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Clinical Innovation: IAPT Complex Cases Pathway

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Commissioning the pathway

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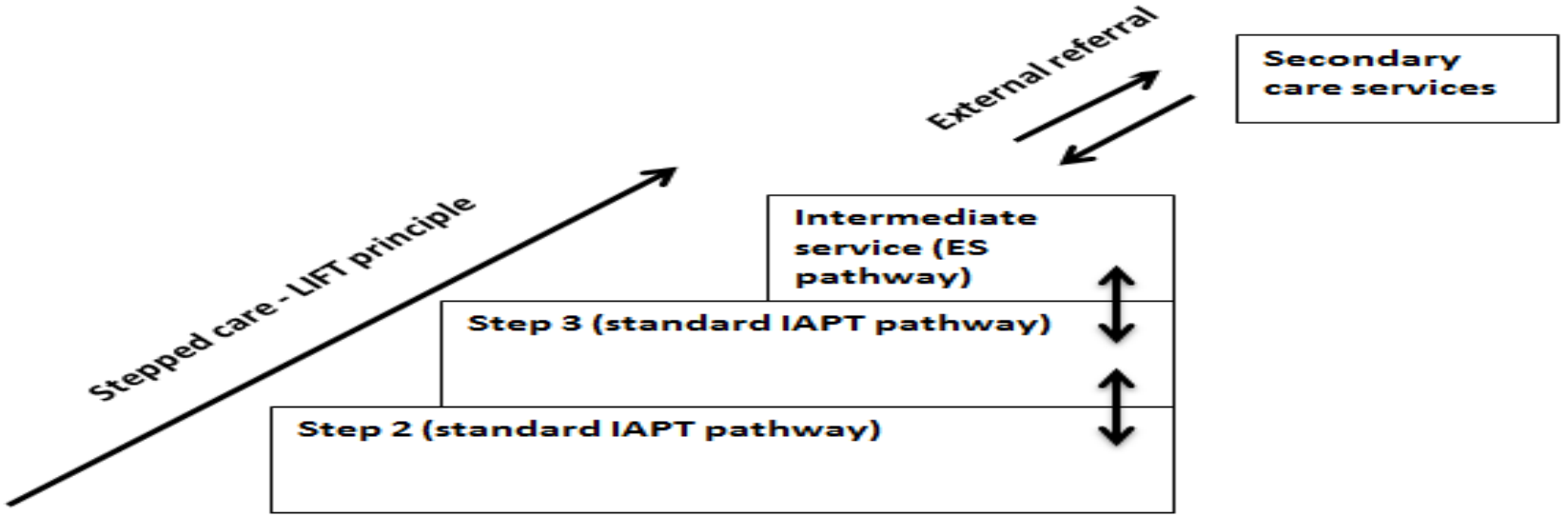
- The initial need for a complex case pathway within IAPT was recognised as a number of referrals did not ‘fit’ the traditional IAPT service structure or those of the secondary care services.
- A business case was developed to illustrate the need and benefits of the pathway.
- The service development need was presented through meetings with CCG representatives.
- The clinical need was mapped out through an initial scoping exercise.

Initial Concept

- A broad concept for the service was generated to match stepped care principles.



Treatments considered

- EMDR & CBT for complex trauma presentations.
- DBT skills group for emotional regulation.
- Compassion focused therapy group
- Assessment & formulation with psychologists, with some service users progressing into ‘multi-model’ one-to-one therapy.
- Support from Psychiatry and Mental Health Practitioners.

Commissioning process

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- A detailed business plan was created including costings and a suggested staff mix for the service.
- After consideration of the business plan with commissioners, a budget allocation for service development was agreed.

Who is the Complex Case Pathway designed to support?

- Clients who present with common mental health problems that have greater chronicity or complexity than would be typically seen in an IAPT service
- Including clients who require idiosyncratic formulation (which would fall outside the manualised IAPT offer), and present with multiple co-morbidities
- Typically treatment may be trans-diagnostic in approach

Typical Presenting issues

- Complex multiple trauma
- Emotional and behavioural dysregulation
- Dissociative difficulties
- Moderate or chronic self-harming behaviour, but not severe or life threatening self-harm

