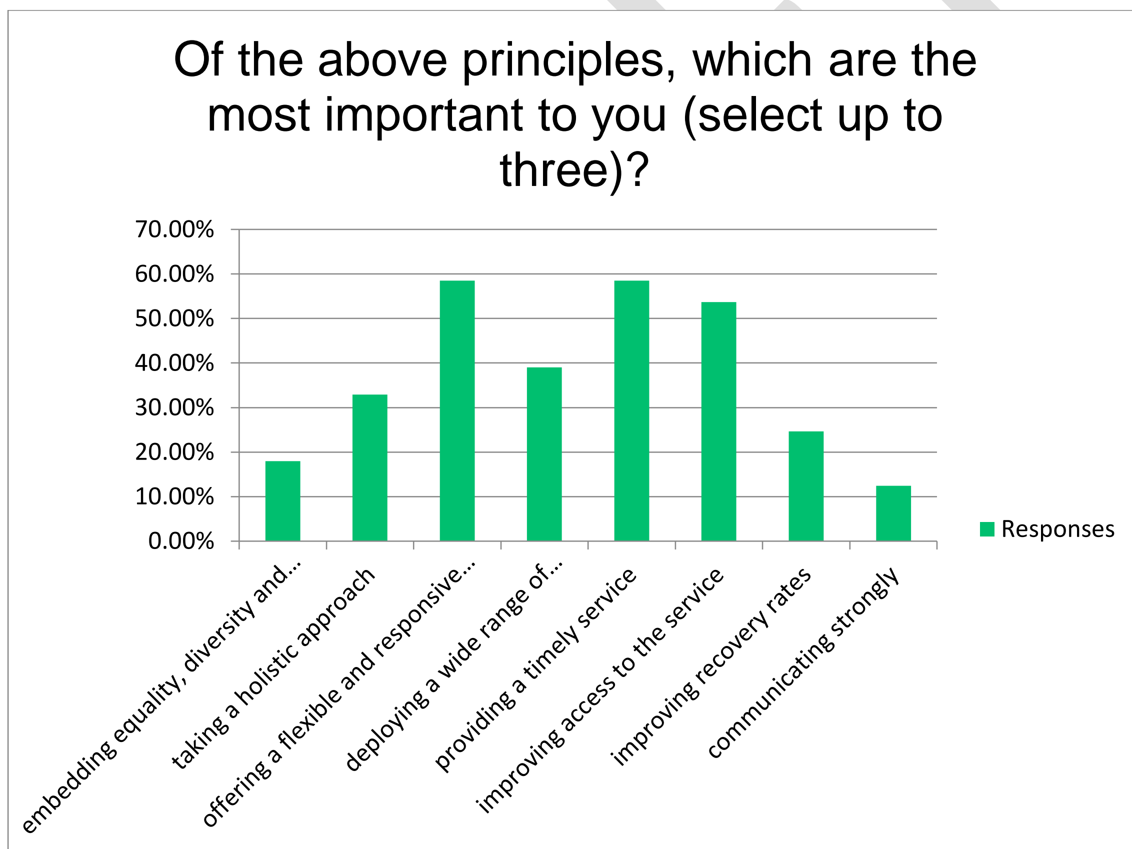
Question 3

Of the above principles, which are the most important to you (select up to three)?

Answer Choices	Responses
embedding equality, diversity and inclusion	17.97%
taking a holistic approach	32.89%
offering a flexible and responsive service	58.51%
deploying a wide range of approaches	39.01%
providing a timely service	58.51%
improving access to the service	53.73%
improving recovery rates	24.67%
communicating strongly	12.43%



Question 4

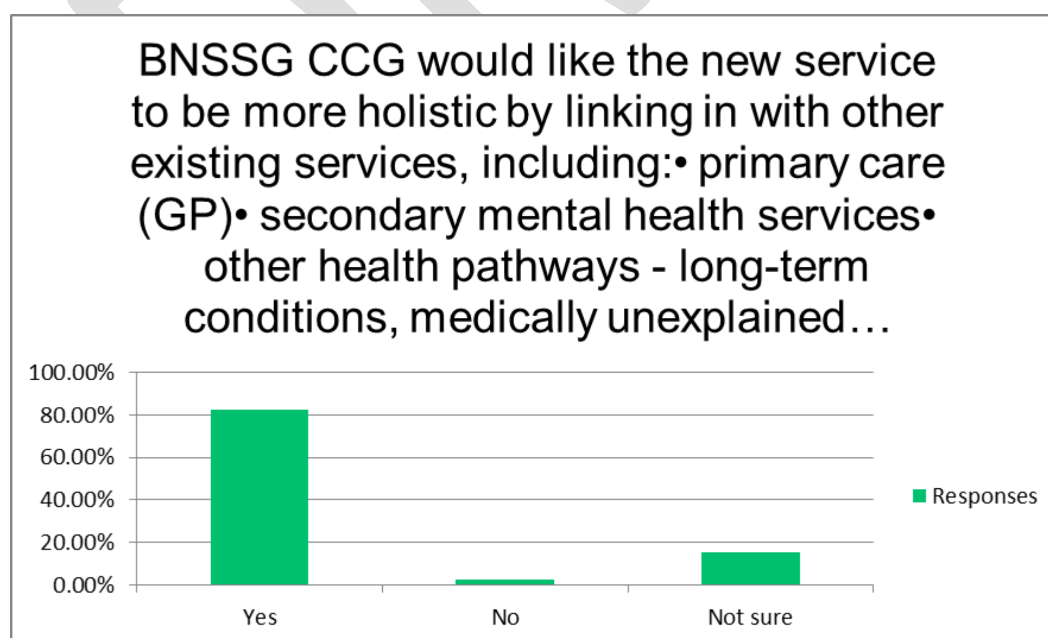
Feedback on the future of IAPT (talking therapies) services

