Expert Focus Group 1:

Care models for people with long-term conditions and medically unexplained symptoms - How do we embed collaboration?
Care models for people with LTC/MUS-how do we embed collaboration?

Prof André Tylee MBBS MD FRCGP MRCPsych
IAPT Expert Advisor, Long Term Conditions
Background

- The Improving Access to Psychological Therapies (IAPT) programme was set-up in 2006. It aims to improve public access to a range of NICE–approved psychological therapies for depression and anxiety disorders through:
  - provision of an appropriately trained workforce;
  - delivering therapies to specific quality standards;
  - routine monitoring of patient reported outcome measures;
  - Defined care pathways (characterised by a stepped care model) and
  - flexible referrals routes (including self-referral by potential patients)
- £400m in *No health without mental health*
- Talking Therapies: Four Year Plan of Action – includes high level plans to extend the benefits of improved access to TT to a wider range of groups.
Start Point & Planning Assumptions

- 900k present to services
- 600k complete treatment
- 6m in need

300k Recover
(25k Move off Benefits)
IAPT

Programme Aims
– complete the roll out of IAPT services
– expand access to IAPT in specific areas of need

Deliverables
– an appropriately trained workforce,
– specific quality standards ie NICE compliance, equitable access, integrated employment options
– session by session outcome measures,
– stepped care model relying on flexible referral routes

Extended Scope
– children and young people,
– those with physical health long-term conditions and mental health issues,
– those with medically unexplained symptoms and
– those with severe mental illness

Outcomes
– improved access to evidence-based psychological treatments;
– improved mental health and wellbeing;
– more people with lived experience of these situations involved in leading the changes
– more people able to resume or start normal working lives

Benefits of £400m investment
– over £700 million savings healthcare, tax and welfare gains
– further 1.2 million people able to access therapies with effective services available across the country
– of these, 0.5 million helped to move to recovery or measurable improvement.
Talking Therapies: four – year plan of action

- Complete roll-out of services for adults
- Ensure older people have proper access
- Initiate stand – alone programme for children and young people
- Develop models of care for:
  - People with Long Term Physical Health Conditions
  - People with Medically Unexplained Symptoms
  - People with Severe Mental Illness
### Service Targets

<table>
<thead>
<tr>
<th>SHA</th>
<th>Regional Allocation</th>
<th>Prevalence</th>
<th>2015 Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>East of England</td>
<td>10.26%</td>
<td>684,797</td>
<td>92,509</td>
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<tr>
<td>East Midlands</td>
<td>8.13%</td>
<td>448,652</td>
<td>75,619</td>
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<tr>
<td>London</td>
<td>15.86%</td>
<td>1,018,112</td>
<td>137,683</td>
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<tr>
<td>North East</td>
<td>5.59%</td>
<td>330,385</td>
<td>51,179</td>
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<tr>
<td>North West</td>
<td>14.83%</td>
<td>1,004,581</td>
<td>133,390</td>
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<tr>
<td>South Central</td>
<td>6.96%</td>
<td>384,730</td>
<td>61,432</td>
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<tr>
<td>South East Coast</td>
<td>7.90%</td>
<td>430,321</td>
<td>70,020</td>
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<tr>
<td>South West</td>
<td>9.59%</td>
<td>613,546</td>
<td>86,310</td>
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<tr>
<td>West Midlands</td>
<td>10.75%</td>
<td>568,463</td>
<td>97,363</td>
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<tr>
<td>Yorkshire &amp; Humber</td>
<td>10.12%</td>
<td>630,658</td>
<td>94,495</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>6,114,245</strong></td>
<td><strong>900,000</strong></td>
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<tr>
<td>Type</td>
<td>MPET Assumptions</td>
<td>Planned</td>
<td>Deficit</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------</td>
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<tr>
<td>CBT (High Intensity)</td>
<td>559</td>
<td>387</td>
<td>-172</td>
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<tr>
<td>PWP (Low Intensity)</td>
<td>567</td>
<td>464</td>
<td>-103</td>
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<tr>
<td>• Counselling for Depression</td>
<td>67</td>
<td>73</td>
<td>+6</td>
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<tr>
<td>• Interpersonal Psychotherapy (IPT)</td>
<td>66</td>
<td>133</td>
<td>+67</td>
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<tr>
<td>• Dynamic Interpersonal Therapy (DIT)</td>
<td>66</td>
<td>49</td>
<td>-17</td>
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<tr>
<td>• Couples Therapy for Depression</td>
<td>66</td>
<td>45</td>
<td>-21</td>
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<tr>
<td>Supervision Training</td>
<td>260</td>
<td>463</td>
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<tr>
<td>TOTAL</td>
<td>1,651</td>
<td>1,614</td>
<td>-37</td>
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## Resources Available

