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# Improving competencies of PWPs/counsellors to work with people with long- term conditions: Final Report

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Version 1. December 2017

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# Executive Summary

## Background

There are around 15 million people in England living with a long-term physical health condition; of these, around 30% also have a mental health condition. Research indicates that people find it harder to manage their long-term condition in the context of reduced psychological wellbeing.

Statistics for the NW London area reflect the national picture, with increasing prevalence of long-term conditions, including co-morbid mental health needs. The pressure on services associated with rising prevalence of long-term conditions and psychological comorbidities underlines a need to make changes in terms of the way people with mental health needs are supported and how the wider population is supported to stay mentally healthy.

To improve mental health and wellbeing across NW London, the NW London Consortium of Clinical Commissioning Groups has established a new strategy called 'Like Minded', which is about working in partnership to look at how to deliver excellent, joined up services that improve the quality of life for individuals, families and communities who experience mental health issues. Part of this strategy is to ensure that the mental health workforce is able to work effectively with people with long term conditions.

## Methods

A team of experts at the University of Kent's Centre for Health Services Studies (CHSS) was commissioned to develop a training workshop focused on three long-term conditions, which are particularly prevalent in the local area: diabetes; chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD). The CHSS team worked closely with stakeholders to develop training that enables Psychological Wellbeing Practitioners (PWP) and Counsellors to provide effective support to people living with these conditions.

Training covered 'key facts' (informed by a review of relevant literature), opportunity to engage with the 'lived experience' of people with long-term conditions (through

videos, role-plays, case studies and group discussion), and practice using specific assessment and intervention methods. The approach to training was underpinned by psychology theory, particularly the Common Sense Model of Illness Representations (Leventhal et al., 1998) and social cognitive theory (Bandura, 1977).

Training was delivered as a two-day workshop in July/August 2017. An online version of the training was also developed covering the same themes as the workshop, with links to further information and resources. A questionnaire was developed to assess participants' knowledge of the topics covered in training as well as their self-efficacy (confidence in using condition-specific assessments and interventions). Participants were asked to complete this at the start and end of training; open-ended questions on their experience of the training workshops were also included.

## Findings

Questionnaire responses at baseline indicated limited knowledge of long-term conditions, underlining the need for further training in this area. Participants' knowledge of diabetes, COPD and CHD increased significantly following training ( $p < .0001$ ), along with their knowledge of the impact of poor psychological wellbeing on physical health ( $p < .05$ ) and awareness of the role of psychological therapies in supporting people with long-term conditions ( $p < .0001$ ). Self-efficacy also improved significantly following training ( $p < .001$ ). Participants reported that they found the workshops informative and interactive and that they particularly valued the group activities, videos of patients with LTCs and training on outcome measures, as well as the resources provided for further information and support. PWPs and Counsellors indicated that they would be interested in further training covering other long-term conditions, including information on other assessment and intervention approaches (particularly mindfulness-based therapies). They also highlighted the importance of receiving training from workshop facilitators with relevant knowledge and expertise. User feedback on the online training programme indicated that it was useful, interesting and easy to understand.

## Discussion

Our findings indicate that knowledge and self-efficacy among NHS mental health workers can be significantly improved via a two-day interactive training workshop delivered by trainers with relevant expertise and with input from stakeholders.

Further work will be needed to examine long-term impacts of training and implications for patient outcomes, including 'soft' outcomes, such as satisfaction with therapy and 'hard' outcomes, such as change in clinical measures of depression, anxiety and condition-specific distress. It will also be important to determine whether provision of psychological support benefits patient self-management and physical health outcomes.

## Background

### National Context

Long-term conditions (LTCs) or chronic diseases are those that can be managed but often not cured, such as diabetes, arthritis, asthma, a number of cardiovascular diseases, HIV/AIDs and certain cancers (Naylor et al., 2012). It is estimated that 15 million people in England – around 30% of the population - have one or more LTCs and this figure is predicted to rise (Department of Health, 2012). LTCs are more common in older people and low socioeconomic status groups. Multi-morbidity is also more common in these populations and is becoming increasingly prevalent, with the number of people living with three or more LTCs predicted to reach 2.9 million in 2018 (Department of Health, 2012).

Research indicates that people with LTCs are at greater risk of poor psychological wellbeing. Around 30% of all people with a long-term physical health condition also have a mental health condition and this figure may be closer to 50% for those with two or more LTCs (Naylor et al., 2012). Psychological problems not meeting criteria for formal diagnosis, such as difficulties with stress and coping, are even more common (NHS Diabetes & Diabetes UK, 2010; NHS Confederation, 2012). Perhaps unsurprisingly, people with LTCs find it harder to manage their treatment regimes in the context of reduced psychological wellbeing (NHS Diabetes & Diabetes UK, 2010). Mental health co-morbidities in people with LTCs have been linked to poorer clinical outcomes, reduced quality of life and increased costs to the health service (Naylor et al., 2012). Overall morbidity is also increased in people with LTCs when mental health problems are present (NHS Confederation, 2012).

NHS services currently offer a very wide range of approaches to psychological intervention for people with LTCs – as yet, there is insufficient evidence to evaluate the efficacy of these interventions, or calculate cost savings associated with provision of psychological care (NHS Confederation, 2012). A systematic review of psychological interventions for people with diabetes concluded that psychosocial interventions, particularly cognitive behavioural therapy (CBT), anti-depressant medications and collaborative care are effective in the treatment of depression in patients with diabetes; whether these are also effective in improving self-care and

physical health outcomes requires further investigation (Markowitz et al., 2011). Studies evaluating group interventions indicate that these have benefits in terms of 'knowing you're not the only one', feeling able to open-up to others, normalising experience of negative emotion (e.g. guilt/fear/worry) and providing an opportunity to learn practical skills to aid self-management (e.g. cognitive-behavioural/motivational strategies, dose adjustment) (Archuleta et al., 2012; Lawton & Rankin, 2010).