BNSSG CCG would like the new service to be more holistic by linking in with other existing services, including:

- primary care (GP)
- secondary mental health services
- other health pathways - long-term conditions, medically unexplained symptoms etc.*
- perinatal mental health pathways*
- social care
- wellbeing and healthy lifestyles provision
- social prescribing
- welfare rights/debt advice
- housing and homelessness services
- sexual violence services
- substance misuse services
- employment and job retention support

*Note – A pathway can be defined as an evidence-based approach to health and social care services a patient in the UK receives after entering the system during a particular episode of care. Implementation of care pathways has been shown to reduce variability in clinical practice and improve health outcomes for people. Is this an approach you agree with?

Answer Choices	Responses
Yes	82.36%
No	2.40%
Not sure	15.23%



Based on your experiences, how do you think this more holistic approach could work and are there any changes you would make to the list above?

Overview

- Many respondents were very positive about a more joined-up system,
- But some pointed out that this question was not at all clear. What kind of links are we talking about? Did it refer to links in to IAPT or on from IAPT?
- Being clear about the links we were talking about was felt to be important to the commissioning as well as this survey. As one respondent put it, 'the links will only happen if they are commissioned for.'
- There were also concerns about this approach, that:
    - more emphasis needs to be placed on the quality of the therapeutic relationship itself rather than linkages;
    - data handling could be an obstacle;
    - we must not create inflated expectations, for example making patients imagine that IAPT services have any power to influence housing;
- there was strand of thought that suggested that IAPT itself was not best placed to be the hub

Better links **to** IAPT

- Many thought this seemed like a good approach. And several said they liked the list. There were some specific additional linkages:

social care	speech and language therapy service	physical health	teachers
employers	education	domestic abuse	bereavement
social isolation	community workers	physiotherapy	Long term conditions
Prison/probation service	Carers' support	Crisis team	Children's centres

- several respondents argued that we need to open IAPT by
    - for example through training and education of 'first point of contact' staff about 'early warning signs', and
    - Wider information to GPs and others about IAPT
- there was a view that a wider range of professionals should be able to refer in
- others suggested a **single point of access**, with IAPT as one possible destination, made the most sense to manage 'in links' to IAPT

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Better links from IAPT

- Many respondents voiced a view that IAPT needed to link on effectively to its 'bread and butter' connections – **especially to secondary care**. In support of this view, respondents raised concern about patients – themselves and others - who:
    - were deemed not ill enough for secondary care but who present with a symptom – such as hearing voices – which bars them from IAPT;
    - were in IAPT but for whom IAPT-style interventions are not appropriate;
    - were 'in the void' after IAPT.
- Beyond this 'bread and butter' linkage, wider linking work was felt to be high-skill: suggestions included distinct signposting workers in IAPT as well as broader information provision
- Tension around whether this type of on-linking should 'be 'fire and forget' or whether the IAPT worker should be case holder.
- Some felt that embedded pathways were more appropriate than signposting

Comments on the principle of linking as a whole

- Others were more sceptical, arguing that
    - more emphasis needs to be placed on the quality of the therapeutic relationship itself rather than linkages;
    - Data handling could be an obstacle
    - we must not create inflated expectations, for example making patients imagine that IAPT services have any power to influence housing

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Question 5

Are you a resident of...?

Answer Choices	Responses
Bristol	54.56%
North Somerset	20.12%
South Gloucestershire	20.12%
Prefer to self-describe	5.19%

