Mental Health Access Team	2017

Psychotherapy Provision within the Critical Care Rehabilitation and Follow up Team. The Intensive Care Unit, Barnsley Hospital: A Service Evaluation

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Background

The service evaluation has taken place to determine the recovery of patients referred, and to gather data from patients who have used the service.

Method

Eight patients were sent a questionnaire at 18 months post therapy.

Data from routinely collected outcome measures was analysed using a database of all patients referred to the service.

Findings

The recovery rate was good, especially in relation to the reduction of psychological trauma. The psychotherapy had been helpful, however two responses indicates that distress remained and that the patient believed that this was something they would never recover from.

Recommendations

There is capacity for more patients and staff to be seen.

A need for a bereavement group has been identified and it may be that partnership working with the Recovery College could be a way forward in developing this.

Several members of staff used the service; however it has not been within the scope of this evaluation to ask for their feedback. This may be something that could be addressed in future evaluations .

1. Introduction

The Critical Care and Rehabilitation and Follow up Team (CCRAFT) is established at Barnsley District General Hospital .Patients are reviewed in clinic three months after discharge .This is led by the Consultant and the team comprises of nursing and physiotherapy staff ,In 2013 funding was made available for Psychotherapy to be available within the team. This part of the service started in March 2014 and has been provided by psychotherapists with experience in CBT and EMDR. Clinical Supervision has been provided by a Principal Clinical Psychologist within the Mental Health Access Team.

This evaluation will cover the use of the service and the recovery rates of the patients referred to Psychotherapy. This was undertaken at the request if the Consultant Intensivist There is also analysis of the data of eight patients who were followed up at 18 months post discharge.

1.2 **Aims** The aim of the evaluation was to collect data from patients at 18 months post discharge , looking at their recovery and to determine whether the therapy had been helpful

1.3 **Methodology** A Feedback Questionnaire was developed , and data from routinely collected outcome measures (, eg PHQ9, GAD7, WSAS and IES-R)was analysed

1.4 Sample: The Sample consisted of 8 patients that were seen within the service for psychotherapy .

2. Overview of the Psychotherapy Service in the Intensive Care Unit at Barnsley Hospital

2.1 Referral Process:

Most patients are referred directly from the Follow up Appointment which is offered with Dr Wenham and other members of the CCRAFT team, including Physiotherapists and Nursing staff. The Follow up Appointment is usually around 3 months post discharge. Some patients have been referred through the Intensive Care Unit (ICU) Support Group. Other patients have been identified through GP or Self-referral to the Mental Health Access Team and IAPT.

There was also capacity to see Staff who are suitable for IAPT. Five members have staff have used the service; two of these were already on the waiting list for IAPT. Data from staff has not been included in this report.

There have been two referrals which were not suitable for Primary Care Mental Health where the patient was within Secondary Care Mental Health Services and waiting for psychological therapy, however this was not known until after referral. The ICU staff do not have access to the Mental Health Care Information systems.

2.2 Presenting Problems of Clients Referred to the Service

Table 1 shows the reported presenting problems of clients referred to the psychotherapy CCRAFT service and the frequency of each problem. Some clients reported more than one presenting difficulty.

Presentation/Problem	No. of clients
Post-Traumatic Stress Disorder (PTSD)	31
Anxiety ,fear of relapse	24
Being distressed about not remembering anything "lost days or weeks "	29
The experience of being in ICU ,seeing other critically ill patients , being next to someone who died	22
Coping in the night, fear of staff at night.	3
Anticipatory anxiety related to further surgery	6
Depression , fatigue, low motivation	31
Feeling guilt for the impact the experience has had on family and friends	26
Bereavement	4
Family and relationship problems ,	17
Social stressors (including DWP)	8
Adjustment to disability , immobility and having to depend on others	3
Not coping with a stoma	3
Panic attacks and agoraphobia	5
Relatives, both bereaved.	2

2.3 Mode of Therapy / Treatment Received/Offered

Three types of treatment were offered by one therapist, trained in each of the modalities:

a. CBT was used for the treatment of anxiety and depression.
b. Eye Movement Desensitisation Reprocessing (EMDR) was offered (for those suitable) for the trauma of ICU Psychosis . EMDR is contraindicated for people who have epilepsy, or those who are taking benzodiazepines.
c. Counselling was used for bereavement and adjustment.

2.4 Factors Influencing Treatment/Engagement

a. Pre-existing Trauma

9 patients on the database of 50 had pre-existing trauma. As many people do not disclose previous trauma, particularly in childhood, it is not known how many other people may have experienced this. 4 of the patients wanted to work on the previous trauma and the other 5 did not.

Difficulties in engagement;

- Poor health,
- Having lots of other medical appointments

b. Non engagement

- 6 people did not attend and were discharged back to the care of their GP.
- 6 have attended once and either dropped out or said they didn't need the service
- 4 people attended twice

c. Delirium

- 21 patients reported delirium. This did not affect their engagement.

3. **Results**

3.1 Feedback Questionnaire

The Feedback questionnaire was sent out in May 2016 .The Questionnaire was sent to 8 patients who were 18 months post admission

There was a 50% response rate and the results below are based on the 4 people who responded. Table 2 represents the quantitative responses to questionnaire items 1, 2, 4, and 6 and qualitative responses to questions 3 and 5 are detailed separately after the table.