Government policy has highlighted the need to extend NHS mental health service provision to meet the needs of those with co-morbid mental and physical health conditions. *No Health without Mental Health* (Department of Health 2011a) identified the national Improving Access to Psychological Therapy (IAPT) programme as a potential mechanism for addressing high levels of unmet psychological need among people with LTCs and medically unexplained symptoms (MUS). The supporting document - *Talking Therapies: a four-year plan of action* outlined how this was to be achieved in the four years from April 2011 (Department of Health, 2011b). Phase 1 of the project involved implementation and evaluation of 15 Pathfinder sites providing pilot services for people with LTC/MUS (de Lusignan et al., 2013). Thirteen pathfinders were selected to continue for a second year during a reduced Phase 2, which aimed to identify optimal care pathways, staff competencies and training needs, and evaluate clinical efficacy and cost effectiveness of interventions. Alongside this work, the UCL Centre for Outcomes Research and Effectiveness (CORE) has developed a competence framework for psychological interventions for people with persistent physical health conditions (Roth & Pilling, 2015). This framework describes the various activities which need to be brought together in order to carry out effective clinical work for people with LTCs<sup>1</sup>. A joint consensus statement of the Royal Colleges of Psychiatrists, General Practitioners and Physicians and the British Psychological Society has been developed setting out the key characteristics of integrated IAPT services<sup>2</sup> and The IAPT Education and Training Expert Reference Group has developed evidence based curricula to support the commissioning of training for IAPT workers. NHS England is currently working

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<sup>1</sup> [https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychological\\_Interventions\\_with\\_People\\_with\\_Persistent\\_Physical\\_Health\\_Problems](https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychological_Interventions_with_People_with_Persistent_Physical_Health_Problems)

<sup>2</sup> [http://www.rcpsych.ac.uk/pdf/PS02\\_2015.pdf](http://www.rcpsych.ac.uk/pdf/PS02_2015.pdf)



with 22 early implementer sites across the country, leading the way in integrating psychological therapies with physical health care<sup>3</sup>.

## Local Context and Project Aims

Statistics for NW London reflect the national picture, with increasing prevalence of complex long-term health conditions, including co-morbid mental health needs. The region has an ethnically diverse population. For example, census data (2011) for Harrow indicates 69.1% BME groups (including 26.4% Indian, 11.3% Other Asian) and 30.9% White British, while census data (2011) for Hillingdon indicates 39.4% BME groups (including 25.3% Asian, 7.3% Black, 3.8% Mixed, 3% Arab) and 60.6% White. Type 2 diabetes is six times more likely in the South Asian population, three times more likely in African/African-Caribbean people and higher than the London average in Hounslow, Ealing, Brent, Harrow and Hillingdon.

The pressure on services associated with rising prevalence of long-term conditions and psychological comorbidities underlines a need to make changes in terms of the way people with mental health needs are supported and how the wider population is supported to stay mentally healthy<sup>4</sup>. To improve mental health and wellbeing across NW London, the NW London Consortium of Clinical Commissioning Groups has established a new strategy called 'Like Minded', which is about working in partnership to look at how to deliver excellent, joined up services that improve the quality of life for individuals, families and communities who experience mental health issues<sup>5</sup>. The ambitions for this work, set out in the Like Minded Programme 'Case for Change' and 'Better outcomes for people with common mental health needs' (DA2c) in NW London's Sustainability & Transformation Plan (STP) include ensuring that the IAPT workforce is able to work effectively with people with long term conditions.

As part of this programme, the Mental Health and Wellbeing Team (MHWT) held a workshop on 'emotional health and long-term conditions', which included presentations on innovative work to integrate support for mental and physical health

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<sup>3</sup> <https://www.england.nhs.uk/mental-health/adults/iapt/mus/sites/>

<sup>4</sup> <https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwondon/files/documents/CaseForChange%20MAIN%20FINAL.pdf>

<sup>5</sup> <https://www.healthiernorthwestlondon.nhs.uk/bettercare/mentalhealth>

conditions, including development of the KCA Diabetes Psychology Service and associated training<sup>6</sup> (Hamilton-West et al., 2014) and the work of the team at Hillingdon Hospital, which formed part of the IAPT LTC/MUS Pathfinder Programme and resulted in the development of the COPD Breathlessness Manual<sup>7</sup> (Howard & Dupont, 2014). Following a tender exercise, the current project was commissioned to build on this work, by improving competencies of IAPT workers to provide support to people with diabetes, COPD and CHD – the three conditions accounting for the largest service spend in the region.

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<sup>6</sup> [www.diabetes.kca.org.uk](http://www.diabetes.kca.org.uk)

<sup>7</sup> <http://www.londonhp.nhs.uk/wp-content/uploads/2012/11/COPD-Manual-excerpt.pdf>

## Methods

### Participants and Procedure

Participants were Psychological Wellbeing Practitioners (PWPs) and Counsellors employed within NW London IAPT Services. Service managers and commissioners identified that around 120 PWPs/Counsellors were employed within the Clinical Commissioning Group (CCG) area and that it would be possible to release 60 staff members for training. Hence, 60 places were made available for a two-day training workshop, with participants offered a choice of three dates during July and August 2017. Staff not able to attend the workshop received access to an online version of the training programme. Copies of the training materials and handouts were also sent to the participants by email after the workshop.

### Content of Training Workshops

Training content was developed between March and June 2017, in accordance with specifications set out in the project tender documents. Specifically, training workshops were designed to provide:

- (a) Key facts (such as information on prevalence of long-term conditions, how these are managed (and self-managed) and how physical health conditions impact psychological wellbeing);
- (b) Opportunity to engage with the 'lived experience' of people with specific conditions (exploring through videos, role plays, case studies and group discussion what it means to live with and manage chronic illness);
- (c) Skills-based training (in the use of specific assessment and intervention methods).

Key facts were informed by a review of published research, as well as publically available health information (e.g. NHS choices, Diabetes UK, British Lung Foundation, British Heart Foundation) and existing training resources (e.g. [diabetes.kca.org.uk](http://diabetes.kca.org.uk); Hillingdon Breathlessness Manual). A list of resources was also developed for the purposes of signposting patients to sources of information and support (including patient support groups, NHS health trainer and smoking cessation

services and information on specific areas of concern, such as managing diabetes during Ramadan).