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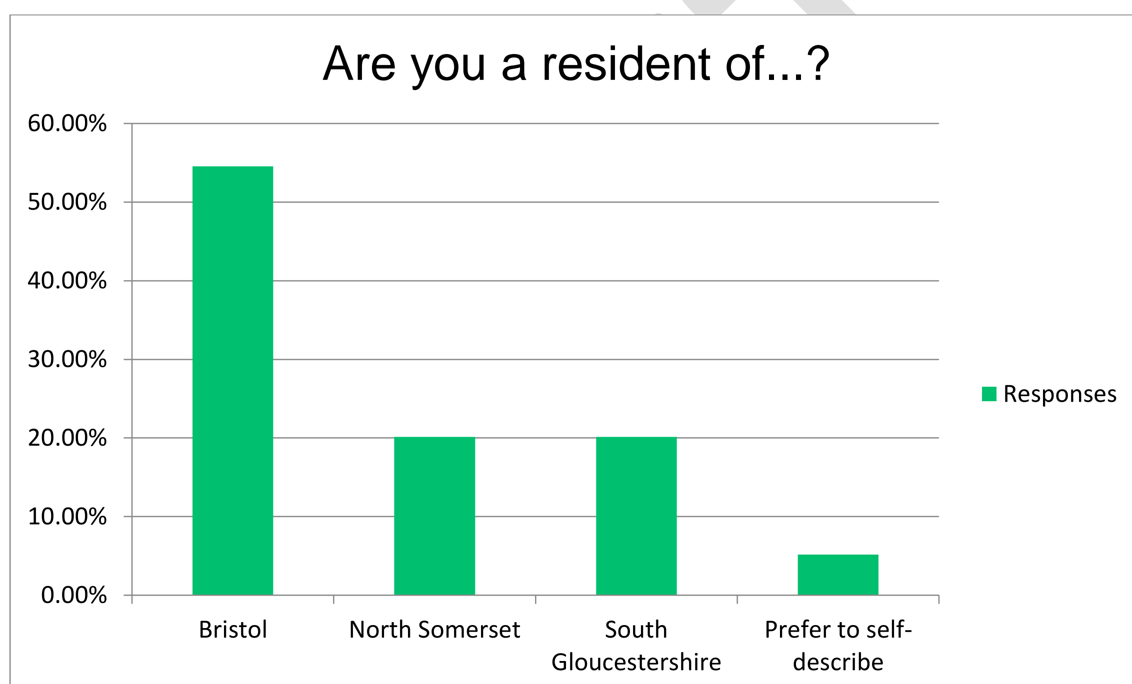

Others

Somerset x 6	Not a resident x 2
Somerset - work in Bristol	are you really thinking this will be communicated through BIMHN who's employees and paymasters are the CCG
SN12	
BANES x 6	Wiltshire
Trowbridge	Former Bristol resident x2
Bath	Former resident of Bath
None of the above.	

Q6 Please could you give us the first part (3 or 4 digits) of your post code (for example BS36 or BS3)?

BS5	55	BS9	21	BS24	11	BS20	8	BS32	9
BS7	48	BS10	20	BS11	10	BS23	12	BS36	6
BS16	46	BS48	17	BS21	12	BS2	8	BS49	5
BS3	36	BS37	15	BA2	17	BS30	8	BS24	4
BS4	35	BS22	12	BS14	9	BS1	9	BS41	2
BS15	27	BS6	18	BS35	9	BA1	6		

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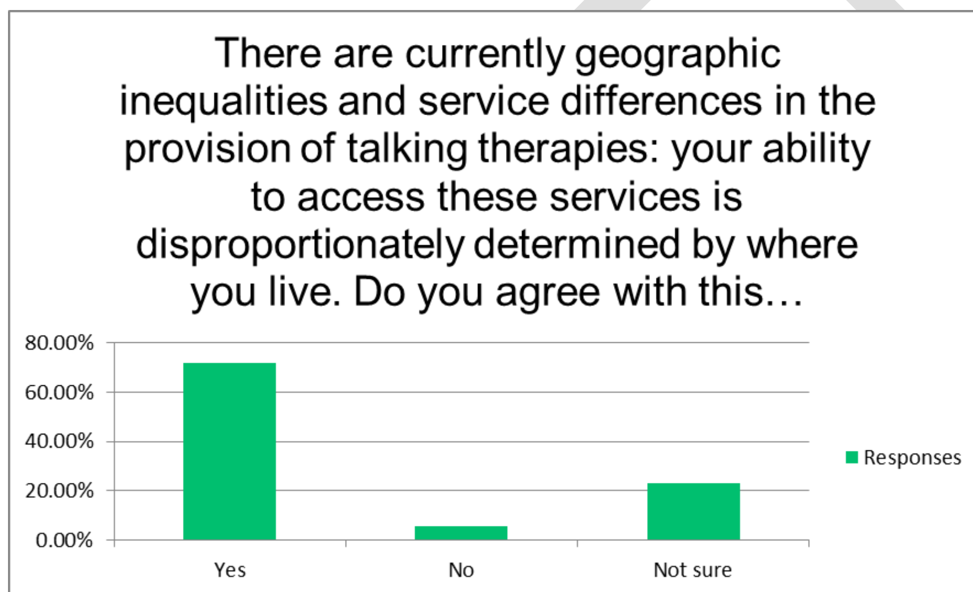
Q7 There are currently geographic inequalities and service differences in the provision of talking therapies: your ability to access these services is disproportionately determined by where you live. Do you agree with this statement?

Answer Choices	Responses
Yes	71.58%
No	5.39%
Not sure	23.03%
Based on your experiences, what could be done to improve this in a new service?	



Based on your experiences, what could be done to improve this in a new service?

Information

- Better information is seen as vital to improve geographic equality – through GPs, surgery noticeboards and social media

More outreach and access points

- Peripatetic practitioners
- IAPT practitioners in general practices
- More trained staff at first line so not everybody needs to get referred on to Bristol (or at all)
- Home visits
- Incentivise and support contractors to conduct outreach
- More access points, and more types of access points

A 'core plus satellite' model

- having one service which covers the county but then refers on to specialists
- first-line treatment in surgeries

A 'free movement' model

- Many respondents liked the idea of freedom to go to any service across BNSSG
- but there were also many concerns that the poor quality of public transport in Bristol would reinforce geographical inequality
- many thought it would be necessary to be near – or improve – bus routes

Remote therapy

- General negativity about therapy by phone, more positive views about online therapy

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Q8

The CCG want to take an approach to monitoring and improving the service that:

- sets local outcomes and performance indicators to satisfy national reporting requirements learns from the existing services;
- learns from South Gloucestershire's research pilot (link to more information?)
- adopts best practice from elsewhere;
- takes note of national guidance, research and review evidence;
- takes note of the experience of people who may / may not have used talking therapies services;
- takes note of the views of carers of people who may have accessed talking therapies services;
- proceeds by testing, exploring and experimenting

Is there anything else you would like to tell the commissioners about your experiences that would help develop a new talking therapies service?

