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Clinical Psychologists Training and Supervising IAPT therapists to work with Long Term Conditions and Medically Unexplained Symptoms- A Service development Project

Dr Julie A Highfield, Previously: Clinical Psychologist, Psychological Services for Physical Health, Coventry and Warwickshire Partnership NHS Trust, Now: Consultant Clinical Psychologist, Critical Care, Cardiff and Vale University Health Board

Kathy Lowe, Clinical Lead for IAPT

Emma Lewis, Psychological Wellbeing Practitioner, IAPT

Dr Rachel Warren Clinical Psychologist, Psychological Services for Physical Health,

Dr Kate Martin Clinical Psychologist, Psychological Services for Physical Health

Elaine Walket, Psychological Wellbeing Practitioner, IAPT

All at Coventry and Warwickshire Partnership NHS Trust

Summary

An IAPT service and a Clinical Health Psychology Team piloted a service development providing step two and three services for individuals with long term health conditions. Results indicate such services may be offered with access to specialist training and supervision.

Introduction

Recent research has highlighted that co-morbid physical and mental health conditions lead to poorer health outcomes and reduced quality of life (Naylor *et al.*, 2012). Evidence consistently demonstrates that people who have Long Term Conditions (LTCs) are two to three times more likely to experience mental health problems than the general population (Kings Fund, 2012). There is strong evidence in particular for a close association between cardiovascular disease, diabetes, Chronic Obstructive Pulmonary Disease(COPD) and musculoskeletal disorders and depression and anxiety (Kings Fund, 2012).

Between 12 & 18 per cent of all NHS expenditure on LTCs is linked to poor mental health, with total health care costs raised by at least 45 per cent per person and £8 to £13 billion is spent in England per annum (Kings Fund, 2012). In the NHS the current separation of mental and physical health care leads to fragmentation. Poor links between these areas leads to lack of integration of care.

No Health Without Mental Health (Department of Health, 2011) gives new responsibilities to Improving Access to Psychological Therapies (IAPT) services to support the psychological needs of people with LTCs. QIPP (Quality, Innovation, Productivity &

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Prevention) challenge calls for innovative ways of providing services which deliver better outcomes with constrained resources. The NHS England Business Plan 2014/15- 15/16 has suggested a parity of esteem between mental and physical health, that both should be valued equally. NHS England intends to roll out Improving Access to Psychological Therapies (IAPT) services for people with LTCs and medically unexplained symptoms (MUS). However, the pathfinder sites have yet to produce their finalised data on the efficacy of managing the psychological impact of LTCs and MUS within the context of an IAPT service.

The project

This service development project was funded by the former strategic health authority. It took place within the Coventry and Warwickshire IAPT service. Within this service, there is limited access to Clinical or Counselling Psychologists, and as such only step two and three services are provided.

Seven High Intensity Therapists (HIT) and six psychological wellbeing practitioners (PWP) were selected to take part in the project across the IAPT service. The selected workers were trained and supervised by Clinical Psychologists with expertise in Clinical Health Psychology who work in local acute hospitals, to deliver step two and step three interventions with individuals experiencing depression and anxiety linked to LTCs and MUS.

Step two intervention

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A generic group “Mind & Body”, was developed as a Cognitive Behavioural Therapy (CBT)-based course for individuals with LTC and co-morbid depression/ anxiety. The course aimed to teach skills to help in living alongside LTCs and manage the psychological impact. The course comprises of seven sessions including goal setting, relaxation, lifestyle advice, adapting activities, and exploring thoughts and feelings.

Step three intervention

Seven HITs were trained and supervised to adapt CBT skills to work with individuals with depression and anxiety associated with LTC and/or MUS. Two and a half days of training were offered to all of the project workers, and included adapting CBT skills to LTCs population (and drawing from third wave CBT approaches) and issues specific to LTCs, such as adjustment. Following training, on-going monthly clinical supervision groups were provided by the Clinical Psychologists to support practitioners working with LTC patients. Separate groups were offered for PWP and HITs.

Outcome Measures:

The Patient Health Questionnaire (PHQ-9; Kroenke *et al.*, 2001) and the Generalised Anxiety Disorder Questionnaire (GAD-7; Spitzer *et al.*, 2001) were used as outcome measures for the step two and three interventions. These are routinely collected by IAPT as outcome measures, and the team wanted to compare against treatment as usual. The recovery rates were evaluated, and compared to date for recovery for those CBT IAPT workers who had not received the training or supervision as a comparison. In addition, the Self Efficacy for Managing Chronic Disease Scale (Lorig *et al.*, 2001) was utilised with the group in the step two intervention.

