Cognitive behavioural training for physical health staff
Lucy Eastlake, Brenda Connolly, Catherine Cooper & Elspeth Desert

CITATION
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Abstract
The psychological needs of people with long-term conditions (LTCs) cannot be met through conventional psychological services, as for many patients this would not be appropriate or financially sustainable. Physical health and rehabilitation psychologists (PHRP) are running cognitive behavioural therapy (CBT) tasters for staff working with LTCs. The aim is to pilot CBT training, give an awareness of CBT, and encourage trainees to progress onto a further CBT course. Evaluations have indicated that participants find training beneficial.

Keywords
cognitive behavioural therapy; training evaluation; physical health

Introduction

Background
An LTC persists for over three months and can be controlled but not cured (Fellow-Smith et al., 2006). Individuals suffering from an LTC are more likely to have a mental-health problem than the general population (Fellow-Smith et al., 2006). Mental-health difficulties can have a detrimental effect on physical health, with a reduction in the ability to manage the condition and quality of life (QoL) (Naylor et al., 2012).

CBT is recommended to alleviate the effects of psychological difficulties (NICE, 2009). The NHS Confederation (2012) recommends further investment to meet the needs of this group. PHRP offers psychological therapies for level 4/5 complexities (Figure 1). That is, patients whose psychological difficulties interfere with their ability to care for themselves, interfere with their QoL and require specialist interventions.

However, a significant proportion of patients with LTCs have levels of distress in level 2/3. Some patients may be effectively treated in other
services, e.g., IAPT; however, because of co-morbid issues, such services cannot offer all patients appropriate support. Thus we are faced with the question of how these needs can be met most effectively in a rural population with higher levels of LTCs and unhelpful health-related behaviours than average.

Mannix et al. (2006) identified the need for healthcare professionals to be competent in delivering psychological support to patients with LTCs. CBT has been shown to be effective for patients suffering from the most common psychological issues in this group. Mannix et al. (2006) trained professionals working in palliative care, finding a mixture of training and supervision increased CBT skills. Anderson, Watson and Davidson (2008) measured the effect of CBT delivered by a healthcare professional on patient outcomes. They found that patients showed improved levels of depression and anxiety after intervention. In addition, Moorey et al. (2009) found when nurses working in palliative care were trained according to the model by Mannix et al. (2006), levels of anxiety significantly reduced. These studies support the provision of CBT skills training for professionals working with LTCs.

The Mannix et al. (2006) programme is being rolled out across Cumbria initially funded by Macmillan Cancer Support. It is intended to be Cumbria-wide for professionals working with LTCs. The intention is not to produce new therapists but to enhance the psychological skills of professionals, enabling them to meet some of the needs of patients with LTCs. These are known as ‘CBT First Aiders’, who are able to deliver care in a CBT style to patients with level 1, 2, or 3 complexity (Figure 1).

The training programme comes in two parts. The core is a six-day course taking place over six months, including three two-day teaching sessions six to eight weeks apart, interspersed with five group supervision sessions. Before completing the six-day course, trainees are required to have prior awareness of CBT. To facilitate this, we offer a CBT taster. This article concerns the evaluation of that day.

**Overview of training**

Trainers were experienced in delivering interventions at levels 4 and 5. The taster day is structured as follows:

1. **Introduction** – Brief overview and use of techniques and applications of CBT in physical health.
2. **Thoughts, moods, behaviours links** – Hot cross bun and links. Emphasise thoughts underlying observable behaviours and brief discussion of unhelpful thinking styles and behaviours.
3. **CBT style and key skills** – Style of collaboration, curiosity, and investigation. Skills of discovery via experiments and questions. Trainers use personal example to demonstrate the style.
4. **Skills practice 1 and feedback** – Trainees use questions to help a colleague to resolve a low-key personal dilemma.
5. Demonstration from trainers of a hot cross bun formulation of a patient
6. Skills practice 2 (role play) – Trainees use a case example to take a history, use questions and summaries to elicit a hot cross bun, invite the ‘patient’ to look for links and use strong emotion to look for hot thoughts.
7. Demonstration from trainers of looking for evidence – Testing beliefs, challenging thoughts, changing behaviours, and setting goals if appropriate.

Objectives of evaluation/study
- To pilot CBT skills training for physical health staff in Cumbria;
- To equip healthcare professionals working in LTC with CBT skills;
- To evaluate the taster by assessing trainees’ perception of training;
- To encourage trainees to progress onto the six-day training course.

Delivery
The training was run in both North and South Cumbria. Trainees were recruited by advertising through the Cumbria Partnership NHS Foundation Trust (CPFT) Learning Network. No experience was required. All trainees were required to have the support of managers in attending the course. A total of 168 trainees completed a taster day. Table 1 shows the profession of trainees.

### Table 1: Profession of trainees

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>68</td>
</tr>
<tr>
<td>Doctors</td>
<td>4</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>30</td>
</tr>
<tr>
<td>Social workers</td>
<td>3</td>
</tr>
<tr>
<td>Assistant Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Complementary therapists</td>
<td>3</td>
</tr>
<tr>
<td>Health visitor</td>
<td>2</td>
</tr>
<tr>
<td>Management</td>
<td>5</td>
</tr>
<tr>
<td>Rehabilitation/Health Care Assistant</td>
<td>11</td>
</tr>
<tr>
<td>Assistant Practitioner</td>
<td>5</td>
</tr>
<tr>
<td>Medical staff</td>
<td>5</td>
</tr>
<tr>
<td>Dietician</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
</tr>
</tbody>
</table>

*9 speech & language therapists, 11 physiotherapists, and 10 occupational therapists

Outcomes
For the taster, trainees were asked to evaluate the day by indicating their level of agreement with each of nine statements (below) on a scale of one to five, where 1 = ‘Totally Agree’ and 5 = ‘Totally Disagree’. A total of 117 evaluations were returned. Figure 2 shows average ratings.