Gap between IAPT and secondary mental health

- Many respondents urged for increased availability of alternatives to CBT
- One strand talked about the importance of IAPT treatment being contextualised within the wider mental health picture, e.g. 'Assessment is key. People need to be able to receive appropriate therapy as soon as possible rather than being "escalated" when the initial approach is clearly inadequate'.
- 'I think IAPT services should work more closely with secondary care services. Psychological services covering both primary and secondary care should be jointly managed.'

Timeliness

- One of the largest concerns. Waiting times are seen as a huge issue. As one respondent puts it 'A lot can happen to a human in six weeks.' There are many more stories that illustrate the cost of long waiting times.
    - One constructive response here: 'While waiting you could provide some self-management advice and basic mindfulness and CBT advice'.
    - Another important point about the importance of not 'punishing' DNAs:
        - 'Attending an appointment is a massive deal and a huge stretch for some people with mental illness. Not attending the appointment doesn't mean I don't want or need the service, it means that the service is not flexible enough to meet my needs'.

Comments on measurement: more integrated and qualitative

- Suggestion that monitoring and evaluation needs to be integrated with wider mental health picture
- Numerous voices for qualitative approaches – talking to practitioners, patients and voluntary sector groups to learn what is happening – or learning about patient experience in a person-centred way

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- Scepticism about outcome-focus:
    a. **undermine accuracy**
        - outcomes can be 'gamed' look good (people singled out PHQ-9 and GAD-7 questions for criticism)
        - one respondent gave a live example of their CBT practitioner gaming evaluation forms
    b. **undermine therapy**
        - sense that 'box ticking' is happening erodes therapeutic relationship
        - patients needing long-term intervention become alarmed that they won't fit

Other General comments

- Learn from the South Glos pilot (not consensus - one respondent emphatically said we should be wary of it)

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Q9 – What is your age?

Age	%
Under 18	0.21%
18-25	7.14%
26-35	23.74%
36-45	27.73%
46-55	23.74%
56-65	12.18%
66+	2.94%
Prefer not to say	2.31%

Q10 – Do you consider yourself to have a disability

Response	%
Yes	27.10%
No	67.44%
I prefer not to say.	5.46%

Q11 – It helps us to know whether we are reaching all disabled people. Please can you tick the relevant impairment (disability) group below, and you are welcome to tick more than one box if appropriate

Impairment group	%
Physical	31.75%
Sensory	9.52%
Learning difficulties/ disabilities	11.11%
Mental ill health	73.02%
Long term condition	51.59%
I prefer not to say	1.59%
Prefer to self-describe	11.11%

Self-description

- Persistent fatigue caused by depression
- ME/Chronic Fatigue Syndrome, Anxiety
- Autistic
- Asperger's
- like I aid
- chronic fatigue

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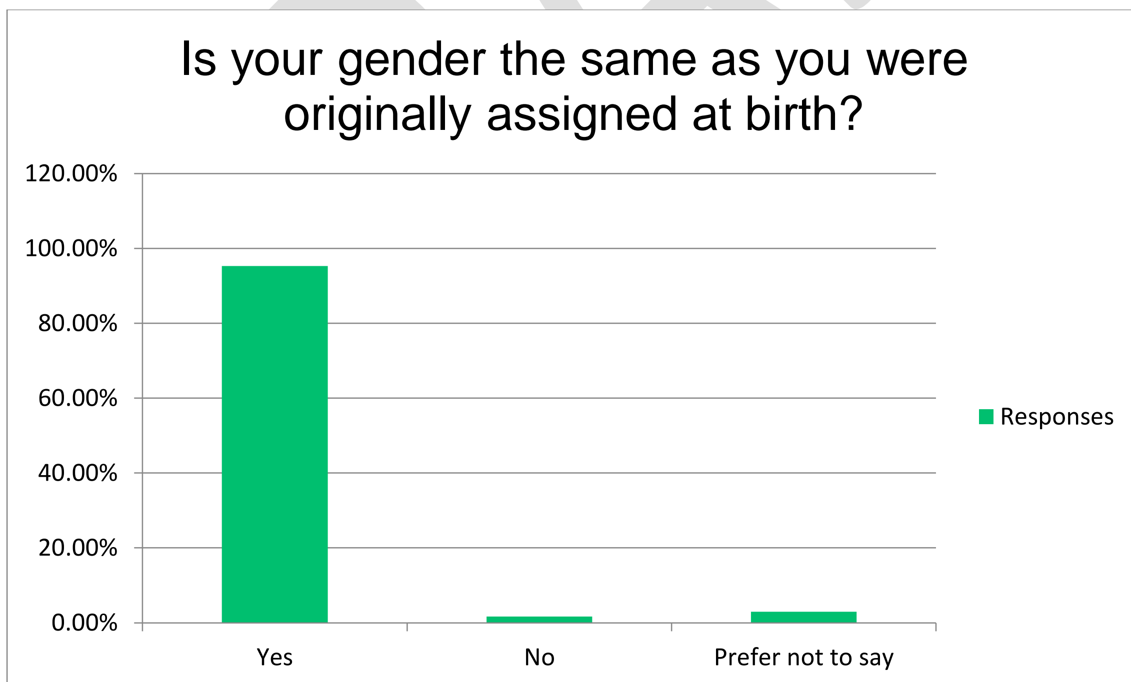
- Asperger's, eating disorder, body dysmorphic disorder, substance abuse and self-harm. Chronic anxiety and hypervigilance. For over forty years.
- As above plus minor brain injury.
- Problem with eyesight which is worse when I get upset or stressed.
- Autism
- had depression since I was a child, anxiety and may have Asperger's/autism
- Dyslexia and mild hearing loss
- Neurological
- This is an out of date way of thinking and doing we are all different human beings that have different needs and diff experiences and learning and treating each other with full respect and responsibility and accountability and true meaningful understanding to different experiences of life experiences and a true none judgment services for all and staff as well and management testing are responsible and how we treat each other and having a true meaningful solution is key at every levels of a service and clear 100%