To help participants engage with the 'lived experience' of people with long-term conditions, training materials included video interviews available via [healthtalk.org](http://healthtalk.org). These interviews, conducted by qualitative researchers at Oxford University provide valuable insight into the experiences of patients with a range of conditions. Videos relevant to the current project were selected - i.e. focusing on experiences of people with diabetes, COPD and CHD. Concepts of health equity and equality were discussed in relation to patients' experiences of living with and managing their condition. We also engaged with local people with these conditions, including people from BME groups, to seek their perspectives (e.g. on what it means to live with their condition and what they would like health professionals to know about their experience). These individuals were identified via the CHSS Patient and Public Involvement group (which comprises people with a range of health conditions, including diabetes, COPD, CHD and multimorbidity), and other patient groups in the NW London area (e.g. Harrow Diabetes UK, and the BME Health Forum).

Skills-based training was informed by health psychology theory and designed to provide participants with skills in evidence-based methods for supporting behaviour change/psychological adjustment in people with long-term conditions (described further below).

### Stakeholder input

Training was developed with input from a team of stakeholders including commissioners, service managers, programme/work stream leads, clinicians and service users. Stakeholder input was valuable for ensuring that the training content was appropriate for PWP's and Counsellors and met service needs, as well as the wider priorities of the national IAPT programme. Changes made in response to stakeholder feedback included: deemphasising the role of mindfulness-based approaches (which were included in the original training specification); covering specific outcome measures requested by commissioners; amending a reference to reflect recently updated NICE guidance; and including additional information on

diabetic neuropathy in line with patient feedback. A slide was also added to each module entitled 'what people with diabetes/COPD/CHD want you to know' – summarising points highlighted by service users with lived experience of the conditions, as part of the public engagement process within the project.

### Theoretical underpinning

The approach to training was informed by social cognitive theory (Bandura, 1977), which holds that individuals are more likely to carry out a behaviour and to persist with the behaviour in the face of difficulties if they are high in 'self-efficacy'. Self-efficacy refers to the individual's level of confidence in their ability to perform specific behaviours under specific conditions. There are four main routes to developing self-efficacy; mastery experience (i.e. performing the behaviour successfully); vicarious experience (i.e. observing others performing the behaviour successfully); discussion of worries and concerns; and supportive feedback.

In order to enhance participants' confidence in relation to providing psychological support to people with long term physical health conditions, these four elements were built into the workshop – i.e. training provided opportunities for participants to practice using specific assessments and intervention methods in the workshop, to observe others using these methods successfully, express worries and concerns and receive supportive feedback. They were also taught about the concept of self-efficacy and approaches for enhancing patients' confidence in their ability to perform health-related behaviours.

The approach to training was further informed by Leventhal's 'Common Sense Model of Illness Representations' (Leventhal et al., 1980) – this widely used theory sets out the dimensions along which individuals' perceptions of illness may vary. It is useful for understanding the individual's 'personal model' of their condition (i.e. what the condition means to them and how it impacts their daily life) and how this shapes the way each person copes with/manages their condition.

## Evidence-based methods for supporting behaviour change/psychological adjustment

Participants were trained (via patient case studies and role-play) to use the Brief Illness Perceptions Questionnaire (BIPQ; Broadbent et al., 2006) to identify inaccurate illness perceptions, or beliefs contributing to psychological distress/poor self-management. Training also covered the use of condition specific assessment measures, including the Diabetes Distress Scale (DDS; Polonsky et al., 2005), COPD Assessment Test (CAT; Jones et al., 2009) and Minnesota Living with Heart Failure (MLHF) Questionnaire (Rector & Cohn, 1999). Participants were trained to use open-ended questioning, reflective listening and regular summarising to explore patients' responses to these assessment measures and develop a shared understanding of their individual needs and priorities. Participants were then asked to consider how this assessment could inform the use of motivational, cognitive-behavioural and educational strategies, including:

- Helping patients to access information about the condition that is relevant to their specific areas of concern and reviewing this with them (links to relevant information and resources were provided in the workshop).
- Working with the patient to develop 'SMART goals' and/or draw up a 'balance sheet' to support health behaviour change (the workshop included group exercises to practice using these techniques).
- Signposting patients to self-management programmes, the NHS Health Trainer Programme, and/or patient support groups (e.g. Diabetes UK, British Lung Foundation, British Heart Foundation) – further information and links were provided.

Key principles for supporting patients with long-term conditions were drawn from 'Concordance Therapy' which aims to support people to manage their condition skilfully and flexibly, drawing on available sources of support as necessary (Higgins, Livingston & Katona, 2004; Hamilton-West et al., 2010; 2013; 2014). Key principles include:

- A non-blaming atmosphere;
- Emphasis on personal choice and responsibility; and
- Development of self-efficacy.

The Acceptance and Commitment Therapy (ACT) model was also presented, with a particular emphasis on the importance of supporting patients to live the way they want to live, in accordance with their values (Hayes et al., 2006; Gregg et al., 2007). Trainers highlighted that the workshop was not designed to teach participants to *deliver* ACT, but to consider: (1) how living with a long-term condition can interfere with valued activities; (2) how patients can be supported to live in accordance with their values in the context of their long-term condition. Participants were shown video interviews of patients discussing their experiences of giving up work due to health problems (accessed via [healthtalk.org](http://healthtalk.org)). They were then asked to reflect on what the patients valued about their work (e.g. using their skills/training, feeling 'useful', sense of camaraderie/competition) and how they had found other ways to live in accordance with their values after giving up work (e.g. by studying, spending time with family, taking up new hobbies and activities).

The importance of working within the IAPT framework and in accordance with individual skills and competencies was emphasised throughout the workshop. Participants were also reminded that their role is not to provide medical advice and that patients should discuss any concerns about their condition and its management with their doctor/nurse. We also discussed the importance of language – for example, considering that PWP's and Counsellors might use different terms to describe similar concepts (e.g. beliefs/thoughts/cognitions). Participants were encouraged to consider how they would describe the concepts discussed in the workshop and how therapeutic strategies/techniques relate to their existing training/ways of working.

### Online training

An online training programme was developed between July and October 2017, covering the same themes as the workshops, with links to further information and resources (e.g. the [healthtalk.org](http://healthtalk.org) videos and online patient information). Once the

content of training had been reviewed by stakeholders, we worked with a professional web development team to create a fully functioning training resource. This included questions to assess individuals' progress against the intended learning outcomes and videos of simulated therapy sessions. Stakeholders also reviewed and provided feedback on the structure and format of the online resource and visual content, such as images and logos.