Table 2: Responses to questionnaires at 18 month post admission

Q1. How are you feeling now in terms of your physical wellbeing?	Very well	Well	Okay	Poorly	Very poorly
No. of responses			**4**		
Q2. How are you feeling now in terms of your mental wellbeing?	Very well	Well	Okay	Poorly	Very poorly
No. of responses		**1**	**3**		
Q4. Do you feel you have been able to resume your normal way of life?	Completely	Almost completely	Almost	Somewhat	Not at all
No. of responses			**2**	**2**	
Q6. Were you aware that there is individual support available for your relatives and friends provided by the ICU Psychotherapist and that there is a monthly support group?	Yes	No	No response		
No. of responses	**3**		**1**		

Q3: What do you think was the hardest thing to cope with during your recovery?

- *"Nightmares were a big problem, enclosed spaces /panic attacks. Talking about my experiences with family .Not knowing whether my experiences were real or imaginary .Returning to hospital was sometimes necessary for therapy and that was difficult "*

- *My "mental wellbeing" is much as before .I have not and never will come to terms with the tragedy that affected me so much".*

- *Trying to come to terms with illness and not being able to remember things leading up to ICU admission .Lack of energy*

- *Hallucinations which still trouble me at times even now. Flashbacks to when I felt in fear for my life during the hallucinations*

Q5: What other kinds of support do you think would have been helpful to you?

- *Nothing! I thought the service was fine for my needs*
- *No response.*
- *Can't think of anything else.*
- *If there had been more understanding and communication coming out of ICU onto the general ward .I found no understanding of my hallucinations on the ward I was put on .It was as if they blamed me and my family for what I was going through.*

3.2 Quantitative Analysis of Client Database

3.2.1 Overview of Results of Outcomes and Measures Used

The outcomes for 52 clients were analysed as part of this service evaluations. The results show that the average number of sessions clients were seen for was 4.

Within IAPT services, standard questionnaires are routinely administered at each client appointment in order to measure outcomes. The measures used are PHQ9 (measuring symptoms of depression), GAD7 (measuring symptoms of anxiety, Work and Social Adjustment Scale (WSAS) and a phobia measure. The Impact of Events (IES) scale is also used to measure symptoms of Post-Traumatic Stress Disorder (PTSD). All measures are self-report and completed by clients.

Table 3 lists the measures used and some of their relevant features.

Table 3. Scoring for relevant IAPT measures

Measure	***Diagnosis***	***Range***	***Reliable Change Index***	***Caseness Threshold***
PHQ9	***Depression Disorders***	***0-27***	***_>6***	***_>10***
GAD-7	***Generalised Anxiety Disorders***	***0-21***	***_>4***	***_>8***
IES-R	***Posttraumatic Stress Disorders***	***0-88***	***_>9***	***_>33***
WSAS	***N/A***	***0-40***	***N/A***	***N/A***
Phobia	***N/A***	***0-24***	***N/A***	***N/A***

For a referral to be recorded as 'moving to recovery' at the end of treatment, it must have been at caseness at the beginning of treatment.

To be at caseness, a referral must score above the clinical/non clinical cut off on either the assessment for depression (PHQ9), the assessment for anxiety (GAD7) or both.

To move to recovery, a referral needs to move from caseness to below caseness on both sets of measures by the end of treatment.

We can also measure how much a patient has improved throughout the course of treatment by looking at reliable change. A patient would reach reliable change if their assessment scores are 5 points lower, or more, on the assessments than they were at the start of treatment, for the GAD-7 and 6 points or more for the PHQ-9. Therefore, even if a referral hasn't moved to recovery, it's possible that the patient may have improved significantly.

3.2.2 Data Analysis Results

Table 4 shows the average scores of clients at the beginning of treatment and at the completion of treatment on the IAPT measures and calculation of change scores, recovery rates and reliable change. This relates to 52 clients.

Table 4: Mean client score pre and post treatment with difference, recovery and reliable change scores.

	PHQ-9	GAD-7	IES	W&SAS	Phobia Scale
Mean at Pre-treatment	17.7	15.2	55.7	X	X
Mean at End of Treatment	11	9.3	11.1	X	X
Mean Difference	6.7	5.9	44.6	X	X
End in Recovery	20 (38.4%)	20 (38.4%)	15 (28.8%)	n/a	n/a
Reliable change.	23/52				

4. **<u>Conclusion</u>**
   - Patients are seen quickly after referral .There is no waiting list.
   - Staff have also used the service and recovered. Data from staff was not included in this evaluation .This is for the purpose of confidentiality
   - The recovery rate is good. In particular the recovery rate using the IES-R (Impact of Events Scale –revised .The data showed that 20 patients reached recovery and 23 had reliable change. Of a total of 51 clients, 23 showed reliable improvement. Of the 31 clients that didn't reach recovery, 4 of those showed reliable improvement .12 of those with reliable improvement had CBT only.7 had EMDR only and 4 had CBT and EMDR.
   - There was a 50 % response rate for the questionnaire developed to look at outcome at 18months post therapy and qualitative data shows an improvement in mental wellbeing and patients were able to resume their normal way of life.
   - Referrals have been appropriate however ICU staff do not have access to the Mental Health record (RIO) which gives information about any current and previous use of the service. This is checked when referrals are received and then anyone who is currently with secondary care or on a waiting list with secondary care is not taken on.

5. **Recommendations for future development for Psychotherapy in ICU.**

- There is capacity to see more patients and staff.
- One of the clients referred would like to be involved in developing Bereavement Group, this may be something that could possibly be done in partnership with MHAT and the Recovery College as this has been difficult to get off the ground with Nursing staff on the unit due to service pressures.
- Further learning and sharing of the experiences of other services is likely through the attendance of a recently developed special interest group of psychological therapist working in critical care.