Indicators of Complexity

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- 2 previous evidence-based psychological interventions relating to similar presenting issues
- Typically present with severe long term interpersonal complexity, including;
  - History of negative interaction with services
  - Difficulties with managing emotions safely
  - Difficulties establishing or maintaining positive relationships
- Multiple co-morbidity
  - e.g. ASD Spectrum disorders, health complexity, ADHD, Anger, Narcissism, multiple diagnoses
- Social instability;
  - finical, housing, difficult family dynamics, chaotic lifestyle

Barriers to Engagement

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- Changes in the pattern of self-harming behaviour
  - Increase in severity or frequency of self-harming behaviour
  - Change in pattern of self-harming behaviour
  - Change in methodology of self-harming behaviour
- Need to be able to attend regular appointments
  - Some flexibility in attendance policy, however rationale for any variations from policy need to be clearly documented

Complex Case Staff Mix

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- Clinical Lead & Team Manager – shared across all steps of IAPT service
- Psychiatry 1 day a week
- 4 Senior Clinicians:
  - 2 Clinical Psychologists
  - 1 Counselling Psychotherapist
  - 1 Senior CBT therapist working towards EMDR consultancy
- 2 Mental Health Practitioners

Psychiatry Role

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- Psychiatric/diagnostic assessment of complex presentation
- Medication review
- Shared risk assessment and management
- Input into staff training, supervision, consultation
- Liaison with physical health & mainstream psychiatry services
- Not a standalone intervention or replacement for out-patient psychiatry – aim to facilitate talking therapy

MHP Role

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- Needed to be mindful of limited resources of MHP and how to utilise this support to most effect
- Training and development of DBT skills for MHP support role
- MHP role can support clinicians at any step of service
- Provided staff training on how to identify presentations that may require additional support/assessment such as Personality Disorder, Bi-Polar Disorder, Psychosis, etc.

MHP Role

- Triage professional referrals
- Contribute to daily MDT meeting consultation
- Majority of work is co-working with a treating clinician
  - Mental health assessment and stabilisation
  - DBT skills such as emotion regulation & distress tolerance
- Some complex assessment of those whom ability to engage with talking therapy is limited by social instability
  - Do not provide generic mental health assessment to all
  - Aim is to facilitate engagement in talking therapy rather than stand alone treatment

Clinical leadership

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- Shared team management
- Daily MDT
- Development of local operational procedures, treatment option guidance, local risk protocol
- Development of service pathways
- In development – complex case assessment clinics
- Development of DBT skills group
- Focus on staff wellbeing
- Development of monthly CPD plan

Shared Team Management

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- 3 Team Managers share management duties for Step 2, Step 3, and Complex Case Pathway
- This ensures
  - good communication,
  - shared decision making,
  - ability to provide effective cover for each team,
  - leads to team cohesion
- “We’re all in this together” approach V’s Splitting between services
  - NB when working with clients with complex presentations and a history of negative interactions with services

Daily MDT lunch time meetings

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- Daily drop in session for all staff
  - Face to face or by telephone
  - Attended by Clinical Lead, Team manager, MHP
- For discussion of triage decisions, assessment outcomes, movement to Complex Case pathway, MHP OR Psychiatry involvement, clinical “stuck-ness”, or discussion of next step in care plan
- Open transparent meeting where clinicians can receive consistent messages and any gaps in service provision or protocol can be identified and addressed

MDT – Development of LOG

- Initially oversubscribed, but gradual reduction over time as inconsistencies or need for further written guidance was identified & developed
- Differing views among senior staff on how best to respond to different presentations were identified
  - discussed in weekly Operational Meeting and consistent service response developed
- Lead to development of written guidance Local Operational Guidance (LOG)
  - coincided with development of Trust Wide Operational Policy
  - improved induction experience & confidence of existing staff members

MDT- Development of Treatment Options Guidance (TOG)

- Outlines all treatment options offered at each step of the service and criteria for these treatment options
  - E.g. individuals, groups, difference between Step 2 and Step 3 intervention for certain clinical presentations, etc.
- Aids triage, step up, step down, and step across internal referrals & understanding between clinician groups of each others roles
- Large team whom work in varied geographical locations, so improves communication between busy clinicians on developing treatment options available, including new groups, within the service

MDT- Development of Local Risk Protocol

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- Starts with “what’s your question?”
- Development of daily Duty Manager to respond to risk
- Development of Local Risk Protocol outlining local contacts and procedures in clear accessible format
- Improved clinicians' confidence, incident reporting and risk assessment and management skills
- Reduce risk factors for clients
- Development of pathways with other services