## Evaluation questionnaire

A questionnaire was developed to assess:

- Knowledge and understanding of the three long-term conditions covered in training (10 'yes/no' items, e.g. "I understand the difference between Type 1 and Type 2 diabetes").
- Relationships between mental and physical health and the role of psychological therapies in supporting people with long-term conditions (3 'yes/no' items, e.g. "I understand how poor psychological wellbeing can impact physical health in people with LTCs").
- Participants' self-efficacy in relation to using condition-specific assessments and interventions (seven items, scored from 0 'not at all confident' to 10 'very confident', e.g. I am confident that I would be able to select appropriate (condition specific) measures for assessing patients with diabetes, COPD and CHD').

Participants were asked to complete this at the start and end of the two-day training workshop. The post-workshop questionnaire also included open-ended questions on the training provided (e.g. which aspects participants found useful and ways in which the training could be improved). A unique participant identification number was used to match participants' baseline and follow-up questionnaires.

A feedback questionnaire embedded in the online training programme asked respondents to indicate whether they found the training useful, interesting and easy to understand ('yes', 'no', or 'to some extent'). They were also asked to provide a



satisfaction rating from 0-10 and invited to comment on what they liked about the training programme and how it could be improved.

### Data analysis

Quantitative data were entered into SPSS (version 22) and both descriptive (Means and standard deviations) and inferential statistics (McNemar's test and paired-samples t-tests) were computed. The standard level of significance ( $p < .05$ ) was used to examine change from baseline to follow-up.

Responses to the open-ended questions were entered into Excel and read multiple times to identify general themes highlighted by the workshop participants. These were then grouped thematically, paying close attention as to whether the theme was evident across the dataset or described with strength of feeling. The process was then repeated to ensure that the entire dataset was represented in the analysis and subsequent themes.

Responses to the open-ended questions were entered into Excel and read multiple times to identify general themes highlighted by the workshop participants. These were then grouped thematically, paying close attention as to whether the theme was mentioned often or described with strength of feeling. The process was then repeated to ensure that the entire dataset was represented in the analysis and subsequent themes.

For the online training, data were downloaded one month after the programme launched. These were analysed to examine uptake of the training programme (number of participants accessing the programme in the first month) as well as user satisfaction and suggestions for improvement.

# Findings

## Quantitative Analyses

### Knowledge and understanding of LTCs

The evaluation questionnaire was completed by 56 participants (93.3% of those who attended) at the start and 55 participants (91.7% of attendees) at the end of the two-day workshop. The proportion of 'yes' responses (indicating agreement with the knowledge and understanding statements) at baseline and follow-up are shown in Figure 1 and discussed below.

The proportion of 'Yes' responses to the diabetes items at baseline ranged from 57.1% to 70.4%. For COPD and CHD, the proportion of 'Yes' responses at baseline was considerably lower; ranging from 16.1% to 42.9% for COPD and 5.4% to 26.8% for CHD, indicating that knowledge and understanding of these conditions were particularly limited at the start of the workshop. At the end of the two-day workshop, the proportion of 'Yes' responses for all 10 condition-specific items increased significantly ( $p < .0001$ ), with most reaching 100% (range from 94.6-100).

### Relationships between mental and physical health

Scores for the three items assessing relationships between mental and physical health and the role of psychological therapies in supporting people with long-term conditions were higher at baseline than for the condition-specific items, with 'Yes' responses ranging from 76.8% to 94.6%. This proportion increased to 100% for all three items at the end of the workshop. The change was statistically significant for two of the items: 'I understand how poor psychological wellbeing can impact physical health in people with LTCs' ( $p < .05$ ) and 'I understand the role of psychological therapies in supporting people with long-term physical health conditions' ( $p < .0001$ ). The only statement that did not demonstrate significant change from baseline was 'I understand how living with a long-term physical health condition can impact on psychological wellbeing'. This is most likely due to ceiling effects (i.e. scores at baseline close to 100%).