The inclusion and exclusion criteria for patients in the project are given in table one. Conditions were those recommended in the IAPT Long Term Conditions and Medically Unexplained Symptoms Data Collection Summary (2012).

At the conclusion of the project a focus group was held with the IAPT therapists to allow them to reflect on their experiences and offer feedback.

Insert table one here

Findings

Step two intervention

Thirty six individuals attended the Mind and Body group (although only 28 complete data sets are available), with an age range of 21-72 years (mean= 47 years), and 79 percent of which were female. Thirty nine percent of cases had multiple health co-morbidities, 11 percent chronic fatigue syndrome, 25 percent chronic pain, 11 percent muscular-skeletal issues, seven percent diabetes, four percent neurological, and three percent other disorders.

Outcome data are given in figure one, indicating an improvement. A t-test was conducted to compare the minimum data set scores before and after the group. There was a statistically significant improvement between baseline PHQ-9 (M= 17.8, s.d.=3.5) and end of group PHQ-9 (M=10.9, s.d.=3.6); $t(8) = 3.9, p \leq 0.01$. There was a statistically significant improvement between baseline GAD-7 (M=16.2, s.d.= 2.8) and end of group GAD-7 (M=10.6, s.d.=4.1); $t(8)=2.9, p \leq 0.05$. However, when recovery was calculated in accordance with IAPT guidelines (whereby recovery is achieved when a patient scores above caseness

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on the PHQ-9 and/or the GAD-7 at assessment and scores below caseness on both of these measures at final contact) the overall recovery rate for all patients attending the Mind and body course was only 35.71%. All Mind and Body attendees showed some improvement in illness-related self-efficacy, as illustrated in figure two. Although the improvement in score may appear slight, this represents a clinically significant change ($p < 0.01$).

Insert figure one here

Step three intervention

Following the completion of the training, the seven HITs were allocated step three patients with LTCs. The “active treatment” phase of the project was seven months during which time 28 patients received a service from the additionally trained and supervised workers. Twenty four patients with LTCs were allocated to other workers. Table two shows the comparable recovery rates, where recovery was calculated in accordance with IAPT guidelines (see above), with better rates achieved by those who were additionally trained and supervised.

Insert table two here

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Five of the eight HITs involved in the project attended to a focus group facilitated by an assistant psychologist to discuss their experience of the project. A thematic analysis produced themes, with example quotes given in table three.

Insert table three here

Discussion

The results indicate that a step two group intervention for mixed LTCs delivered within IAPT can have impacts upon general self-efficacy, and the standard IAPT minimum data set measures of low mood and anxiety.

The results indicate that a step three intervention delivered by High Intensity CBT therapists can improve low mood and anxiety levels. However there is a clear indication that training and ongoing specialist supervision from Clinical Psychologists increases the efficacy of the intervention. These are pilot results and numbers are low, so further investigation is required with higher numbers. It would also be of interest to re-visit the outcome results of those IAPT workers who were under the project and now no longer receive the specialist supervision, to see if gains have been maintained without ongoing supervision. IAPT services vary across NHS England, with some having access to step four interventions while others do not, and some services having a wider skill mix of psychological therapists. Having access to clinical or counselling psychologists with experience in medical settings as specialist

supervisors, and having a pathway for step four referrals would be key in considering any developments of IAPT services for LTC/MUS.

The experience of the high intensity therapists explored within the focus group indicate that delivering step three interventions for individuals with LTC/MUS proved challenging within the IAPT model of service delivery in terms of the generic nature, the fully booked day, and the ability to offer services to those with complex needs. Those professionals involved in the project speculated that patients without multiple co-morbidities, who have conditions that are largely managed by the GP are more likely to benefit from GP based IAPT services. However more research would be needed to investigate this further. The discussions in the focus group indicated the complexity of some LTCs and how difficult it was to translate generic services to such individuals. Individuals with multiple co-morbidities and complex needs are often under the care of acute trusts, where psychological services may be better provided by hospital based integrated psychology services. This warrants further study.

