# Telephone delivery of the NHS's IAPT service providing low-intensity psychological treatment for anxiety and depression disorders

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Since the COVID-19 lockdown, it is temporarily not possible for IAPT practitioners to deliver psychological therapies face-to-face. For Psychological Wellbeing Practitioners (PWPs) who are unused to telephone and online delivery, this may present something of a challenge. Many PWPs and indeed many patients prefer meeting face-to-face, feeling more comfortable being able to see one another, to see how each is responding, and to be able to assess a patient's state visually. However, it is worth bearing in mind that many PWPs and patients actually prefer talking on the phone; they appreciate the flexibility (e.g. as to when and where they 'meet', not having to travel), and the relative anonymity of their encounters. In this brief note, we offer some practical suggestions to help you in this transition, based on our ongoing research into the delivery of IAPT by telephone.

Over the past 24 months, we have been conducting research into the telephone delivery of low-intensity IAPT, as part of a larger project led by the University of Manchester and funded by the National Institute of Health Research: *Enhancing the quality of psychological interventions delivered by telephone* (EQUITy). Having closely examined over 120 recorded telephone sessions (including assessments, first and second treatment sessions), using the method of Conversation Analysis, we have been able to identify various challenges that PWPs face when working over the telephone, from which we have developed a number of practical suggestions that might help to maintain a personalised and patient-centred experience, when working remotely.

Although IAPT is a structured and protocol-led intervention, you will know from your training that it is expected to be delivered in ways that are patient-centred, responsive, tailored to the needs of the individual patient. However, you will also know from experience that this can be challenging: there's so much to get through, so much to deliver, in so little time (usually around 30 minutes). With these pressures, sessions can become rather 'standardised', delivered in a way that might seem to prioritise the protocol over the patient. A PWP's objective is, of course, not simply to tick the boxes, but to hear the voice of the individual patient and respond to their concerns and needs, to help them through

whatever they are troubled by. ***From our research it's possible to make some suggestions to help you in achieving this objective, and thereby to enhance the personalisation of IAPT treatment – to put the individual patient's concerns at the centre of each telephone conversation with a patient, while still completing the required processes.***

- Greetings over the phone will, inevitably, be rather different than if you were meeting a patient face-to-face; you cannot offer a smile or a handshake. The very first words by PWPs over the phone are therefore very important. It's ***worth making greetings and introductions as warm and welcoming as possible***. Instead of simply giving one's name and role in the IAPT service (which can seem rather businesslike), convey a genuine sense of positive anticipation at working with and supporting that individual patient in their recovery. For example: "My name is … and I will be working with you over the next few weeks/months. I'm looking forward to getting started today and learning about you and the help you would like".

- Although the IAPT model sets out the tasks to be completed during assessment and treatment sessions, it's worth remembering that the order in which these tasks are conducted can be approached flexibly. Our research found that PWPs very often deal with the routine outcome measures as the first activity of sessions. Although this can provide clinical information that will be useful later in the session, starting the session by instead asking some more *open, patient-centred* questions can create a more personalised experience. Although it is of course necessary to complete routine outcome measures at every session, deferring this until after there has been some patient-led discussion of their situation can help to lend a more personalised character to the opening of sessions; research in other medical settings has found that beginning with an open question is associated with greater patient satisfaction.

- So, as the first component to the conversation (after initial introductions and preliminaries), consider ***asking the patient to describe in their own words what has brought them to the service, or how they've been since the last session***. Asking patients to describe just briefly what's been happening in their life puts the patient first and allows subsequent questioning to take into account what you've learned about them and their problems, helping to further personalise the conversation. Something along the lines of "Could we begin by you telling me, just very briefly, what it is that's brought you to seek support" [assessments]. "I've seen the notes from your assessment, but as you and I haven't met before, please could you start by telling me, in your own words, what's brought you to seek support" [1st Treatment]. "So how have things been since we last spoke?" [2nd and subsequent Treatment]).

You may understandably be concerned that inviting patients to tell their 'story' might lead to very long accounts that take up a lot of your appointment time. From the evidence in our study, this does not seem to be a problem; where PWPs asked patients, early in the session, to outline their reasons for seeking help, the patients usually spoke for only a couple of minutes, and sessions did not run over the allocated time.

