CLINICAL HEALTH PSYCHOLOGY INTERVENTIONS IN ESSEX AND BEDFORDSHIRE

Introduction

Mental health problems are also much more common in people with physical illness. People with diabetes, hypertension and coronary artery disease have double the rate of depression compared with the general population. They are also at risk of developing vascular dementia. Those with chronic obstructive pulmonary disease, cerebro-vascular disease and other chronic conditions have triple the rate of depression. People with two or more chronic physical conditions are seven times more likely to have mental health problems. Having both physical and mental health problems delays recovery from both conditions.

Recent government guidelines on the development of services for people with physical health problems consistently stress the importance of incorporating psychological assessment and intervention as an integral part of effective health care (e.g. NICE guidance on Diabetes, Coronary care, Cancer, COPD; National Service Frameworks for Cancer, Coronary Heart Disease, and the Management of Long-term Conditions; No Health without Mental Health). There is an increasingly compelling body of research evidence that health outcomes as well as satisfaction with care are improved by addressing patients’ psychological and emotional needs. Neglecting these aspects of care is likely to result in longer hospital stays, poorer life expectancy, poorer adherence to medical treatment, increased demand on healthcare resources, and unnecessary distress and dissatisfaction with care.

Whilst Psychiatric Liaison services have a specific and effective role to play in addressing both the physical health needs of people with mental health, and acute mental crises in people with physical health, there is an equally important and effective intervention pathway incorporating biopsychosocial intervention for people with physical health problems, particularly long term conditions, with Clinical Health Psychology as a key intervention.

Clinical health psychologists draw upon a wide knowledge and skills base, which is developed during their six-year training and maintained through continuing professional development. In essence they are experts in assessment and in developing interventions based on the interrelationship between behaviours, emotions, thoughts, social relationships and biological aspects of health and disease. Clinical health psychologists use in-depth and up-to-date knowledge of research evidence to improve health outcomes and maximise health gains. Many patients seen by psychologists are distressed as a result of their medical condition. Some have co-morbid mental health and physical health problems. Whilst clinical health psychologists have competency in assessing the influence of mental health problems on physical welfare due to their mental health training, the focus of work is on the management of the physical condition.

Clinical Health Psychology Services operate in primary, secondary and tertiary care, and often adopt multidisciplinary approaches, incorporating direct assessment and intervention, consultation, teaching and supervision, with clinical health psychology, psychotherapists, occupational therapists and physiotherapists, and nurses.

The South Essex Partnership Trust (SEPT) Clinical Health Psychology Service employs 18.8wte staff, encompassing 3 Consultant Clinical Psychologists, 3 principal Clinical Psychologists, 6.6 Clinical Psychologists, 1.4 OT and Physio, 3.3 Assistant Psychologists, and 1.5 administrators. We provide CHP services (bariatric surgery assessment, cardiac care, diabetes care, pain management, limb loss care, MS care, etc) at Luton & Dunstable Hospital and Bedford Hospital, Cancer & Palliative Care services in Bedfordshire and Hertfordshire, a CMS service in Luton, COPD services in Southend and Bedford, Stroke services in South Essex and West Essex, a CFS service in Bedfordshire, and assist in leading a PHC based MUS intervention service in IAPT south Essex.

Four innovative projects are described below. All are initially one-year pathfinder or QIPP projects, but with potential to be funded through their effectiveness in saving general health care costs.
Trans-Diagnostic CBT Interventions for Medically Unexplained Symptoms –
A Pathfinder Project for IAPT

This one year project is close to completion, having been unfortunately delayed. It seeks to test an intervention pathway for the identification and treatment of MUS in primary health care settings in South Essex, utilizing the stepped care approach successfully applied within the IAPT service in south Essex utilizing two unique intervention approaches which can be applied through all IAPT stepped levels, and can be used in secondary care. Funding was provided as one of 15 successful bids for pathfinder projects in MUS and LTC treatments through IAPT.