Development of Pathways

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- Identification of themes of inappropriate/incomplete referrals led to pathway meetings with other services to clearly communicate role of IAPT and Complex Case Pathway
  - Improved appropriateness of referrals & client expectations
  - Improved quality of professional referral information so more appropriate triage decisions could be made
  - Reduced need for triage staff to liaison with referrers/other services, reducing staff workload, and unnecessary delays in triage decisions
  - Reduced need for multiple assessment & improved wait time to treatment

Service Pathways Developed

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Regular meetings	One off meetings
MIND charity co-working	Health Visitors
Access Team- risk management & triage	Children's Social Care
Secondary Care Psychology Interface meetings	Physical health services; Dentistry, Diabetes clinic, MSK service
Older Adults Memory and Psychology services	RAID & Home Treatment Team
Healthy Young Minds (CAMHS) & Transitions Team	CMHT Team Managers
	Outpatient Psychiatry

In development – Complex Case Assessment Clinics

- For clients who may struggle to access lower steps without first developing a comprehensive formulation and treatment plan
  - May then be seen by another clinician for discrete piece of work, e.g. Sleep hygiene, TF-CBT, etc.
  - Can be reviewed by senior clinician after discreet piece of work

Benefits to Service

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- Reduces stress & burn out at Steps 2 and 3 where clinicians may feel under qualified to appropriately assess and formulate clients with complex presentations
- Improves clinician confidence to work on “discrete piece of work” within complex presentation, with clear indicators of how to assess deterioration requiring further input
- Also allows senior clinicians to discuss issues such as dependency on services, therapy interfering beliefs or behaviours, or ambivalence around change or endings
  - Improving client motivation & engagement and reducing drop out

Benefits to Clients

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- Improves motivation & engagement through validation and comprehensive assessment, so feel understood
- Reduces sense of being “bounced around services” because clients feel held by senior clinician
- Allows complex clients to make use of appropriate steps in care model in a formulation driven pathway
- Hopefully this will lead to improved outcomes for clients!

Skills Only DBT group

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- Development of content, risk agreements, therapy contracts, and resources – very boundaried
- Support from senior management to undertake pilot
- Training and development of staff skill set and supervision
- Evaluation and involvement from research department
- Complexity absorption, supports client who would otherwise struggle to find appropriate service for their needs
- Results encouraging so far

Focus on staff wellbeing

- Audited staff wellbeing, compassion fatigue, stress and burn out
- To improve staff retention, reduce need for agency and multiple wind down and induction periods, reduce staff absence and improve performance
- Plan to repeat annually
  - Development of emotional resilience groups for admin workers, Step 2, and in development Step 3
  - Established Supervision of Supervision groups at all levels
  - Increased risk training to level 3 child safeguarding
  - Development of IAPT specific monthly CPD program

Development of CPD program

- Learning needs analysis results
- Recovery rates by diagnosis and profession
- Repeat themes identified in clinical supervision, managerial supervision or MDT
- 1 day a month for team meetings, peer supervision groups, team lunch and CPD
- Focus on team building, joint problem solving, and improving communication
- Feedback from staff members have been very positive

CCG Position

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- 2016/17 service redesign process
- Investment in ‘IAPT Plus’
  - Step 1 Wellbeing and Social Inclusion
  - Step 2/3 Core IAPT
  - Step 3.5/4 Intermediate Psychological Therapies
- Access, recovery and waiting time standards
- Next steps: IAPT-LTC, Psychological Medicine in Primary Care