- Sometimes, patients provide details about their situation (precipitating events, contextual details), during phases of routine information gathering. It may be tempting to pass over such disclosures or to come back to them later, in order to complete the current section of the protocol being addressed. But bear in mind the need to be responsive. **It's important to have the confidence to respond in the moment to the substance of a patient's disclosure and to respond sympathetically**. Whenever routine information is gathered, the aim should still be to deal with questions in a patient-focused way – that is, listening to how the patient responds to each question will give an additional level of clinical data to the PWP. A sympathetic, compassionate response need not be long – and lets the patient know that a PWP has properly understood and acknowledged what something has meant to the patient.

- Institutional language can be offputting for many people, especially those who are anxious and depressed, or in distressing circumstances, and who want to feel they are being treated, as individuals. For instance, although it is important to outline to patients what sessions will involve, direct use of the term "agenda" might sound less personal to a patient. A more personal alternative might be, "What we will talk about today is..." or "What I'd like us to do today is...". It is important to ***avoid or minimise explicit references to 'what the system requires'***. "We'll complete some questionnaires to give us another piece of information about how you are feeling" is more personal than "We have to do these at every session so let's just get them out of the way first". It's worth also giving a clear sense of how much time you have to spend together on this occasion, without at the same time conveying pressure on the patient. So, whilst it is important to explain at the beginning of session that, for example, "We will have around half an hour together today", as sessions progress, try to avoid such comments as "We don't have much time left" or "I need to move us on now before we run out of time".

- When talking with patients over the phone, it is tempting to type up notes as the patient is speaking. The click of the keyboard is audible to patients; and typing can distract a PWP from listening carefully to the patient. If at all possible, according to a PWP's working habits, ***it's worth finding an alternative***

***to typing notes simultaneously whilst conducting a session***. PWPs might instead make any necessary notes by hand and type them up afterwards (as in a face-to-face sessions); this may enable PWPs to focus entirely on what the patient is saying, without having simultaneously to type and prepare for a next question.

- PWPS and patients can find the co-construction of visual models challenging when done over the phone. For instance, explaining to a patient how to draw a diagram of the cognitive behavioural conceptual model, in order to populate it with their symptoms, can be tricky over the phone. It may be more straightforward (and thus make for a smoother interaction) to **explore the CBT conceptual model verbally with patients, without having to ask patients to find some paper, draw circles and so on.** Returning to our first recommendation, if the patient has been invited to describe their experiences first and foremost in an open, patient-led way, it may then be possible to fit their experiences and problems appropriately to sections of the conceptual model implicitly.

- The volume of psychoeducational information provided in Step 2 treatment can be quite difficult for some patients to absorb in one go. ***It is worth breaking up long explanations into shorter sections, leaving space (gaps) for patients to respond or ask questions***. It may be useful to mix information giving with a questioning approach, in order to keep patients involved and engaged in the interaction during the explanation of substantial quantities of psychoeducational description. Similarly, when explaining homework tasks over the telephone (particularly where the patient does not yet have the printed material), pace explanations gradually and seek confirmation from the patient that they have understood what they are being asked to do in between sessions. In treatment sessions, when agreeing homework tasks with patients, it will be helpful to allow time to talk through, together, the detail of what a homework task involves (rather than simply referring patients to sections or page numbers). ***It will help patients enormously, and encourage them, if PWPs explain clearly what patients are agreeing to do, and how and why completing homework tasks will be beneficial to them.***

- Finally, when closing the session, it is important to encourage patients, and convey a sense of hope for the future. This can be done by ***summarising the progress made to date, steps taken, goals achieved, and expressing optimism about improvement, change and recovery - complimenting the patient on their achievements and thereby encouraging the patient and motivating them to return for their next session***.

We hope that these suggestions will be helpful, especially for PWPs who are transitioning to delivering IAPT sessions by telephone for the first time. They are based on our ongoing research, the results of which we are currently writing up for publication – so it's important to add the caveat that these results have not yet been peer reviewed. We are highlighting these suggestions – which are very much in line with existing training and practice – to help support front-line practitioners in conducting this vital service, in such challenging circumstances.

You may also be interested in another output from this research, which assessed the evidence for any differences in therapeutic alliance in telephone vs. face-to-face physiological treatment*. This paper has been peer-reviewed, published and a copy can be accessed here.

The EQUITy programme has developed an intervention to support IAPT practitioners, services and patients in the delivery and receipt of telephone-delivered psychological interventions. In response to the current COVID-19 outbreak, this intervention has been modified to rapidly respond to the immediate needs of practitioners working at Step 3 who have little or no training in telephone-delivery.

If you have ideas or views or experiences to share about communicating with patients in IAPT telephone sessions, or views about the suggestions above, we'd very much like to hear from you.

Thank you for reading this – we hope that it was worthwhile.

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