Q12 – Is your gender the same as the one you were assigned at birth?

Answer Choices	Responses
Yes	95.35%
No	1.69%
Prefer not to say	2.96%



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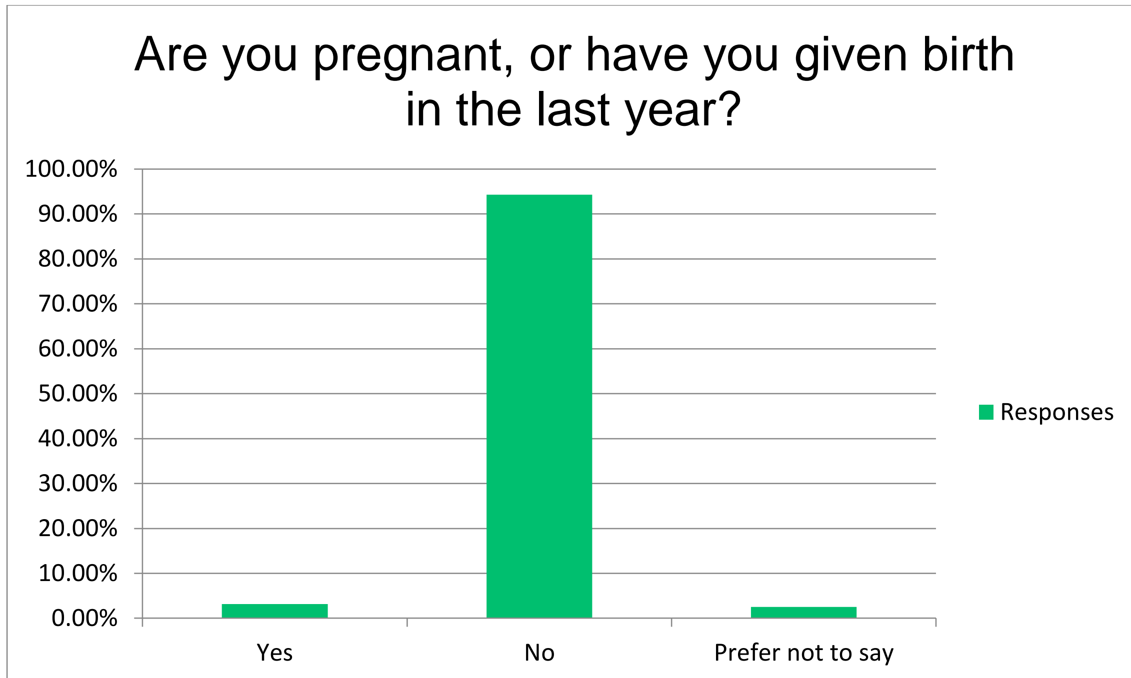
Q13 - Are you pregnant, or have you given birth in the last year?

Yes	3.17%
No	94.29%
Prefer not to say	2.54%



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Q14 - What is your ethnic group?

Answer Choices	Responses
Indian	0.00%
Pakistani	0.00%
Bangladeshi	0.00%
Any other Asian background	0.00%
Caribbean	0.85%
African	0.00%
Any other black background	0.00%
Chinese or other ethnic group	0.00%
White and Black Caribbean	0.21%
White and African	0.21%
White and Asian	1.06%
Any other mixed background	1.27%
White British	84.36%
Irish	1.27%
Any other white background	5.71%
Prefer not to say	4.02%
Prefer to self-describe	1.06%
Answered	**473**
Skipped	**234**