<table>
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<tr>
<th>Policy</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
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<tbody>
<tr>
<td>Completing roll out</td>
<td>43</td>
<td>88</td>
<td>133</td>
<td>133</td>
</tr>
<tr>
<td>Children &amp; Young People Pilots</td>
<td>8</td>
<td>8</td>
<td>8</td>
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<tr>
<td>MUS/LTC Pilots</td>
<td>2</td>
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<td>tbc</td>
<td>tbc</td>
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<tr>
<td><strong>Total</strong></td>
<td>53</td>
<td>96</td>
<td>141</td>
<td>141</td>
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Assumptions for 11/12:
- Further training & education commissions - £32m
- PCT costs associated with employment support - £11m

SHA “bundle”:
- IAPT Central Team Costs - £1.5m
- SHA IAPT Team & other costs - £3.5m
The Clinical Background-LTCs

• Approximately 15 million people with LTCs
• Many LTC patients – mixture of multi-morbidity best addressed by a bio-psycho-social personalised care approach
• There is a strong link between physical long term conditions and psychological distress/disorder
• LTCs (e.g. diabetes, CVD & COPD) up to 3-4 times prevalence of anxiety and depression; poorer health outcomes & increased costs
The Clinical Background-LTCs

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The Clinical Background-LTCs

- Approximately 15 million people with LTCs
- Many LTC patients – mixture of multi-morbidity best addressed by a bio-psycho-social personalised care approach
Themes (Rose D, Simmonds R, Walters P and Tylee A submitted)

- Emasculated by CHD / loss of perceived gender role ‘breadwinner’
- Loss of sexual intimacy and self worth
- Loneliness
- Bereavement/grief
- Relationship breakdown: partner and children
- CHD and Distress / Depression
  A ‘personal and social story’ of loss

- Preferred treatment type and self-help strategies involving interpersonal / social factors
- Relationship with GP and surgery
- Being a carer / loss of freedom
- Interpersonal factors and Loss
- Control

- Erectile dysfunction
- The ageing body / fears for the future
- Resistance to medical interventions for depression
- Patien’t’s own self-help Strategies involving control And individual (lone) approaches
- Loss of employment and self worth
- Lack of financial resources
The Clinical Background-LTCs

• Approximately 15 million people with LTCs
• Many LTC patients – mixture of multi-morbidity best addressed by a bio-psycho-social personalised care approach
• There is a strong link between physical long term conditions and psychological distress/disorder
• Relative risk of healthy people with depression developing CHD is 1.64 (CI 1.29–2.08) for any CHD event

• The risk of depressed patients dying in the 2 years after the initial MI/assessment is two times higher than that of non depressed patients (OR, 2.24; CI: 1.37–3.60).
The Clinical Background-LTCs

• Approximately 15 million people with LTCs
• Many LTC patients – mixture of multi-morbidity best addressed by a bio-psycho-social personalised care approach
• There is a strong link between physical long term conditions and psychological distress/disorder
• LTCs (e.g. diabetes, CVD & COPD) up to 3-4 times prevalence of anxiety and depression; poorer health outcomes & increased costs
The Clinical Background

- MUS/chronic functional syndromes (e.g. IBS, fibromyalgia etc) are often associated with significant psychological distress.
- MUS/chronic functional syndromes can result in unnecessary and costly referrals, diagnostic tests & operative procedures.
- Psychological treatment can improve outcomes and reduce health care consumption.
- NICE Guideline 91 recommends the use of psychological interventions in people with depression and chronic physical health problems.
The IAPT LTC/MUS Project aims to extend the benefits of improved equitable access to psychological therapies to people with long-term physical conditions and/or medically unexplained symptoms.
IAPT LTC/MUS – what are we doing?

