**Evaluation of an Integrated Improving Access to Psychological Therapies (IAPT) Pilot Pathway for Long-Term Health Conditions**

By Laurie Josephs & Dr Claire Coysh

***Abstract***

*This article describes an evaluation of a Talking Health pathway for clients with long-term conditions within an IAPT service.*

It has been estimated that up to 30% of the UK population are living with a long-term condition (LTC), and projections predict that this figure will continue to increase due to an ageing population and lifestyle choices (Naylor et al., 2012). LTC refers to chronic physical health conditions that can be managed but not cured, such as diabetes and chronic obstructive pulmonary disease (COPD). Individuals with LTC’s are intensive users of healthcare services accounting for 50% of GP appointments and 70% of inpatient bed days. Figures suggest that 70% of the total health spend in England is attributed to caring for this client group (Department of Health, 2012).

Approximately one third of individuals living with an LTC also experience concurrent mental health problems (Naylor et al., 2012). High rates of anxiety and depression exist in diabetes (Vamos et al., 2009) and COPD (Livermore, et al., 2010), both of which require high levels of self-management. Unsurprisingly, mental health problems can have a substantial impact on engagement in self-management and treatment (Krass et al., 2014), leading to deterioration in quality of life (Moussavi et al., 2007) and poor physical health outcomes (Carney et al., 2004). Subsequently, there is a marked increase in the use of physical healthcare services and associated healthcare costs in this population (Chiles et al., 1999; Egede, 2007).

It has therefore been argued there is a need for integrated physical and psychological healthcare services (Royal College of Psychiatrists, 2015). Research has shown that integrating services leads to better outcomes for both mental health and self-management of the LTC (Coventry et al., 2015; Li et al., 2017). As such, ‘The Five Year Forward View’ planned for the expansion of IAPT services to include integrated pathways specifically for individuals with LTCs (NHS England, 2014).

**Service context**

The current service was identified as one of the ‘Early Implementer’ sites for the first wave of the pilot. The pathway, named ‘Talking Health’, offers psychological assessment and intervention specifically for individuals with diabetes or COPD through a stepped-care approach. All pilot sites were required to monitor clinical outcomes for (i) mood, (ii) perception of physical health, (iii) healthcare utilisation and (iv) patient experience (NHS England, 2018). This project therefore aimed to address the following questions:

1. Does psychological support for LTC clients result in fewer visits to other healthcare services?
2. Do LTC focused interventions lead to improvements in client’s perception of their health and emotional wellbeing?

**Participants**

60 clients were initially identified as having completed the Talking Health pathway. For the first question addressing healthcare service use, seven clients were excluded due to missing the Client Service Receipt Inventory (CSRI) measure. Of the final 53 clients included for this analysis, 22 had COPD (41.5%) and 31 had diabetes (58.5%), with an age range of 20-86 years of age (M=58.0; SD=16.2).

For the second question addressing clients’ perception of their health (excluding an evaluation of mood as this utilised the larger sample of 53 participants), a total of 34 clients were included in the final analysis (19 of the 53 were excluded due to missing measures). Of these, 24 had diabetes (70.6%) and 10 had COPD (29.4%).

**Measures**

Clients completed the following measures at initial assessment, end of intervention and at three-month’s follow-up:

1. Client Service Receipt Inventory (CSRI; Beecham & Knapp, 2001) is a self-report measure capturing the frequency of attending healthcare services relating to a LTC three months before and after intervention.
2. Diabetes Distress Scale (DDS; Polonsky et al., 2005), requires individuals to indicate their level of perceived distress in relation to the emotional burden, diabetes regimen, interpersonal impact and medical team support.
3. The COPD Assessment Test (CAT; Jones et al., 2009) assesses manifestations of COPD such as coughing, breathlessness, energy levels and impact on daily activities and quantifies the self-perceived impact of COPD on the individual’s health status.
4. The Patient Health Questionnaire (PHQ-9: Kroenke et al., 2001) and Generalised Anxiety Disorder Assessment (GAD-7: Spitzer et al., 2006) were used to measure depression and anxiety levels at each appointment.

**Results**

***Physical healthcare use***

The frequency and percentage change in healthcare service use is shown in Tables 1 and 2, for diabetic and COPD clients respectively.

*Table 1: Frequencies and percentage change in service utilisation for* ***diabetic clients*** *(n=31)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Service** | **Frequency of service use at pre-intervention** | **Frequency of service use at 3-month follow-up** | **Percentage change** |
| GP | 70 | 39 | -44% |
| Practice Nurse | 26 | 14 | -46% |
| Physiotherapist | 9 | 11 | 22% |
| Occupational Therapist | 3 | 4 | 33% |
| Specialist Nurse | 23 | 23 | 0% |
| A&E | 9 | 2 | -78% |
| Hospital | 15 | 3 | -80% |
| Ambulance | 8 | 3 | -63% |

*Note. Negative numbers show a decrease in utilisation, positive numbers show an increase in utilisation.*  
  
Reductions in service use were found for hospital admissions, A&E, ambulance, GP and practice nurse services. Clients reported increased use in physiotherapy and occupational therapy services.