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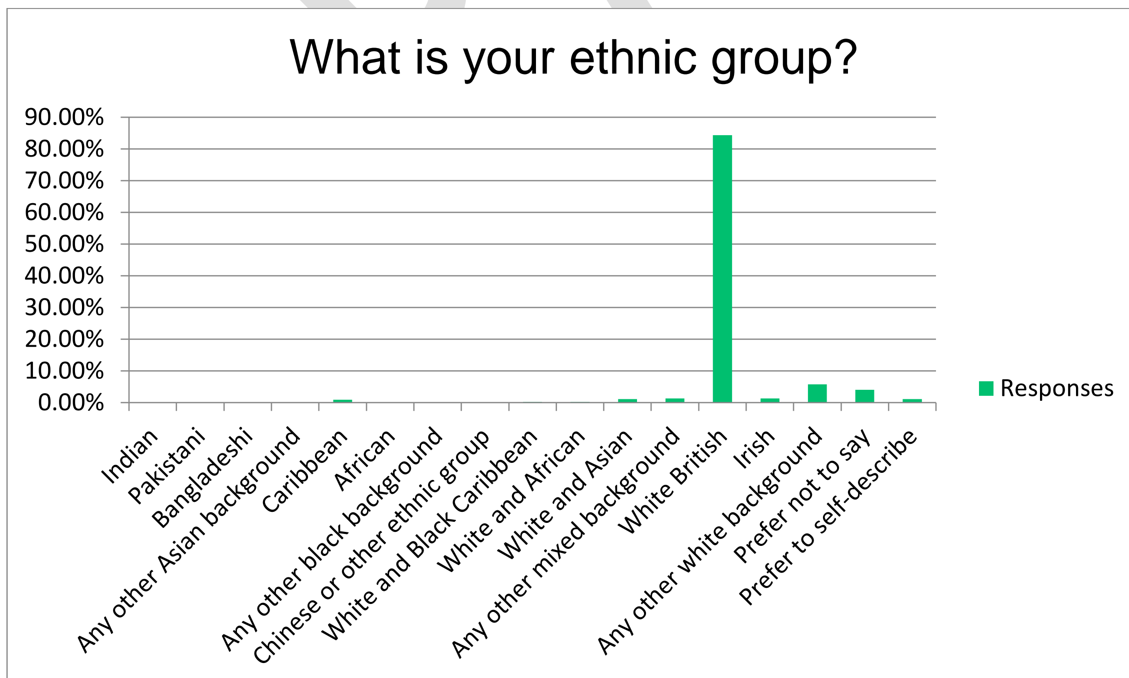

Self-description

- I'd prefer to be screened for my working class status and answering question about parents education level
- Welsh
- Afro Carib euro Celt
- Irish and Jamaican
- Black
- Half Filipino and half Mauritian
- We are all human beings but different in our own way and no one had any rights to make any judgment we don't have that human rights in any way it's the evil systems that put us against each other and take us apart this needs a big changes in all services we are all human beings but we have different needs and experiences and should learn to cope and respect each other's difference and be open mind

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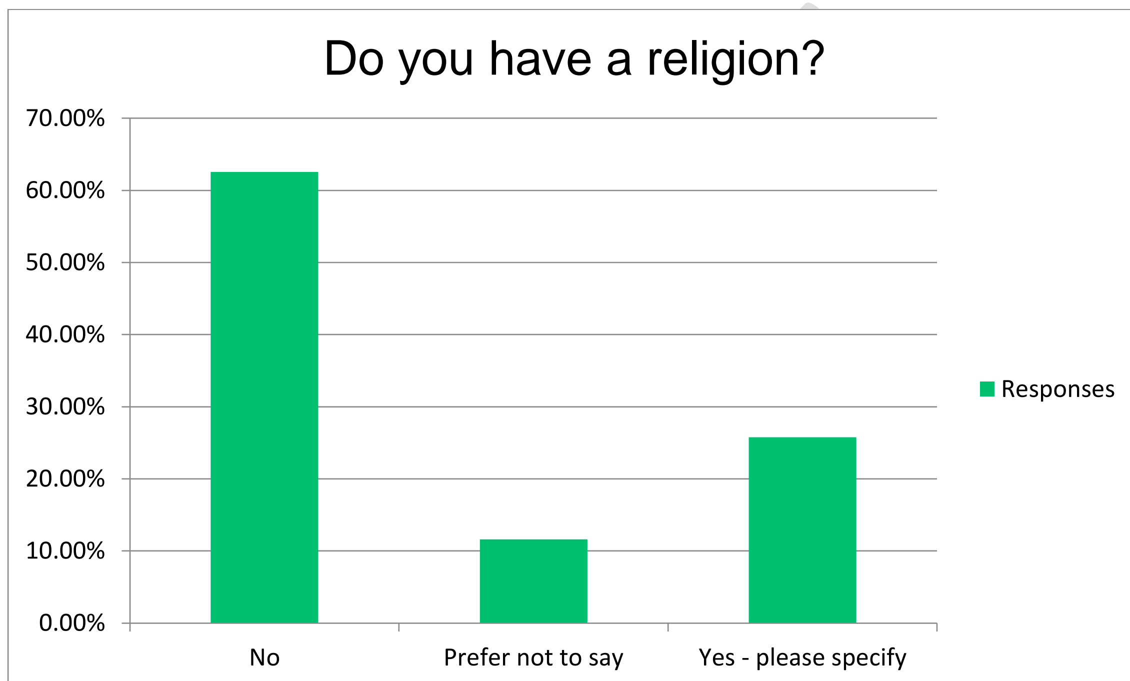
Q15 - Do you have a religion?