The project sought to identify non condition-specific MUS utilising a unique tool developed in conjunction with a team from the University of Bath, followed by CBT intervention for MUS at PWP and HIW level within IAPT. A group of Psychological Wellbeing Practitioners (PWPs) and High Intensity Workers (HIWs) were trained and supported to work with GPs in 9 participating practices to identify people attending with MUS and deliver trans-diagnostic stepped-care CBT interventions. CBT is considered the most effective intervention approach for MUS, supports a multi-modal approach, and can be applied both individually and in groups.

The stepped model has evaluated both a PWP-led Acceptance and Commitment Therapy group intervention for MUS, as well as individual CBT treatment. The ACT treatment (a ‘3rd wave’ CBT intervention) consists of a structured group intervention of 8 weekly sessions of 2 hours, facilitated by two ACT-trained therapists. Content was informed by successful Health Anxiety (HA) and LTC intervention trials, and training for PWPs was provided by the CHPS Lead, and a team from Aarhus University Hospital, who specialise in CBT and ACT for MUS. In the individual CBT intervention, service users (SUs) are given a simple explanation of the nature of health anxiety, and then between 5 and 10 individual sessions of an adapted form of cognitive behaviour therapy. Training for HIWs was provided by Prof Paul Salkovskis from the University of Bath.

The project Clinical Lead gave a presentation to GPs at all participating practices, and all GPs were invited to one of two evening education sessions provided by Prof Salkovskis, who is a leading authority and researcher in MUS. Outcome analysis seeks to identify the extent of cost savings, and the comparative efficacy of the two interventions. The project aims to inform national policy on MUS intervention, and training in IAPT.

The project has experienced a number of barriers, including conflicting demands from the greater IAPT delivery contract (where IAPT managers perceived the MUS project as a drain on their resources, and therapists prioritised their mood intervention work). Therapists were also challenged by resistant clients, frequent cancellations due to illness, and client reticence to accept that MUS has psychological aetiology. However, the greatest barrier was the reluctance of GPs to refer their patients into the service, with only a fraction of the expected referrals materialising. This necessitated outreach to patients with specific diagnoses, which caused a high level of drop-out. To date, the overwhelming conclusion of the project team is that PHC may not be the best source for MUS referrals, and step-down services originating between secondary care (such as specialist CFS services or acute hospital outpatients services) and primary care would be (and have proven in the research to be) far more effective. IAPT PHC services are considered to be one of the intervention points, but not sufficient. Dedicated HIW posts funded to support CHP services have proven to be more effective.

The ACT groups were extremely well received, with all completers to date praising the effectiveness and accessibility of the approach. However, of 20 starters to date, only 7 are expected to complete, so again, there has been a high drop-out rate. PWPs were found to be excellent in delivering structured manualised group intervention, and expressed a desire to continue delivering these approaches. Outcomes from the final dataset will be analysed after July 2013 (with initial analysis of data to date as part of the national dataset which is to be submitted on 26th April).

Qualitative data will provide feedback on the HIW and PWP training and delivery of CBT and ACT interventions, service user perceptions of the treatments and the service, GP perception of the service and any barriers that might have interfered with take-up, and experiences and perceptions of the project team and IAPT service leads. Outcome data will give clarity on the effectiveness of interventions.
QIPP Project in South Essex providing Clinical Psychology intervention for people with COPD

The EoE SHA have funded South Essex as a pilot site to take forward work on providing psychological interventions for people with LTCs, specifically in COPD intervention and Stroke rehabilitation. Two QIPP projects were set up by the (then PCT) South Essex CCG, one with a target group of primarily older people with COPD on the LTC caseload.

The addition of clinical psychology input to the existing LTC service is expected to have a significant positive impact on the quality of life of people with COPD and to reduce hospital admissions, emergency service use and primary care consultations. It aims to make cognitive behavioural therapy (CBT) interventions available for people with COPD. This graduated approach, in line with NICE guidance, includes guided self-help, psycho-educational groups for patients, one to one therapy, and referral to and liaison with specialist mental health services, as well as training for community and hospital based staff.