*Table 2: Frequencies and percentage change in service utilisation for* ***clients with******COPD*** *(n=22)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Service** | **Frequency of service use at pre-intervention** | **Frequency of service use at follow-up** | **Percentage change** |
| GP | 46 | 39 | -15% |
| Practice Nurse | 7 | 4 | -43% |
| Physiotherapist | 17 | 3 | -82% |
| Specialist Nurse | 12 | 3 | -75% |
| A&E | 5 | 3 | -40% |
| Hospital | 19 | 2 | -89% |
| Ambulance | 3 | 3 | 0% |

*Note. Negative numbers show a decrease in utilisation, positive numbers show an increase in utilisation.*

Reductions in healthcare service utilisation were found across the majority of services in COPD clients.

***Client’s perception of their health***

The median, standard deviations and ranges of pre-intervention, follow-up and change scores for both the CAT and DDS are shown in Table 3.

*Table 3: Pre-intervention and Follow-Up Medians, Ranges and Change in Scores for the DDS and CAT*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Pre-intervention** | **Follow-up** | **Change from pre-intervention to follow-up** |
| **CAT (n=10)** | Median (SD) | 29.50 (7.3) | 27.00 (10.3) | -2.00 (7.5) |
| Range | 12-33 | 7-34 | -2 to +22 |
| **DDS (n=24)** | Median (SD) | 1.91 (0.89) | 1.24 (0.82) | -0.41 (0.77) |
| Range | 1.06-4.12 | 1.0-3.94 | -1.88 to 1.18 |

***COPD and the CAT***

The Reliable Change Indicator (Morley & Dowzer, 2014) was used to calculate reliable and significant change in pre-intervention and follow-up scores for the CAT. Norms from Fisher and colleagues (2012) were used as a clinical reference group. Three out of ten clients showed reliable improvement (30%), seven showed no reliable change (70%) and no clients met criteria for clinically significant change.

***Diabetes and the DDS***

Reliable and significant changes in DDS scores were calculated. Norms from Jones and colleagues (2011) were used as a clinical reference group. 11 clients demonstrated reliable improvement (45.83%), 11 showed no reliable change (45.83%) and two clients showed deterioration in scores (8.33%). No clients met clinically significant change criteria.

**Mood questionnaires**

The means, standard deviations and ranges of pre-intervention, follow-up and change scores for both the PHQ-9 and GAD-7 are shown in Table 4.

*Table 4: Pre-intervention and Follow-Up Means, Ranges and Change in Scores for the PHQ-9 and GAD-7 (N=53)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Pre-intervention** | **Follow-up** | **Change from pre-intervention to follow-up** |
| **PHQ-9** | Median (SD) | 15.00 (6.22) | 6.87 (6.14) | -8.13 (6.86) |
| Range | 1-26 | 0-26 | -22 to 2 |
| **GAD-7** | Median (SD) | 11.78 (5.13) | 6.02 (5.40) | -5.77 (6.83) |
| Range | 3-21 | 17-67 | -21 to 8 |

**Discussion**

The results indicate a general pattern of reported reductions in visitation to healthcare services following Talking Health interventions. The greatest reductions were seen in high-cost services such as hospital admissions and A&E visits, which may reflect greater awareness of the LTC and improved self-management skills. This is consistent with existing literature in both COPD and diabetes (Howard & Dupont, 2014; Uchenda & Blake, 2016).

Interestingly, clients with diabetes reported an increase in visitation to physiotherapy and occupational therapy services, and no changes were seen in specialist nurse visits. These services have been shown to support individuals to maintain good glycaemic control through self-management behaviours such as exercise programmes and adherence to monitoring blood glucose levels (Smith et al., 2003). This finding may be reflective of clients becoming less avoidant of their diabetes and engaging more with specialist support for self-management demands.

Exactly half of COPD clients showed a total score reduction of two or more units on the CAT, thus meeting criteria for Minimum Clinically Important Difference (MCID; Kon et al., 2014). MCID refers to the smallest difference in scores that patients perceive as beneficial, regardless of clinical significance (Jaeschke et al., 1989). Similarly, over half of diabetes clients showed an overall reduction in distress scores. No clients across either groups met criteria for clinically significant change which is likely due to a large number of clients scoring in the ‘very high impact’ range for COPD and ‘little to no diabetes’ distress range at pre-intervention, therefore requiring greater changes in scores to achieve clinically significant change. However, just under a third of clients with COPD and half of clients with diabetes demonstrated reliable improvement, suggesting that Talking Health psychological intervention is associated with improvements in client’s perceptions of their health.

**Limitations**

The findings from the study are limited as a result of missing questionnaires from clients. The use of questionnaires may have introduced self-report biases and response fatigue, which may further impact the validity of the results. Additionally, the self-report nature of the CSRI creates difficulty in asserting accurate frequency of service use. As such, the service is in the process of comparing actual healthcare service use data with the CSRI to establish better accuracy.

**Conclusions**

Evaluation of the Talking Health pilot pathway found that psychological intervention within the service is related to a reduction in clients utilising a number of physical healthcare services and improvements in self-reported perception of their health status and emotional well-being. Reduced physical healthcare service use also contributes to cost-savings, which is increasingly important for commissioning. Service use increase was demonstrated in services supporting self-management demands and is likely reflective of improved understanding and LTC management. Together, these findings suggest that the pathway is a valuable addition to the current IAPT service, delivering efficacious interventions for those with LTCs. However, further work is needed to better understand the most effective interventions and pathways for this client group.

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