NW Positive Practice into Action Launch Event 2020

Interactive workshop feedback

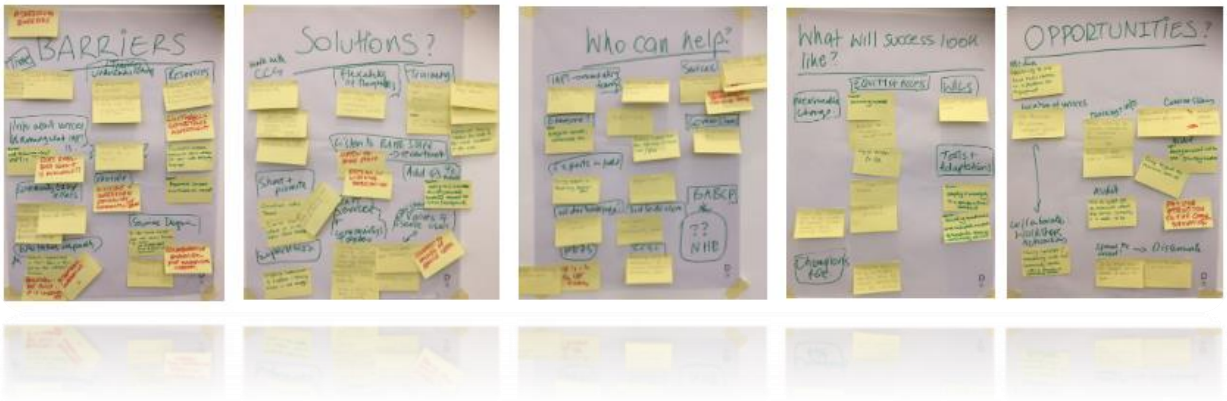

Figure 1. (L-R) Group 1 - 5

During the afternoon session, all delegates took part in an interactive workshop in which they were split into 5 groups to discuss the following topics surrounding IAPT:

1. **Barriers**
2. **Solutions**
3. **Who can help?**
4. **What will success look like?**
5. **Opportunities**

Feedback from group 1 - Barriers:

- Time – to be protected to develop this area from clinical work, time needed during sessions to clarify understanding
- Learning about cultures
- To secure BME training to develop staff skills
- No equality in training across IAPT
- Limited access to materials / resources in different languages
- Culturally competence assessment
- Assumed consent and withdrawn consent
- Translated outcome measures don't always fit well with every language
- Lack of resources asset-based community developed
- Nothing is for free
- Does everyone know resources are available?
- Not knowing what IAPT is

- Morale - Invisible and hopelessness demoralizes community
- Religious beliefs could be a barrier

Community based assets:

- Community places taken for granted
- Not many clinics spaced available in community settings

Who takes responsibility:

- Whose responsibility is this? Does it then fall on the individual clinician?
- Strategic imperative needed
- Good guide but only if it is implemented

Service design:

- If the service design doesn't allow flexibility e.g. data, number of appointments offered, time spent with communities
- Strict / rigid targets
- Collaborative empiricism – stop manualizing therapy

Feedback from group 2 - Solutions:

- Work with CCG's – Discuss monies generally
- Offer some flexibility with certain client groups (DNA policy, length of sessions,) adaptation of tools / interventions i.e. BA
- Flexibility of therapists – pre-therapy workshops, joint community projects

Training:

- Appropriate training needed for staff to feel more competent in this area,
- Tools for learning training resource,
- Clinicians go into natural gatherings,
- Put on new IAPT trainee programme
- Masterclasses
- Put on agenda for team meeting

Share and promote:

- Champions within teams
- Liaise with services where it is working well – share strategy

- Listen to BAME staff on recruitment
- Spotlight on widening participation
- Add Q's into metrics – add 1 or 2 more clinically focused questions relevant to culture / background
- Supervision – ongoing needed, training alone isn't enough

IAPT / services / communities together:

- Collaborative working with all IAPT services, sharing ideas and barriers
- Community based IAPT services
- Connect to values of service users
- Being a familiar face in that community
- Neighborhood teams – community links
- Connect to values of service users

Feedback from group 3 - Who can help:

- IAPT mandatory training – specific training for IAPT r.e. BAME for everyone (services, commissioners)
- Policy of public services have meetings in VCSE buildings
- Getting support from the equality and culture SIG / PPN
- Religious leaders

Experts in fields:

- Using experts in field e.g. Andrew Beck
- BABCP
- NHE

Wider workforce:

- Fire and Police
- 3rd sector and community groups

HEI's:

- Adapt core training PWP / CBT courses

CCG's:

- Improving CCG awareness of current needs and prevalence data

Services:

- Recruitment of staff from BME communities
- Incorporating diversity in recruitment
- Organization development training teams
- Encourage team to use – BME audit tool

Feedback from group 4 - What will success look like:

- Measurable change
- Increasing Access
- Equality of recovery and reliable change
- Equality of provision
- Equal access for all
- Lower waiting lists
- High recovery rates

Champion roles:

- Commissioners – raise with for funding
- Local community
- Need communities to be more aware of mental health issues and early warning signs
- Champion role being allocated specific time to improve community links

Tools and adaptations:

- Adapting it successfully to a specific culture / background
- Promoting questionnaire to be included as a part of therapeutic process
- More clinically relevant

Actions:

- Auditing and measuring
- Training (cultural competency)
- Champions role

Feedback from group 5 - Opportunities:

- Media –use local radio stations as a platform for engagement

Location of services:

- NHS building to clinical neutral service locations
- Collaborative workshops / networking with local community centers to offer therapy

Training & info:

- Knowledge base that is accessible
- More training for current workforce on cultural differences

Audit:

- Use of audit tool to measure currently is and needs to be
- Having an audit tool to use to build evidence
- Going beyond the minimum data set
- Paying attention to the community population

Spread the word – disseminate:

- Sit on national council TA Therapist – document promoted and spread the word
- Raise the agenda in our own teams

Commissions:

- Accountability of expenditure for spend
- Opportunity to engage with commissioners
- Co-operate procurement needs to be changed to help local communities