• Approximately £1.7 million 2011/12 committed to LTC/MUS developmental work - needs to begin early 2012

• Completed scoping work – mapping current LTC/MUS work reported by regional IAPT leads and other sources

• Around 70 reports in reply to “What are you already doing for people with LTC/MUS?” or “Work with physical teams?”
IAPT LTC/MUS – what are we doing?

• Useful starting point – any evidence of collaborative work either with primary care, physical health teams, liaison psychiatry, etc

• Identifying good and innovative practice which adds to IAPT core business

• LTC/MUS Expert Advisory Group established - met Nov 2011 and a sub group are establishing;
  • Bid/selection criteria
  • Evaluation criteria-will be conducted externally
IAPT LTC/MUS – what are we doing?

• Needs mostly to be up and running and able to start in early 2012 (i.e. Q4 of 2011/12)

• Several sites could be chosen which complement each other and build up an overall picture of what’s possible

• Could be several LTC’s (e.g. diabetes, COPD, CHD etc)

• Could be several MUS (e.g. IBS, fibromyalgia, CFS etc)

• Could be 1-2 non IAPT led projects which involve IAPT (e.g. GP or secondary care led etc)
IAPT LTC/MUS – what are we doing?

• Could involve training IAPT workers in physical care and physical health workers in psychological approaches.
• Over half of the reports involved COPD services
• Others reported a range of LTCs (e.g. CHD, diabetes, chronic pain/rehabilitation, CVA, sickle cell and pain, heart failure, CKD etc)
• Collaborating with a very wide range of physical health teams (e.g. cardiac and pulmonary rehab, health psychology, physio, liaison psychiatry, community matrons, nurse practitioners, pain management, palliative care, older person’s services, GPs, community diabetes, podiatry, dietetics, cardiac teams, community nurses, haematology, stroke, oncology etc)
• MUS mentioned by around 1/3rd of reports
Tees Time to Talk service

- Identification of patients with LTC and MUS as priority groups
- Close links with practice based nurse practitioners and local commissioning groups
- Joint assessments and development of management plans (PWPs and Nurse Practitioners with Sis)
- Specific PWP training sessions around cardiovascular disease, diabetes mellitus, chronic pain and chronic respiratory problems by practice nurse practitioners with special interests (community based “virtual wards”)
**Oxfordshire**

- COPD - integrating CBT and health psychology approaches into treatment and rehabilitation

- Training respiratory nurses and physiotherapists to provide evidence-based CBT interventions within pulmonary rehab and 1:1 home visits

- Cardiac rehab: including CBT approaches and treatment where necessary into rehab programme; psychologist included as part of cardiac rehabilitation education sessions

- “Pre-CBT Psycho-education” and CBT based mindfulness for CFS
Discussion
Any questions/suggestions, please contact

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New Projects Development Lead
IAPT, Department of Health

www.iapt.nhs.uk
A Cognitive–Behavioural Approach to Persistent Physical Symptoms

Professor Trudie Chalder
King’s College London
Objectives

- To present the evidence for treatment of Persistent Physical Symptoms
- To describe predisposing and perpetuating factors for persistent physical symptoms
- To broadly describe interventions for persistent physical symptoms
## Hospital Specialists

<table>
<thead>
<tr>
<th>Medical Discipline</th>
<th>Conditions</th>
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<tbody>
<tr>
<td>Gastroenterology</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>Chronic fatigue syndrome</td>
</tr>
<tr>
<td>Neurology</td>
<td>Headache / Non-epileptic seizures</td>
</tr>
<tr>
<td>Hand surgery</td>
<td>Repetitive sprain injury</td>
</tr>
<tr>
<td>Dental</td>
<td>Atypical facial pain</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Non-cardiac chest pain</td>
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<tr>
<td>Gynaecology</td>
<td>Chronic pelvic pain</td>
</tr>
<tr>
<td>Urology</td>
<td>Irritable bladder syndrome</td>
</tr>
</tbody>
</table>