### Statements
1. Overall this teaching met the stated objectives and aims;
2. This teaching was relevant to my clinical practice;
3. I have learnt new skills from this teaching;
4. The material was all new to me;
5. The teaching has encouraged me to consider further training in CBT;
6. Discussion of issues was encouraged;
7. As a result of this teaching I feel more prepared for my role;
8. My confidence will be increased in coping with clinical situations as a result of this teaching;
9. I would recommend this day to colleagues.

Participants were also asked to provide comments about the taster. Some 44 of 168 trainees left qualitative feedback. The feedback which was received has been grouped into themes, and the number of responses in each theme and examples are displayed in Table 2.

### Figure 2: Taster day ratings

Participants also made several suggestions which could be considered for future training, these include:

- *Example of real life patient interaction. The exercises given – if they could be enacted by trainers.*
- *As discussed scenarios relevant to sexual health would be useful.*
- *Extend variety of situations for role playing or encourage triads to use a situation from their own clinical experience to encourage (better!) questioning.*
Table 2: Themes arising from the qualitative feedback

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to practice skills</td>
<td>1</td>
<td>“It has made me realise I need to do further practice and training to embed this into my practice.”</td>
</tr>
<tr>
<td>Enjoyable, good, great, etc</td>
<td>18</td>
<td>“Enjoyed immensely.”</td>
</tr>
<tr>
<td>Venue</td>
<td>6</td>
<td>“Venue cold in the morning.”</td>
</tr>
<tr>
<td>Helpful/beneficial to their practice</td>
<td>7</td>
<td>“Very beneficial day, look forward to learning more!”</td>
</tr>
<tr>
<td>Desire to progress to six-day course</td>
<td>3</td>
<td>“I am hopeful I shall continue to be able, with the six-day course, to enhance my skills.”</td>
</tr>
<tr>
<td>Informative</td>
<td>2</td>
<td>“An informative session, would encourage other team members to attend.”</td>
</tr>
</tbody>
</table>

I would have liked to have longer to read and absorb the case (patient role) than was available, otherwise fine. More on finishing techniques – difficult in time schedule. Thank you. Maybe having different scenarios in the group would have been more interesting.

Discussion
This paper has described an evaluation of a CBT taster day for healthcare staff across Cumbria. Evaluations of the taster day were generally positive with trainees agreeing or totally agreeing with the majority of items on the questionnaire. In particular participants agreed that the training was relevant to their clinical practice and that it had encouraged them to consider further training in CBT. In fact, three trainees specifically stated in their qualitative feedback their desire to progress onto the six-day course.

Trainees also agreed that they had learnt new skills, which indicates that the training met another of its aims. The only item that trainees did not agree with was ‘The material was all new to me.’ This is understandable as some trainees may have already had some prior awareness of CBT or have been using CBT skills in their clinical practice without realising.

Limitations and future plans
Of the suggested improvements to the course, all but one concerned the scenarios given to trainees in order to practise their skills. This mainly addressed the lack of relevance of the scenarios to some professionals (e.g., cancer scenarios not relevant for sexual health nurses). We have now started offering taster days on a profession-specific basis. We have already delivered one to staff working with diabetes and are planning to deliver one to physiotherapists working with LTCs which are neurological in origin.

Although several trainees indicated in their qualitative feedback that they would like to progress onto the six-day course, we do not have quantitative data for trainees on whether they would like to do this. The majority of trainees indicated that they would consider further training in CBT, but participants were not specifically asked if they would want to progress onto the six-day course offered in Cumbria. A further improvement to our evaluation questionnaire could therefore be to specifically ask trainees about their intention to progress onto the six-day course rather than just their general intention to consider further training in CBT, as is currently the case. In addition, the item ‘the material was all new to me’ could be removed from the questionnaire as it does not fit in with all the other items. We would expect people to not have prior awareness of CBT and to therefore disagree with this item, whereas the aim of the training is to increase agreement with the other items.

A further limitation was that recruitment of trainees sometimes proved difficult. This could be due to several reasons including a lack of awareness over the impact of CBT ‘first aid’ on clinical practice and patient outcomes leading potential trainees to be wary. There was also, on occasion, a lack of management support, as managers are not aware of the benefits of training in terms of efficiency of the use of resources and patient wellbeing. Some trainees even commented in their feedback that they felt further training would not be supported by their manager. Therefore we plan a further assessment of the impact of training on patient outcomes.
Conclusions
Our evaluation has demonstrated that CBT training for health care staff working with LTCs is feasible in Cumbria. Participants find training in CBT techniques helpful and offering a taster day of these techniques encourages participants to progress onto further training. Furthermore the training was deemed acceptable by trainees, indicating that the course met its aims and trainees felt they would use their new skills to the benefit of their practice.

This has implications for the provision of psychological support in a physical health care setting. If training can be further rolled out amongst healthcare professionals, this will greatly reduce the strain on psychological services and ultimately benefit the patient care journey.

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References

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