Figure 1. Knowledge and Understanding Scores at Baseline and Follow-up

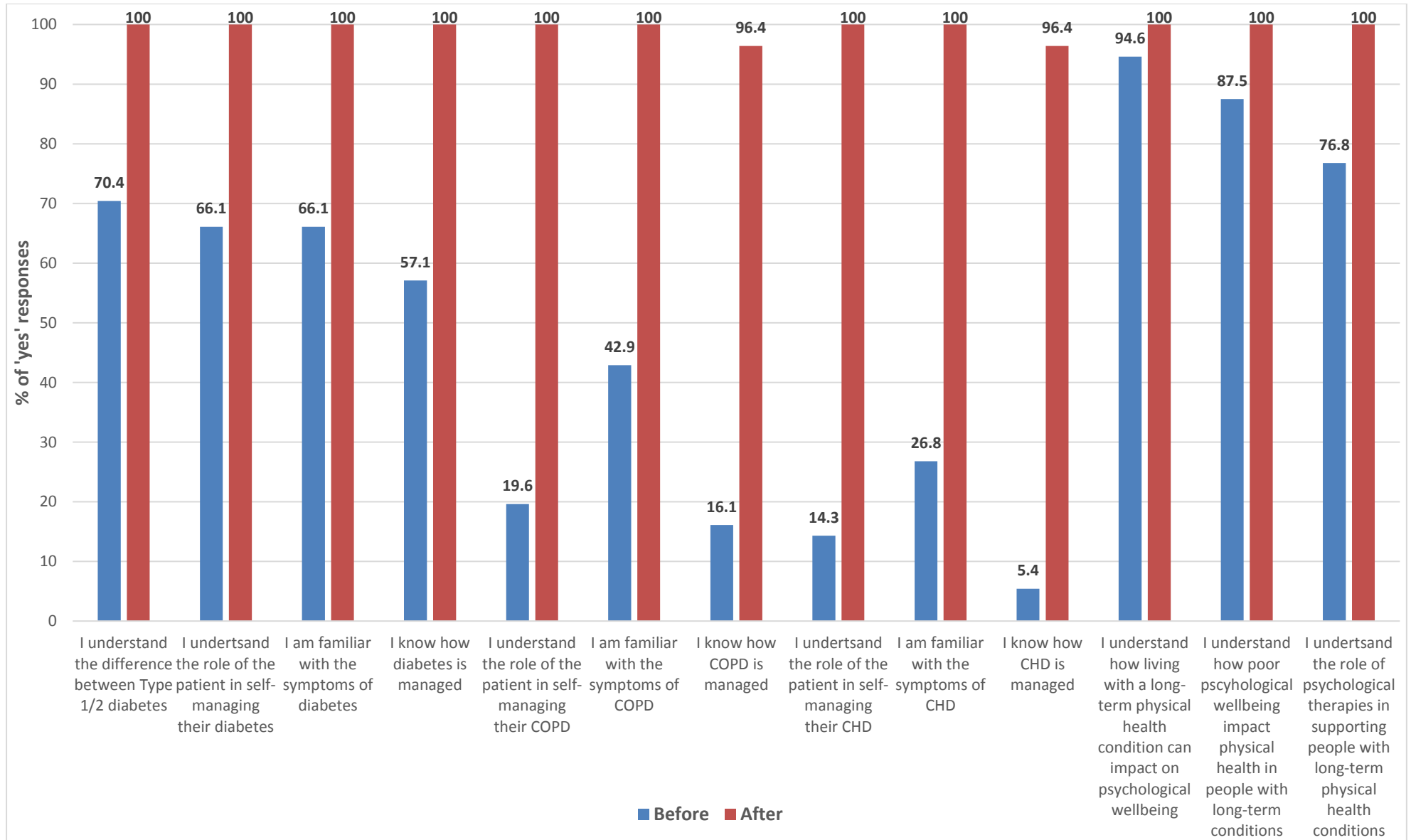
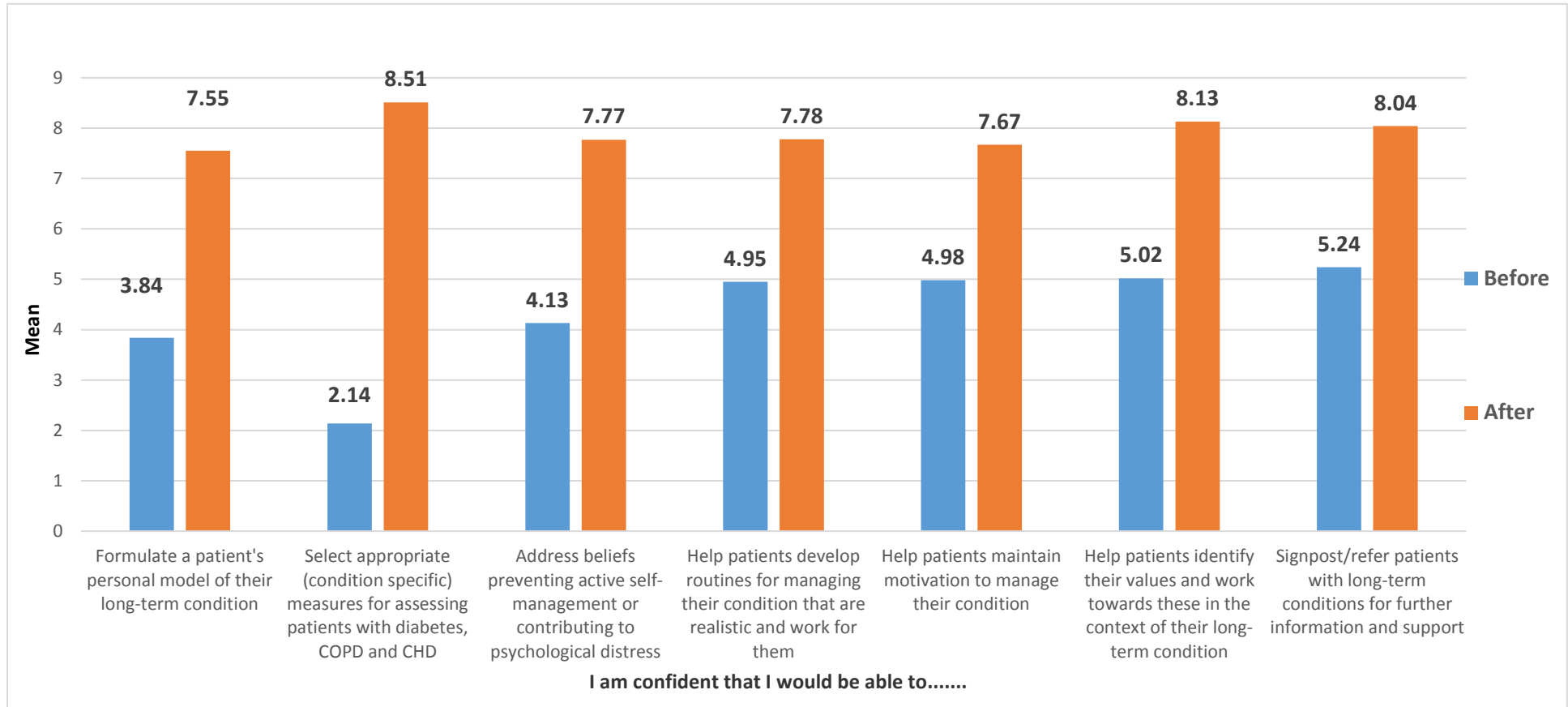


Figure 2. Self-efficacy Ratings at Baseline and Follow-up



## Confidence in working with LTC patients

Mean scores for the self-efficacy items at baseline and follow-up are shown in Figure 2 (above). Scores at baseline ranged from 2.14 ('I am confident that I would be able to select appropriate (condition-specific) measures for assessing patients with diabetes, COPD and CHD') to 5.24 ('I am confident that I would be able to signpost/refer patients with long-term conditions for further information and support'). Scores for all seven items increased at the end of the workshop, ranging from 7.55 to 8.51.

Since self-efficacy items formed a reliable scale (Cronbach's alpha = .92 at baseline and .90 at follow-up), a total self-efficacy score was calculated summing across all seven items. The total score increased significantly from baseline (M=25.75; SD= 13.41) to follow-up (M= 55.45; SD = 8.35). A paired-sample t-test revealed that this change was statistically significant ( $p < .001$ ).

