NHS
Yorkshire and the Humber
Clinical Networks

Older People in IAPT Conference 22.06.17

Q&A Summary

1. **Question to Beverley Costa: How do you get people to come to your service initially and how do you promote yourselves to hard to reach communities?**

We have built very strong relationships with other health care professionals who are working in hard to reach communities. Professional staff are then able to promote the services offered. Networking and building relationships with professionals is essential to increasing access and promoting the service.

2. **Question to Beverley Costa: How do you counsel people within families where their cultural values clash to the point of possible radicalisation?**

Cultural clashes and intergenerational clashes do occur and so we have developed specific cultural and couples counselling. Regarding radicalisation this is a product of marginalisation, which leaves people vulnerable to gangs, addictions etc. We try to work at a preventative level by helping families, parents and children to work together and integrate.

3. **Question to Beverley Costa: Do therapists have training in understanding variances within similar cultures for example, Sunni and Shia Muslims and how do you ensure translators are impartial to specific religious or cultural differences?**

It is useful for our therapists to have some background information of differences in cultures but as long as our therapists show they are interested, curious and collaborative with each patient that is more important. Regarding interpreters it is very important that we source someone who is culturally and religiously impartial.

4. **Question to All Speakers: What support is available for a person who suffers from loneliness and depression and is housebound with no family?**

It is essential for all IAPT services to map out what is available in their locality, for example befriending services, and connect with these services. Knowing what is on offer in a locality and ensuring staff are aware of this is essential. Additionally, Public Health England have included combating loneliness within their strategy so more information and ideas about support will become available.

5. **Question to Manreesh Bains and Heather Stonebank: Did you have any contact with voluntary sector organisations or social prescribing to help with your research?**

In terms of recruitment for the research groups we did not involve the voluntary sector or social prescribing organisations. However, in the last session of the overcoming worry

groups we do work with the voluntary and community sector to provide patients with relevant information regarding activities, such as a walking group, that they may have expressed an interest in throughout the sessions.

6. **Question to Louise Unitt: How do you ensure your materials are accessible for people with sensory impairment?**

We assess each patient individually and based on need we will then change our materials accordingly. For example, if a patient has a visual impairment we will ensure materials have an enhanced font. Additionally, we also work with the voluntary and community sector to support services to meet the sensory needs of patients in the best possible way.

7. **Question to All: Clients who are bereaved find the completion of PHQ 9 and GAD 7 measures can make them feel worse. Please will IAPT recognise the need for a measuring tool for bereavement that could be included in clinical systems as an alternative to PHQ 9 and GAD 7?**

PHQ 9 and GAD 7 are symptom measures that are an essential part of the IAPT dataset. When using the measures with people who have been bereaved you should talk to them about the measures and relate them to bereavement, use them carefully and clinically to best effect. Outcome measures ensure that care is transparent and we can identify any potential issues with access, waiting times and recovery. The dataset means questions about mental health can be researched in England unlike anywhere else in the world.

8. **Question to Alison Hobbs and Louise Unitt: Regarding volunteers working in your IAPT service is there a specific specification on what they will do?**

There isn't a national specification for IAPT volunteers. However, within the Tees, Esk and Wear Valley Trust there is a team that helps to design volunteer roles. The person specification and job description for our IAPT volunteers is on NHS Jobs.

9. **Question to Manreesh Bains and Heather Stonebank: In your opinion to what extent is the inequality older adults experience in mental health services due to mental health workers preconceptions about older adult patients? How best do we overcome these preconceptions?**

Before I worked with older adults I had a preconception that it would be a miserable job, however, having worked with older adults I can say I absolutely love it. Training is the key to breaking down preconceptions, working with trainees and PWPs to talk about confidence levels when working with older adults and discussing stereotypes breaks down preconceptions. Also having people work with older adults, sharing those experiences and celebrating successes breaks down barriers.

10. **Question to Alison Hobbs: What practical steps do you find helpful to enable older people to access IAPT services, given that North Yorkshire includes sparsely populated areas and not everyone is independently able?**

We assess each patient individually and based on need we will then ensure care is tailored accordingly. We are hopeful that the development of volunteers within our service

will also help with enabling access and we are looking to co-locate our services with other older adult services.

11. **Question to All Speakers: Do you have experience of integrating psychological therapies with physical healthcare services?**

The national Integrated IAPT scheme is focussed on integrated mental health and physical services, including co-location of these services. Integrated IAPT will focus on patients with long term conditions and services are learning to use a different language when presenting psychological therapies to people in a physical healthcare setting, as this is key to being effectual.

12. **Question to Joanne Woodford: Do you have any thoughts on how to overcome carer's perceptions/guilt about accessing mental health services?**

I think working directly with carers to understand how to make services more accessible is essential. Also working with services who already work with carers will enhance our understanding of the barriers and how to mitigate against them.

13. **Question to Dean McMillan: Why did you exclude people with a terminal illness from your study?**

I'm unsure to be perfectly honest. We tried to keep as many people in the study as possible and if we did the study again we would include them.

14. **Question to Alistair Burns: Should we be considered as old at 65 bearing in mind the increase in life expectancy should this now be increased?**

An interesting question for further consideration.

15. **Question to Alison Hobbs and Manreesh Bains: Will IAPT services work with people who have suicide ideation, past or present? If not why not?**

Yes, IAPT services do work with risk. Risk is a fundamental part of the service. However, if a person is so at risk we do not offer therapy rather we ensure they are referred to the appropriate service until they are ready to access IAPT services and care can be provided safely. IAPT services see patients with mild to severe issues and if a person has suicide ideation, but can be safely managed by a therapist, then they can remain in the service.

16. **What is the chance of flexibility around IAPT recovery rates for older people?**

None. The recovery rate for IAPT is 50% and this will not change for the foreseeable future.