Many guidelines suggest the provision of psychological services for LTCs should include some integration into staff delivering medical care, through attendance at multidisciplinary meetings, providing training, supervision and consultation (e.g. NICE 2004). The current configuration of IAPT services does not allow for such integrated working.

Conclusion

There are promising results for the delivery of IAPT services to individuals with LTC/MUS.

The following recommendations are made for the development of such services:

- IAPT therapists should have access to additional specialist training
- IAPT therapists may additionally benefit from access to specialist supervision from a level four practitioner (typically a Clinical or Counselling Psychologist) with experience in working in medical settings
- Patients may be suitable for step two or three interventions if they have a singular health condition that is largely managed by the GP. This could mean that an MDT approach is less likely to be required.

The psychological care needs of patients with multiple co morbidities, or in active treatment (such as chemotherapy or haemodialysis) need to be further investigated. It is not clear whether this may be better provided by integrated step four specialist Clinical Health Psychology services or in the community by IAPT.

References

Bandura, A. (1977). Self-efficacy: Toward a Unifying Theory of Behavioural Change.

Psychological Review, 84 (2), 191–215.

Department of Health (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. UK: Department of Health.

IAPT Long Term Conditions and Medically Unexplained Symptoms Outcomes and Evaluation Group (2012). *Long term conditions and medically unexplained symptoms data collection summary*. UK: IAPT.

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). *Long term conditions and mental health: The cost of co-morbidities*. UK: The Kings Fund.

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Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606-613.

Lorig, K.R., Sobel, D.S., Ritter, P.L., Laurent, D., & Hobbs, M. (2001). Effect of a self management program for patients with chronic disease. *Effective Clinical Practice*, 4, 256-262.

National Institute of Health and Clinical Excellence (2004). *Guidance on Cancer Services. Improving Supportive and Palliative Care for Adults with Cancer*. UK: Department of Health.

NHS England (2014). *Five year forward view – NHS England business plan 2015/16*. UK: NHS England.

Spitzer, R.L., Kroenke, K., Williams, J.B. & Lowe, B., (2006) A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166(10), 1092-1097.

Correspondence:

Dr Julie Highfield, Consultant Clinical Psychologist, A3 Critical Care, University Hospital

Wales, Health Park, Cardiff. Julie.highfield@wales.nhs.uk

TOTAL WORDCOUNT: 2397

Table 1: Inclusion and exclusion criteria

| Inclusion Criteria | Exclusion Criteria |
|--|--|
| <ul style="list-style-type: none"> LTC or MUS LTC relevant to presenting problem Suitable for CBT | <ul style="list-style-type: none"> No LTC LTC irrelevant to presenting problem Received other step 3 intervention (e.g. counselling) Offered CBT but did not attend Offered assessment only |

Table 2: Recovery rate by group delivering intervention.

| | PHQ-9 % recovery | GAD-7 % recovery |
|---|------------------|------------------|
| Pre-project LTC results (N=116) | 52% | 51% |
| During project, non-project workers (N=24) | 58% | 54% |
| During project- trained & supervised workers (N=28) | 79% | 90% |

Table 3: Thematic analysis of focus group for high intensity therapists

| Theme | Example Quotation |
|--|--|
| LTS/MUS work not quite fitting the IAPT core model | <p>“It almost feels like an extra pressure, because you can see the value, there is real value in the work that we do, but it’s not measurable in the time that we’ve got.”</p> <p>“If you measured the amount of time per long term conditions patient that we spend out of the therapy session compared with average, it would be huge in terms of the discussions with other therapists about what’s appropriate, trying to erm to get hold of consultants or doctors, medics, whatever, to get clarification and there’s no allowance for that within our numbers and what have you”</p> |
| LTC/MUS as sometimes too complex for IAPT | “And just through the amount of research you do yourself, you know, your patient says, “I just keep |

| | |
|---|--|
| | <p>dropping off to sleep just like that” and then you think “is this part of the condition or is it because you are not sleeping? Is this because...?””</p> |
| <p>Experience of specialist training</p> | <p>“I think it would have been helpful if we could have had another training day half way along because it was all at the beginning, I think if we could have had that and then another consolidating training day, or based on experiences, that could have guided us to the next part really”.</p> <p>“It opened my eyes a lot and I derived a lot from it...it was nice to have the breadth of training I think”.</p> |
| <p>Experience of specialist supervision</p> | <p>“I think it would be really important to have that specialist supervision”</p> <p>“I was thinking I wouldn’t want to carry on doing this ...without having access to the supervision that we’ve had.”</p> |