## Qualitative Analysis

Three main themes were identified from analysis of participants' responses to the open-ended questions. These are presented visually below, alongside relevant commentary and quotes.

### Theme 1: Workshop style and length

Participants reported that overall they found the workshop style to be interactive (with day 2 highlighted as particularly interactive compared with day 1) and informative. Participants commented that the information provided in the workshops enabled a better understanding of the three long-term conditions:

"Good, robust information with a good balance between thought elements and group tasks."

"Information about different illnesses and symptoms will help me understand what is normal/typical when patients report anything."

Participants further commented that:

“I will use the information to help myself in the sessions, to better understand what my client is struggling with.”

“I feel much more confident working with the LTCs with the knowledge I have gained.”

“(I will) be even more curious and non-judgmental/positive framing to build motivation because there's been such a lifestyle shift/impact for these with LTCs.”

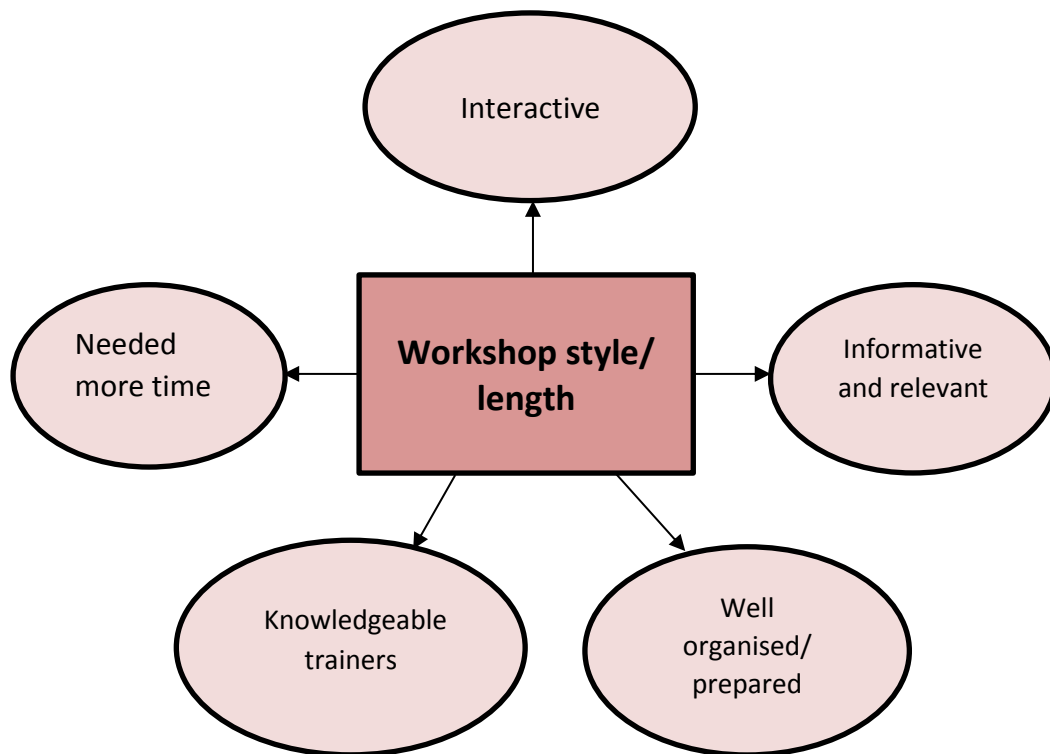
Positive experiences of the workshop were facilitated by the training being: “Well-organised and prepared... it felt hands-on with the... tasks... not just presentations.” Another participant highlighted that the role-plays were “great for learning how to use skills in situ.”

Participants commented that helpful resources and references had been provided, which will make it “easier to signpost people.”

Participants also remarked that trainers were “helpful”, “knowledgeable“, “clear” and “encouraged good group involvement.” Participants stated that they “enjoyed... having different speakers discussing different topics.”

In terms of the length of the workshop, some participants felt that more time would have been useful (i.e. a third day) in order to discuss further the techniques covered in the training, and in more depth.

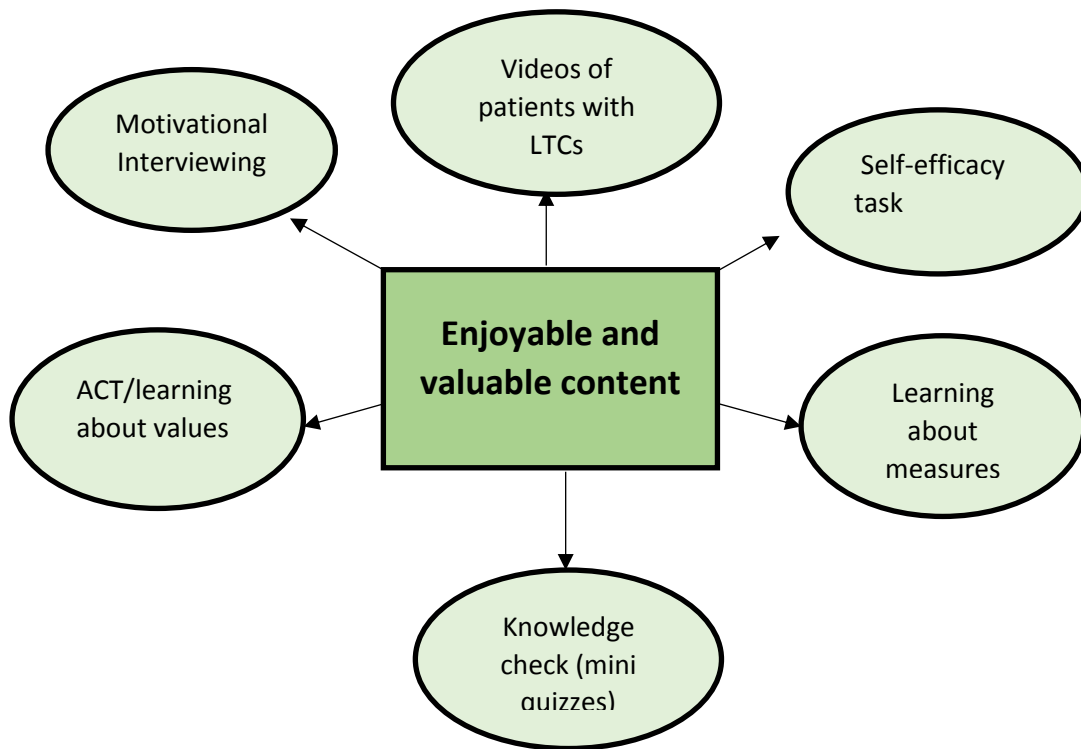
Figure 3: Thematic map of theme 1 – Workshop style and length