Trudie Chalder 2011
Prevalence

- One in five new consultations in primary care are related to somatic symptoms with no organic pathology

- Physical symptoms without organic pathology are amongst the most common reasons for outpatient referrals
# Prevalence of unexplained symptoms in medical clinics

*Nimnuan et al., 2001*

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Prevalence (95% CI)</th>
</tr>
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<tbody>
<tr>
<td>Chest</td>
<td>59% (46–72)</td>
</tr>
<tr>
<td>Cardiology</td>
<td>56% (46–67)</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60% (45–73)</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>58% (47–69)</td>
</tr>
<tr>
<td>Neurology</td>
<td>55% (45–65)</td>
</tr>
<tr>
<td>Dental</td>
<td>49% (37–61)</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>57% (50–68)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>56% (52–60)</td>
</tr>
</tbody>
</table>
What *not* do to patients with persistent physical symptoms

- Say: “there’s nothing wrong with you”.
- Say: “it’s all in your mind”.
- Say: “there’s nothing wrong with you and I want you to see a psychiatrist”.
- Remove the gallbladder, uterus, appendix or teeth.
- Repeat investigations unnecessarily.
- Prescribe possible addictive drugs.
- Retire the patient on medical grounds.
Efficacy of short term psychotherapy for MUS: A meta analysis (Kleinstauber et al 2011 Clin Psy Rev)

- 27 studies
- Small to moderate between group effect sizes (0.40) for disorder specific outcomes,
- Small effect sizes for depressive symptoms and functional impairment and health care utilisation
- Small to large within group effect sizes (0.80)
Evidence from RCTs: CFS

- CBT generally found to be significantly better than control conditions
  (e.g. Sharpe et al., 1996; Deale et al., 1997; Prins et al., 2001; White et al 2011)

- Graded exercise therapy
  (e.g. Fulcher & White, 1997; Powell et al., 2001; White et al 2011)

Treatments with little or no supportive evidence include:
  ◦ Antidepressants; Nutritional supplements
  ◦ Extended rest; Complementary / alternative therapies
Evidence from RCTs: IBS

- CBT:
  (Greene & Blanchard, 1994; Dulmen et al. 1996; Toner et al., 1998)
  - CBT in combination with antispasmodic drugs is superior to drugs alone (Kennedy et al., 2005).

- Hypnotherapy (e.g. Whorwell et al., 1984)

- Psychodynamic interpersonal therapy (Guthrie et al., 1993; Creed et al. 2003)

- Antidepressants – most effective drugs for treating IBS; modify gut motility and alter visceral nerve responses, reduce pain.

- Antispasmodics (e.g. mebeverine hydrochloride) are associated with improvement in symptoms for some people.
Model of understanding PPS
Predisposing factors

Neuroticism & chronic stress

Perfectionism (relating to personality and learning; linked to avoidance of criticism) (Deary & Chalder 2009)

Paternal rejection or hostility (IBS: Lackner et al., 2004)

Childhood experience of illness in self or parent (Craig et al., 1993)

Learning in childhood that symptoms are dangerous or catastrophic (Hotopf et al. 1999)
South London Somatisation Study: Childhood Risk Factors for Somatisation in Primary Care.  
*Craig et al 1993*

<table>
<thead>
<tr>
<th></th>
<th>Psychologisers</th>
<th>Physical illness</th>
<th>Somatisers</th>
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</thead>
<tbody>
<tr>
<td>Physical illness before 17 years</td>
<td>18%</td>
<td>20%</td>
<td>55% (0.001)</td>
</tr>
<tr>
<td>Parental physical illness before 17 years</td>
<td>9%</td>
<td>23%</td>
<td>41% (0.05)</td>
</tr>
<tr>
<td>Parental lack of care</td>
<td>34%</td>
<td>2% (0.001)</td>
<td>36%</td>
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</table>
Predisposing factors