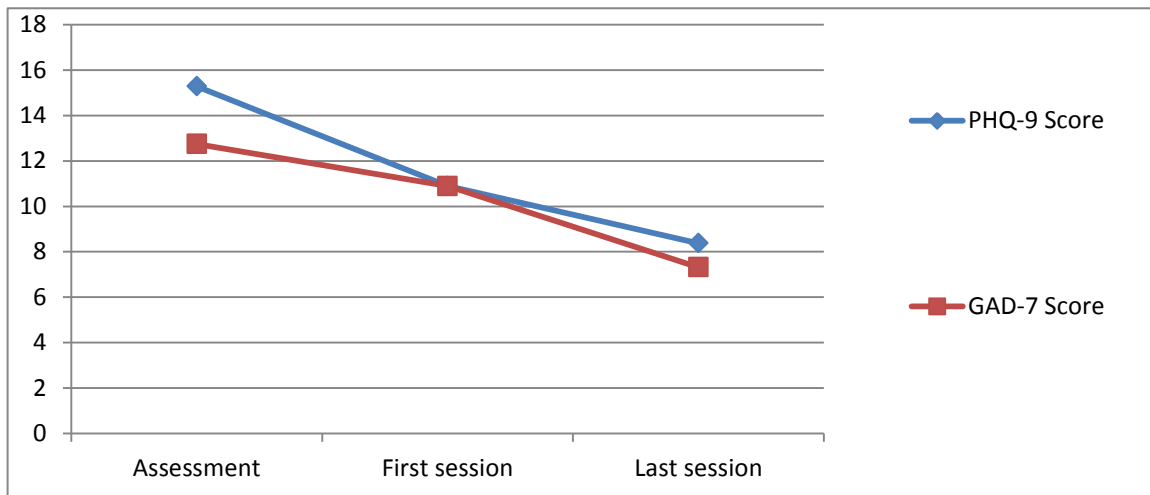


Figure 1: Mood outcome data, before and after step two group intervention (N=28)

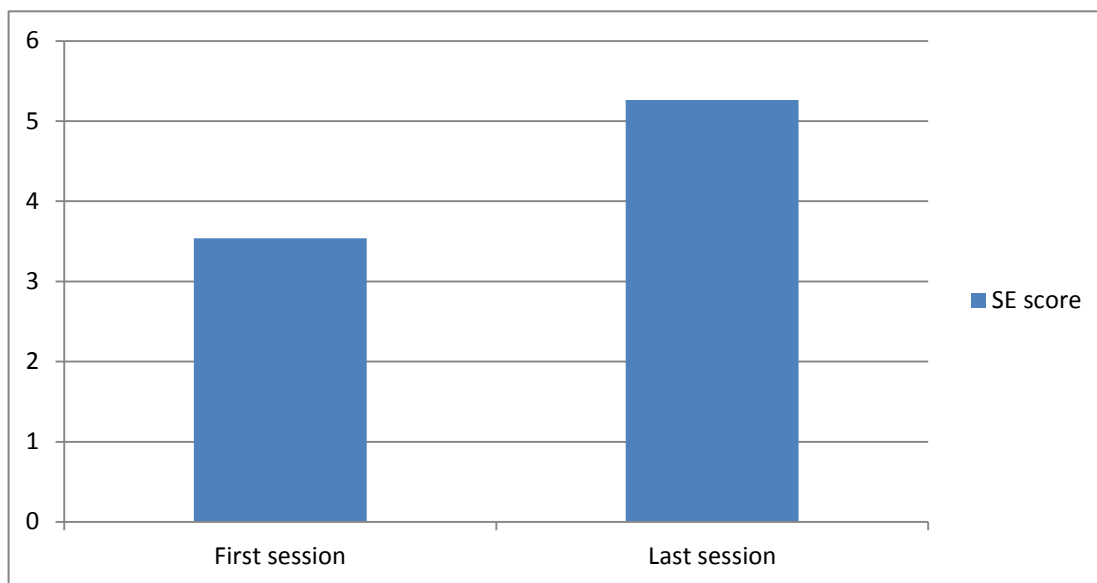


Figure 2: Average Self Efficacy for Managing Chronic Disease Scale scores at first and last session of the group intervention (n=24)