### Theme 2: Enjoyable and valuable content

There were many aspects of the workshop that participants enjoyed and/or thought were particularly valuable, as shown in the diagram below. The most valuable aspect of training, as frequently referred to by participants, was Acceptance and Commitment Therapy (ACT) (small group work on identifying values). The content relating to Motivational Interviewing, and videos of people with each of the conditions covered in training - Diabetes, COPD and CHD - were also considered very useful.

Figure 4: Thematic map of theme 2 – Enjoyable and valuable content



### Theme 3: Further training needs

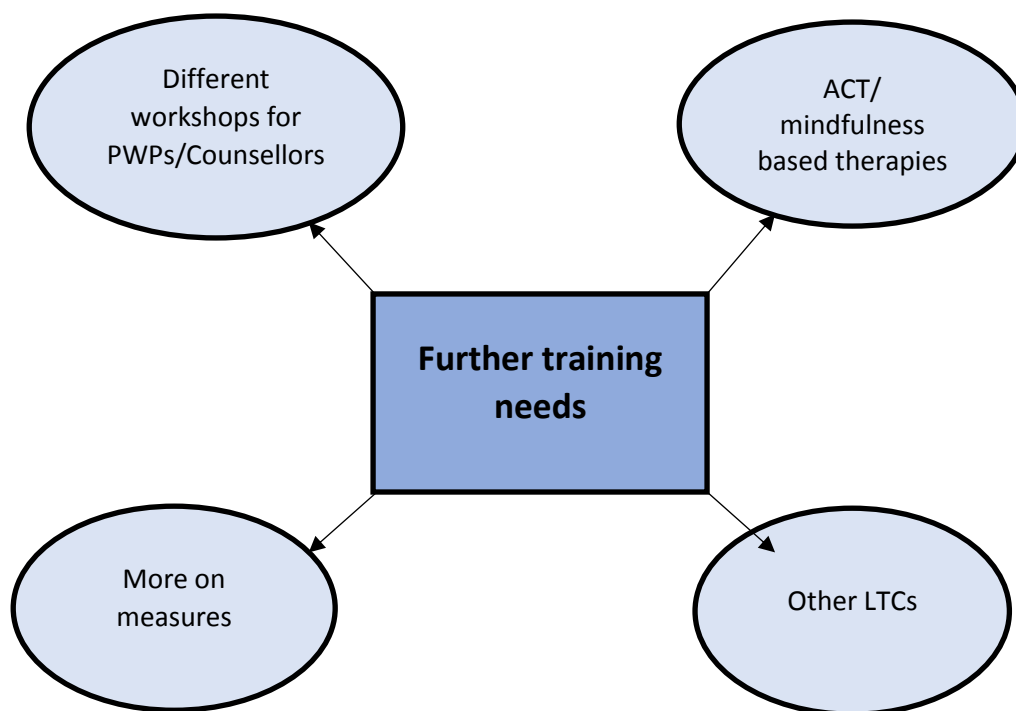
It is understandable that participants mainly asked for further training in the sessions that they found most valuable, for example, ACT. Participants also reported that they would like further training in mindfulness (which was not covered in the workshop). Other long-term conditions such as chronic pain, arthritis and medically unexplained symptoms were also cited as training requests. Some participants highlighted that they would like further training in the use of patient outcome measures for LTCs.

Finally, some participants felt that future workshops could be divided into separate sessions for psychological wellbeing practitioners and counsellors in order to enhance relevance and understanding. However, there were some contradictory views to this, for example:

“The training was especially welcome as being accessible to counselling - very adaptable.”



Figure 5: Thematic map of theme 3 – Further training needs



### Online training

The online training programme was accessed by 328 participants in the first month. Of these, 261 provided information on their occupation, including Psychological Wellbeing Practitioners (N=89), Counsellors (N=40), Other High Intensity Therapists (N=70) and Service Managers/Leads (N=34). Participants were employed within a wide range of National Health Service (NHS), voluntary and community organisations across the UK. Feedback questionnaires were completed by 28 respondents. The vast majority of respondents indicated that the training programme was useful, interesting and easy to understand.

Responses are summarised in Table 1 below.

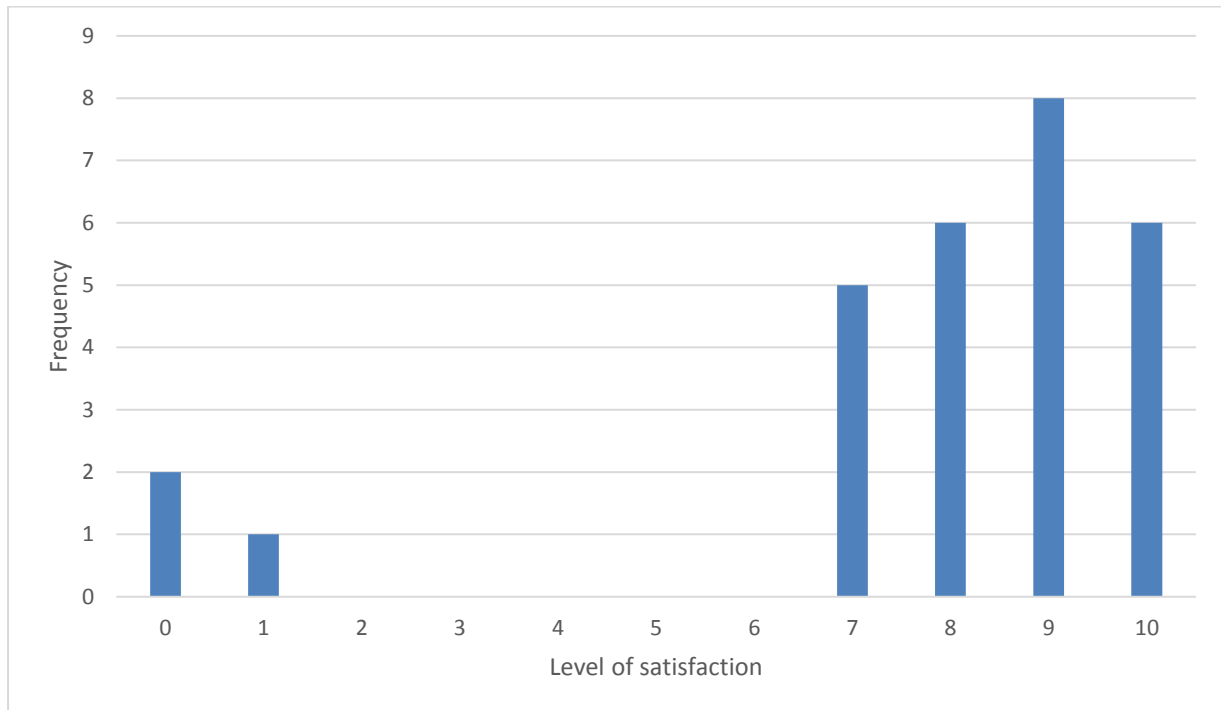
Table 1. Responses to online training feedback questionnaire