These interventions are being delivered by a band 8b principal clinical psychologist and a band 5 psychology assistant. These staff are located both within the long term conditions community team, and the Southend Hospital COPD team, with interfaces to varying degrees with the Community Geriatricians, the End of Life team, day treatment services and IAPT services. In addition to their direct clinical work, the clinical psychologist also provides supervision, support and training for the staff in the LTC service in the identification of mental health problems in older people and the psychological impact of physical health problems.

One of the key outcomes of the pilot, apart from improvement in mood and quality of life of service users, will be a business case for the sustainability of the team. Currently, there is insufficient data available at present to precisely quantify the likely impact of the investment, but a 15% reduction in attendances and admissions seems possible. The impact of pulmonary rehabilitation programmes for COPD can be increased by adding a psychological component, improving completion rates and reducing re-admission for COPD (Abell et al 2008). CBT-based interventions can improve treatment adherence, psychosocial adjustment, coping skills and quality of life for people with co-morbid long-term conditions, as well as reducing use of health care services (Thompson et al 2011; Spurgeon et al 2005). Including a psychological component in a breathlessness clinic for COPD in Hillingdon Hospital led to 1.17 fewer A&E presentations and 1.93 fewer hospital bed days per person in the six months after intervention (Howard et al 2010). This translated into savings of £837 per person – around four times the upfront cost.

Already, the training provided to the hospital and community COPD MDT has increased the recognition of mental health problems, and understanding of the psychological contributors to coping with COPD. THE principal Clinical Psychologist has developed a screening process and pathways for treatment, assessed patients on wards and from the community, and developed a psychology intervention group, as well as taken on an individual treatment caseload.

A number of “psychology champions” have been identified, and include one staff member from rapid response team (acute), COPD nurse specialist (acute), a ward nurse (acute), 3 community matrons (community) and a oxygen at home specialist (community). They will receive basic training in CBT, a full self-help facilitators guide, and ongoing group supervision of 1.5hrs every 3 weeks. Furthermore, training can be accessed by 15 staff, 6 places going to Health Care Assistants so they can support the work of qualified nurses. Various training is to be offered to the wider team e.g. in motivational interviewing.
One of the nine areas for improvements in stroke care identified in the Accelerating Stroke Improvement Programme [ASI] 2010 is psychological support. People using stroke services in South East Essex currently have access to the generic IAPT service (Therapy For You), which is not stroke specific and does not have specialist staff who can meet all of the needs of this patient group.

Evidence suggests that 25% of stroke survivors will have an on-going need for psychological support when they are discharged from an acute stroke ward. At least 30% of those discharged after as stroke will have a mood disorder, and up to 75% will have a cognitive disturbance. If these problems are left untreated they are likely to reduce the engagement with and effectiveness of rehabilitation interventions, leading to poorer outcomes, higher levels of need in the medium to long term and increased use of residential care. People with mood disorders following a stroke also have a higher mortality rate than those who are not depressed (House, Knapp et al 2001, Pohjasvaara et al; 2001). The long term effects of cognitive impairment are barriers in the person’s efforts to re-establish family and reintegration (Dijkerman et al 1996). The absence of specialist support also leads to over-reliance on and inappropriate use of anti-depressants.

A recent audit of patients from Southend Hospital stroke unit found that 66% of patients required psychological input, far in excess of commonly reported estimates of need. This audit of 100 patients admitted to the unit over a 2 month period in 2011 found that 42% either had mood or cognitive disturbance, 8% had a mild stroke, but also had amplified behaviour symptoms that negatively impacted on their rehabilitation, and 16% were stroke mimics – 6% having had multiple admissions for the same complaint with repeat MRI scanning, monitoring, bloods and therapy. One of these patients had been admitted to three different trusts, receiving thrombolysis on two occasions.