No	62.58%
Prefer not to say	11.63%
Yes - please specify	25.79%



Christian	74
Church of England	21
Catholic	15
Buddhist	8
Quaker	4
Pagan	3
Spiritualist	2
Other	10

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Q16 - Do you identify as

Female	86.89%
Male	7.82%
Non-binary	1.90%
Trans	0.42%
Prefer not to say	2.75%
Prefer to self-describe	0.21%

Self-description

Genderqueer

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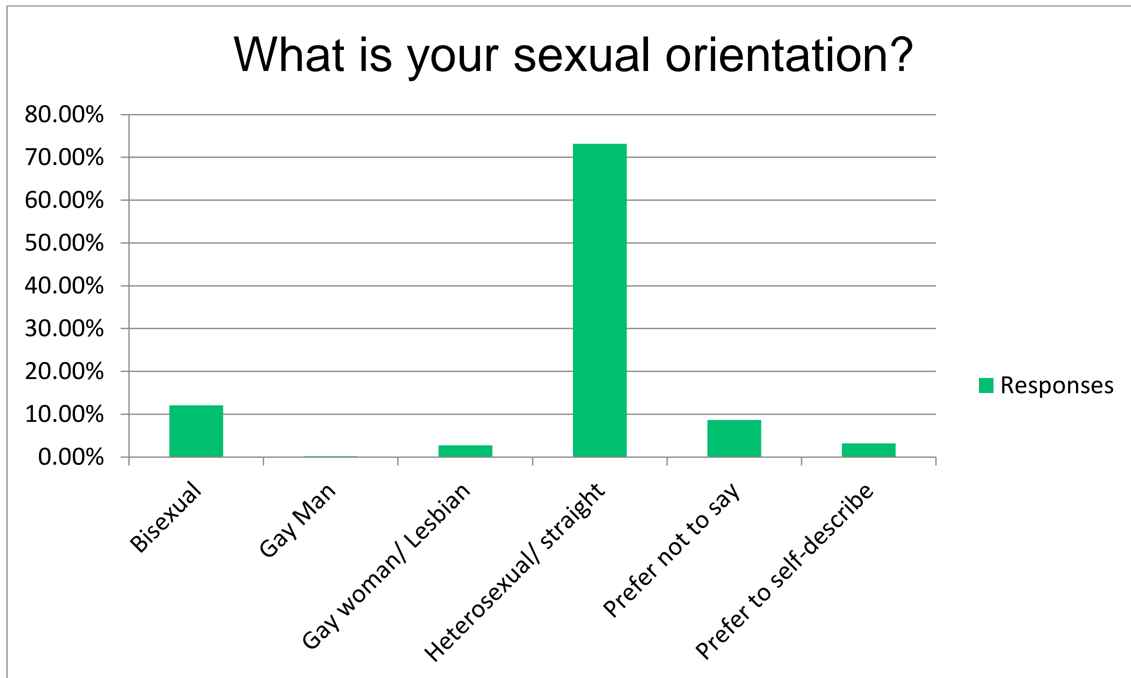
Q17 - What is your sexual orientation?

Bisexual	12.05%
Gay Man	0.21%
Gay woman/ Lesbian	2.75%
Heterosexual/ straight	73.15%
Prefer not to say	8.67%
Prefer to self-describe	3.17%

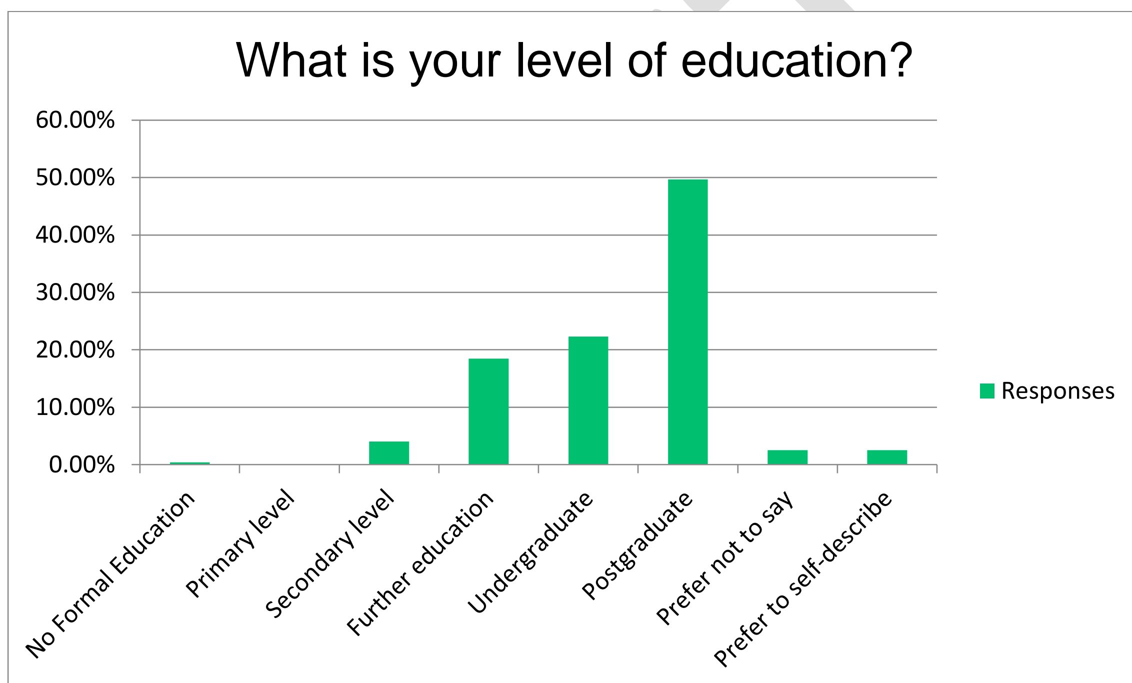


Self-description

Pansexual	4
Asexual	3
Queer	4
Other	2

Q18 - What is your level of education?