N(%)	Did you find the training...		
	Useful	Interesting	Easy to Understand
<b>Yes</b>	23 (85%)	23 (82%)	25 (93%)
<b>No</b>	1 (4%)	1 (4%)	0
<b>To Some Extent</b>	3 (11%)	4 (14%)	2 (7%)
<b>Total no. respondents</b>	27	28	27

The mean satisfaction rating was 7.75 (SD 2.72), with most respondents (89%) provided satisfaction ratings between 7 and 10. A breakdown of satisfaction ratings is provided in Figure 3 below.

Comments indicated that respondents found the training “very relevant” and “easy to follow” providing “the right amount of information at the right level”. Respondents also liked the layout/format, references and links to useful resources. Suggestions for improvement included adding “more video case studies”, “more pictures/diagrams”, “quizzes that have a pass or fail rate” and the option to print a completion certificate.

Figure 3. User satisfaction ratings for online training programme



## Discussion

Training the NHS mental health workforce to provide support for people with long-term conditions is a key mechanism for addressing unmet psychological needs in this population. The aim of this project was to develop and deliver training for mental health workers in NW London, focusing on three long-term conditions, which are particularly prevalent in the local area: diabetes; chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD). Content was developed in line with the tender specification documents, based on research evidence and with input from stakeholders (including commissioners, service managers, programme/work stream leads, clinicians and service users). Training was then delivered in the form of two-day workshops for PWP's and Counsellors; an online version was also created covering the same themes as the workshops, with links to further information and resources.

Baseline responses to the workshop evaluation questionnaires underscore the need for training in long-term conditions. For example, almost a third of workshop attendees did not know the difference between Type 1 and Type 2 diabetes and a similar proportion indicated that they were unfamiliar with the symptoms of diabetes, did not know how diabetes is managed and did not understand the role of the patient in self-managing diabetes. Participants reported even lower levels of familiarity with COPD and CHD with only 16.1% and 5.4% respectively reporting awareness of the management of these conditions. At the end of the two-day workshop, knowledge of the three conditions increased significantly, along with participants' knowledge of relationships between psychological wellbeing and physical health and awareness of the role of psychological therapies in supporting people with long-term conditions. For most knowledge items, 100% of participants gave 'Yes' responses after the workshop and all items were rated 'Yes' by at least 96.4% of respondents. This increase in knowledge and understanding is notable, given that training was delivered over only two days.

Prior to the workshop, confidence in working with patients with long-term conditions varied from low-to-moderate across the different topics. For example, the lowest level of confidence reported on a scale from 0 ('not at all confident') to 10 ('very confident') was in selecting appropriate (condition specific) measures (2.14), while

the highest level of confidence was reported for signposting patients with long-term conditions for further information and support (5.21). After the workshop, higher levels of confidence were reported across all seven topics, with the largest improvement noted in selecting appropriate measures. This suggests the workshop provided the necessary conditions to not only improve attendees' knowledge of long-term conditions, but also enhance their confidence in working effectively with this population.

Participants reported that they found the workshops informative and interactive and that they particularly valued the group activities, videos of patients with LTCs and training on outcome measures, as well as the resources provided for further information and support. PWPs and Counsellors indicated that they would be interested in further training covering other long-term conditions, including information on other assessment and intervention approaches (particularly mindfulness-based therapies). There were mixed views as to whether PWPs and Counsellors should be trained together or in different groups.

Many participants reported that the knowledge gained in training would make a difference to the way they work with clients with long-term conditions in the future. However, it was not possible to assess impacts of training on practice within the context of the current project. It is also important to recognise that changes in knowledge, understanding and confidence were examined immediately after training and we do not know to what extent these changes will be maintained in the longer-term. Future work will be needed to address these questions and to examine the impacts of training on patient outcomes, including 'soft' outcomes such as satisfaction with therapy and 'hard' outcomes, such as change in clinical measures of depression, anxiety and condition-specific distress. It will also be important to determine whether provision of psychological support benefits patient self-management and physical health outcomes.

Responses to the online training programme were consistent with feedback on the workshops, highlighting the importance of clearly presented information, interactive elements and links to sources of further information and support. Respondents also valued receiving feedback on their learning. Online training platforms provide an opportunity to deliver training to larger numbers of people and our findings indicate

that most people found this approach useful, although some of the advantages of face-to-face training (e.g. opportunities for group discussion, and ‘hands on’ activities) are more difficult to provide in this format. Suggestions for improvements will be helpful for building on this work in the future – for example, we have recently built in a function that allows participants to download a certificate of completion at the end of training.

## Conclusions

PWPs and Counsellors’ knowledge, understanding and confidence in providing effective support to patients with LTCs was significantly improved via a brief training programme underpinned by psychology theory. Future work should examine impacts of training on practice and patient outcomes.

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