Psychological intervention and support earlier in diagnosis aims to prevent escalation in complexity and the need for costly interventions and inappropriate service utilisation, as well as improve adjustment, and quality of life. The interaction between the stroke survivor, premorbid styles, comorbidities, current coping preferences and interaction with caregivers and family members all have an impact on long term outcome. To prevent or reduce inpatient stays with more challenging presentations and problems, the East of England Stroke Support Commissioning Guide emphasises “inverting the stepped care pyramid” to ensure that increasing complexity and severity of psychological need is matched with the appropriate level of input and expertise. The psychology stroke intervention service aims to blend stepping up for simple difficulties with focussed high level support for uncertain conceptualisations and challenging presentations.

In order to address specific issues related to conditions that may masquerade as strokes, in depth assessment is provided to tease out the neuropsychological correlates of the presentation. Unwitnessed/unrecognised seizures, complex migraine, CNS tumours, isolated mild neurological symptoms, transient global amnesia, as well as specific psychiatric phenomena, can be common stroke masquerades and will require sensitive and intensive appraisal.

This pilot project aims to identify the scope and nature of quality improvements and financial efficiencies that could be realised through this initiative. A key aspect of this will be to determine whether the introduction of psychological assessment and intervention in the stroke pathway results significant improvements in patient reported outcomes, more cost effective service delivery within one part of the stroke pathway, or system wide savings, or any combination of these three.

The service is being provided by two qualified psychologists (1.0 wte band 8b and 0.6 wte band 8a), and a band 4 Assistant Psychologist who provide specialist psychological and neuro-psychological assessments, therapeutic interventions, advice and support for other members of the hospital and community stroke teams, and liaison with other mental health services. The model will emphasise the early detection and management of psychological issues that may impact on rehabilitation through routine screening and assessment.
Development of a Multidisciplinary Chronic Fatigue Service in Bedfordshire

This one-year pilot project supported by Bedfordshire CCG aims to develop and provide a high quality, accessible and equitable community chronic fatigue (CFS) / Myalgic encephalomyelitis (ME) service to Bedfordshire residents diagnosed with CFS/ME. This will be provided through direct individual and group-based intervention, delivered by a multi-disciplinary team (MDT) consisting of a Consultant Physician/Rheumatologist, Principal Clinical Psychologist/Specialist CBT therapist, Specialist Physiotherapist, Specialist Occupational Therapist, Assistant Clinical Psychologist/Psychological Wellbeing Practitioner (PWP) and CBT therapist. The OT and physiotherapy contribution will be drawn from individuals seconded from the community and hospital MDTs, and who will provide dedicated time to the team. Patients will be assessed at the CFS team base in Dunstable, where some specialist treatment will occur, with the majority of interventions carried out by professionals in the community.

Intervention will be evidence-based and follow NICE clinical guideline 53 recommendations, as well as recommendations based on the outcome of the national PACE trial. The service will provide Cognitive-Behavioural Interventions (CBT) and Graded Exercise Therapy (GET) for moderate and severe CFS/ME in patients who are not suffering from significant comorbid drug/alcohol or psychiatric difficulties. Each patient referred into the service will receive a multidisciplinary assessment to determine individual need, and confirm diagnosis. Medical diagnosis and care plan suggestions will be offered in addition to CBT and GET.

The CFS/ME service is jointly provided by the South Essex Partnership University NHS Foundation Trust, Horizon Health and the Community and Hospital Long Term Conditions teams. Key objectives include increasing patient self-management, enhancing quality of life, reduction of hospital admissions, reduction in length of hospital stay and reducing GP consultations.

This is a community-based multidisciplinary outpatient service providing assessment and intervention based on best available evidence. The referral pathway will follow a stepped approach that utilises both resources in community LTC teams as well as the specialist CFS/ME Service.