Previous history of a psychological disorder
(CFS: Wessely et al., 1995; IBS: Walker et al., 1990)

Pre-existing health anxiety (IBS: Gwee et al., 1999)
Maintaining factors – examples

Behaviours

- Boom-or-bust (all-or-nothing) behaviour: Excessive resting leading to deconditioning, and sleep problems
- Repeated investigations (NHS, privately or alternative practitioners)
- Repeatedly seeking external ‘cure’
- Reading about symptoms e.g. medical textbooks, internet
- Avoidance leading to reduce quality of life, maintenance of beliefs / fear
- Medications can produce side-effects
Perpetuating factors

**Emotional**: Stress, anxiety, frustration, low mood, hopelessness

**Cognitive**
Unhelpful beliefs about symptoms
Unhelpful beliefs about general performance, standards, asking for help
Rumination and worry
Symptom-focusing and monitoring

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Maintaining factors (continued)

Physiological
Hypothalamic–pituitary–adrenal axis disturbance (low levels of cortisol)

Social
Lack of social support
Social support present but difficulty asking for help
Others doing too much
Unhelpful advice (e.g. rest) or lack of specific advice / explanation

Cultural
Mind / body dualism
Stigma around psychological problems
Assumes multiple contributory factors

- Predisposing factors
- Precipitating events or triggers
- Maintaining factors

(Physiological, behavioural, cognitive, emotional, social)

Use information from assessment to develop individualised model of the different contributory factors

Modifying predisposing & maintaining factors can help to:

- reduce symptoms and impairment
- decrease risk of future relapse

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Engagement

- Be empathic
- Explicitly convey belief in reality of physical symptoms; doesn’t mean ‘all in the mind’
- Shift focus from “cause” to “symptom management”
- Avoid physical versus psychological discussions
- Use physical illness analogies to illustrate approach
- Reinforce any helpful responses already using
- Elicit concerns and expectations

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CBT for unexplained physical symptoms: Basic components

- Guided by individual conceptualisation
- Rationale for every aspect of treatment
- Expanding understanding of contributory factors (i.e. childhood factors)
- Physiological explanations where possible
- Begin with behaviour change
- Cognitive work on unhelpful thinking patterns & underlying beliefs
- Normalising and acceptance of symptoms

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- Pain does not necessarily mean damage / harm
- Work on other psychological issues (e.g. low self-esteem, perfectionism).
- Be aware how underlying beliefs may affect therapy
- Recovery defined in terms of concrete behaviour, not necessarily symptom free or returning to previous lifestyle
- Relapse prevention
Other aspects of treatment

- Close liaison with all practitioners (party line)
- Deal with reassurance seeking (provide rationale / liaise with those providing reassurance)
- Suspend further investigations or agreeing a compromise
- Rationalise medication
- Reduce drugs with adverse side effects
Relapse prevention

- Summarise progress & what has helped to achieve this
- Identify remaining steps needed to achieve change
- Predict set backs & plan coping strategies
- Plan return to work in detail
- Phased follow-up / booster sessions
Common problems

- Trying to change client’s attributions from a physical one to a psychological one
- Trying to change things too quickly
- Not giving a clear rationale for every intervention
- Using the word psychological
- Impatience or insufficient empathy (compassion) on part of therapist
Conclusions

Moderate evidence for treatments thus far

The relationship is important but patient factors may be more important in terms of prognostic factors

Need to consider reinforcer’s
Offer booster sessions
Need to include main provider of care i.e. GP
Satisfaction and outcome not linked
Books for clients or therapists

*Overcoming Chronic Fatigue* by Mary Burgess & Trudie Chalder (2005), Constable & Robinson. (Self-help guide for clients but may also be helpful for therapists).

*Coping with Chronic Fatigue* by Trudie Chalder (1995), Sheldon Press (Brief self-help guide for clients).

Its good to talk