IAPT Access

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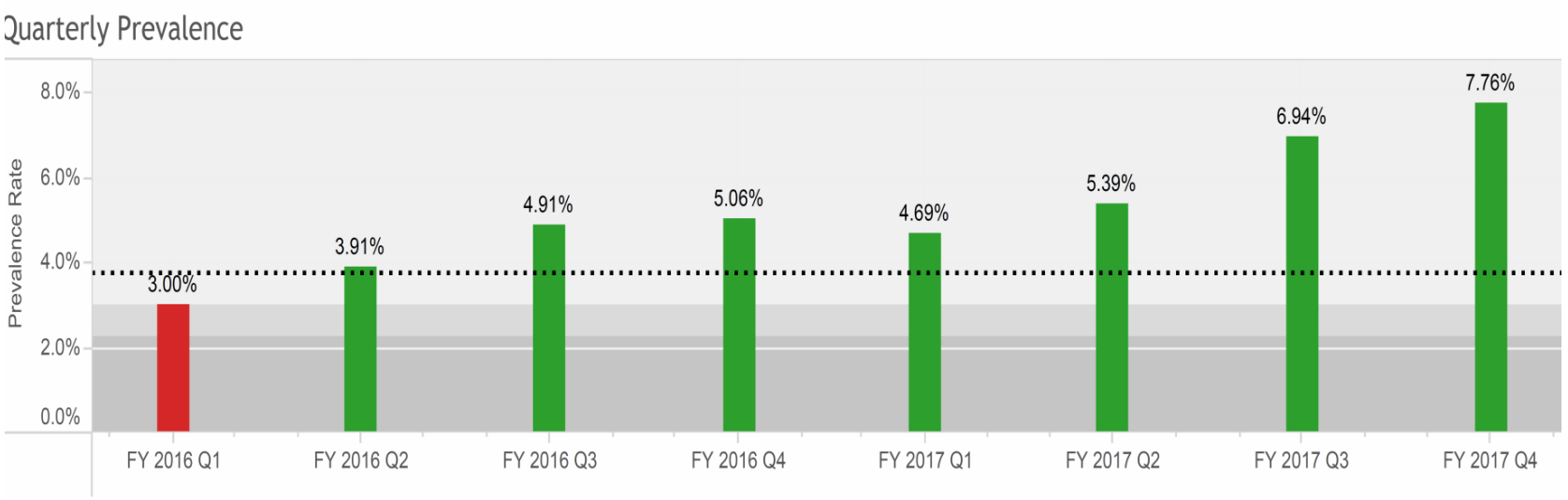

IAPT Recovery

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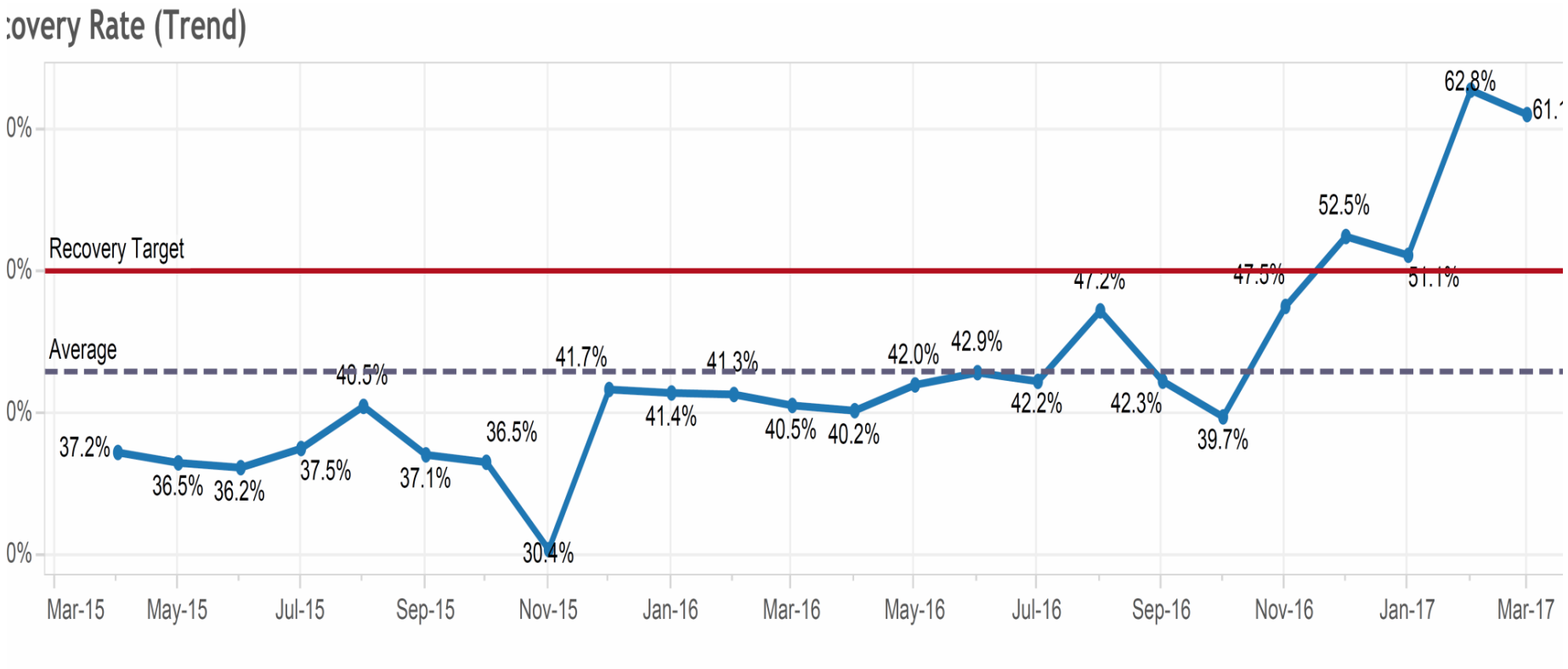