No Formal Education	0.42%
Primary level	0.00%
Secondary level	4.03%
Further education	18.47%
Undergraduate	22.29%
Postgraduate	49.68%
Prefer not to say	2.55%
Prefer to self-describe	2.55%

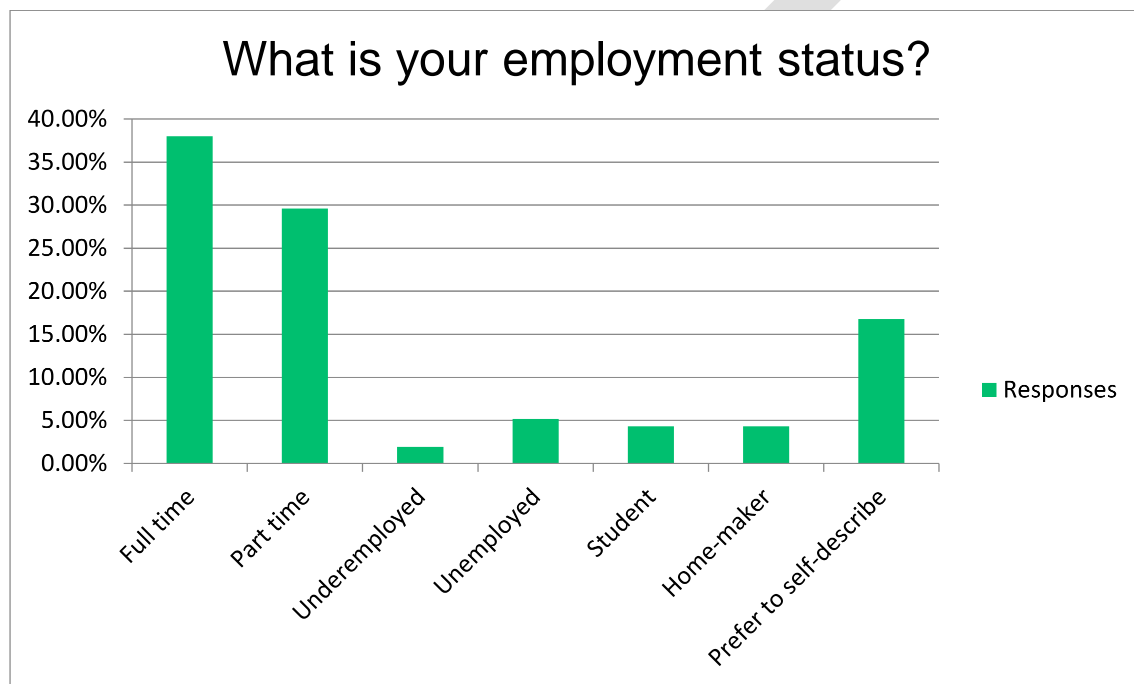


Self-description

Master’s Degree
Trained as a registered nurse.
Masters
My Educational qualifications would be totally outdated now
Completing level 5 diploma in health and social care
Bed English
Undergraduate, currently suspended from study due to MH illnesses
RGN
Just started university
degree level
professional
Have many different specialist hands on real social life experiences and work with many different groups and projects across the UK ???? for 35 years ??

Q19 - What is your employment status?

Full time	37.98%
Part time	29.61%
Underemployed	1.93%
Unemployed	5.15%
Student	4.29%
Home-maker	4.29%
Prefer to self-describe	16.74%



Self-description

Retired	23
Self employed	17
Carer	9
Health	9
Disabled	7
Student	5
Unable to work	4
Long term	3
Prefer not to say	3
Depression	2
Homemaker	2

Appendices

Methodology

- This report represents a collation of responses to three iterations of the same survey, as follows:

Iteration	Launch date	Respondents
1	1-11-17	92
2	2-1-18	152
3	3-1-18	707

- The feedback from two voluntary sector consultation meetings held in December 2017 – as well as an earlier Care Forum consultation in 2015 – as well as the responses from focus groups organised by the following providers:
  - Rethink
  - Carers' Support Centre
  - WECIL
  - Gypsy, Roma, Traveller team

- Combining the numerical responses to three separate surveys presents problems at the analysis stage as answers are not always commensurable. Where possible, numerical answers have been aggregated. Where impossible, numerical answers from survey v3 have been noted. All qualitative input has been read.

- The proportion of respondents educated to postgraduate level is around 50%, which seems exceptionally high. Without further research it would be difficult to say whether this reflects the difficulty of the survey or the difficulty of accessing IAPT.

- It has not been possible within the time allotted to 'slice' answers according to protected characteristics, post code etc. This remains theoretically possible for questions of particular interest.

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