IAPT Waiting Times

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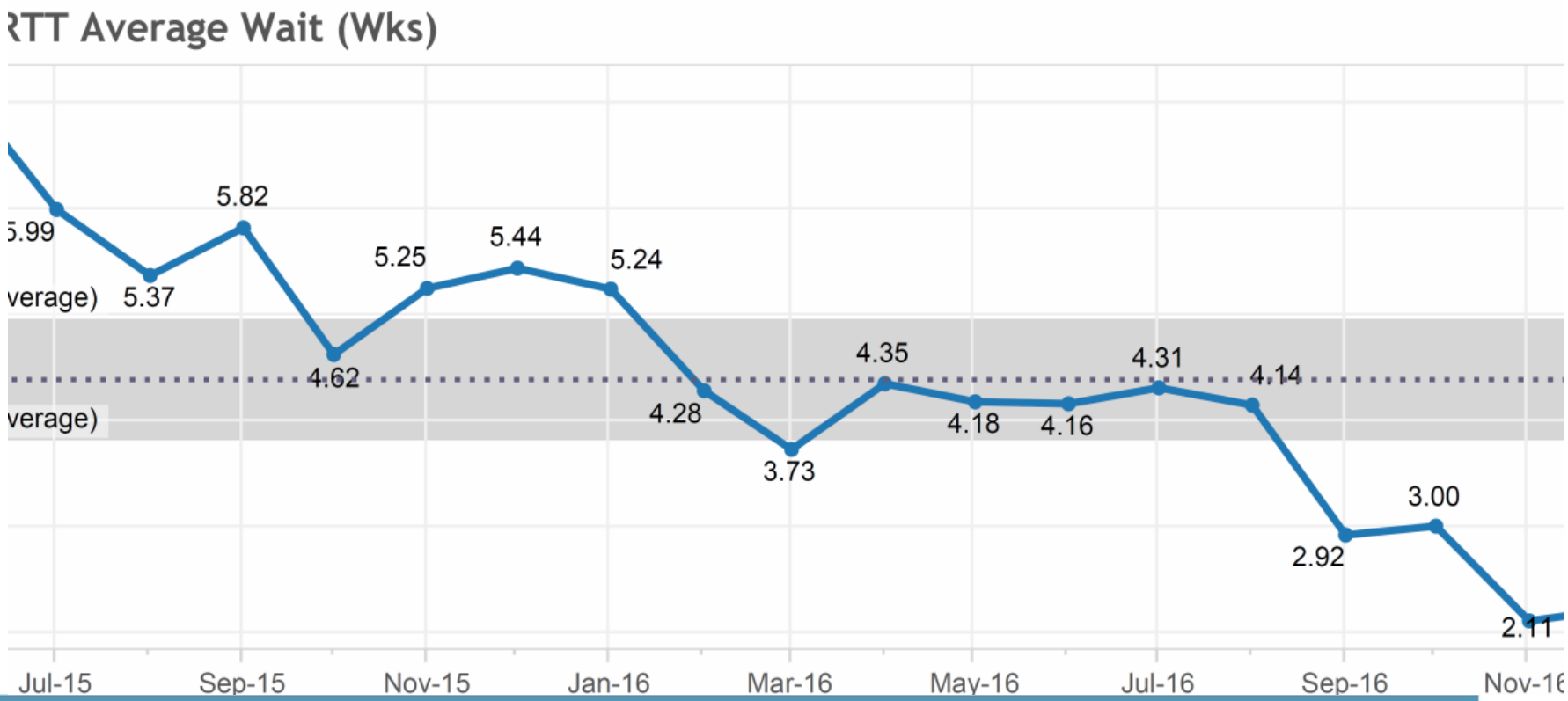

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