Coping with distress about your health

Produced by

NIHR CLAHRC East Midlands
Collaboration for Leadership in
Applied Health Research and Care

This research intends to bring benefits to patients at high risk of anxiety-related healthcare use, by using **remotely delivered Cognitive Behavioural Therapy** (rCBT).

Severe health anxiety causes high levels of preoccupation and worry about having or acquiring a serious physical illness. It can lead to reassurance seeking, repeated medical visits or not seeking medical help when it is needed because of fear. Severe health anxiety also has a serious detrimental and debilitating impact on physical and mental health and a person's ability to function.

People with severe health anxiety contact same day services twice as much as other patients of the same age and gender. They are **twice as likely to have a heart attack or stroke**, and they are also **much more likely to develop depression, medically unexplained symptoms and other anxiety disorders**.

Despite the availability of effective treatment for severe health anxiety, few people take it up.

rCBT is acceptable to a patient group who are often reluctant to engage with traditional mental health services. rCBT improves accessibility by providing care in the patient's home, thus removing travel needs and providing a confidential method of engaging with mental health care. rCBT saves patients and the NHS time and money, whilst providing clinically effective care to a seldom heard patient group.

THE PROBLEM

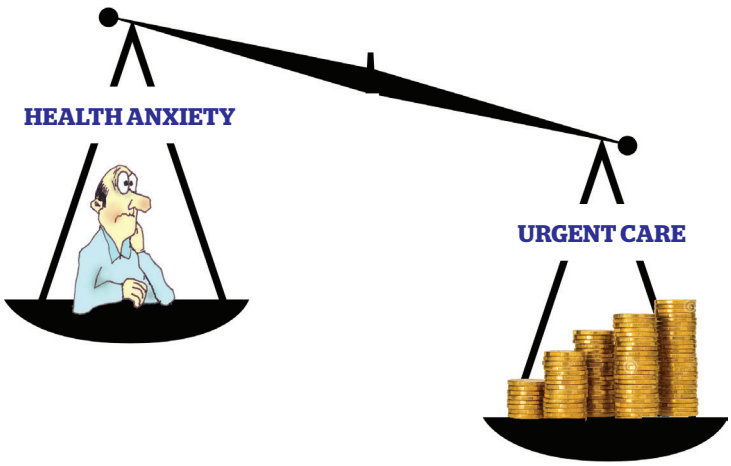
- **One of the most common types of anxiety is anxiety focused on health, where those affected worry that they are currently (or will be) experiencing a serious illness.**
- **Severe health anxiety and similar problems cost the NHS in England an estimated £3billion per year in unnecessary costs. (Bermingham et al, 2010).**
- **Severe health anxiety is common: approximately 5% of the general population experience symptoms. However, the risk of severe health anxiety increases up to five-fold in certain medical settings (e.g. 25% in neurology outpatients; Tyrer et al., 2012).**
- **Traditionally, this patient population rarely seek treatment, but instead become lost in the system as they often access multiple services to establish the cause of their problems. This frequently has little success, leading to growing frustration and mistrust towards health services, coupled with increased fear of serious undiagnosed illness. This consequently leads to repeated urgent and unscheduled care appointments to manage and respond to their symptoms.**
- **Severe health anxiety leads to greater use of urgent/unscheduled care health services, especially Emergency Departments (ED), walk in centres and urgent same day GP appointments.**
- **Severe health anxiety is common in primary care (accounting for up to 3% of appointments) and in secondary medical care settings (involved in up to 10% of appointments) (Tyrer, 2011).**

THE SOLUTION

A remotely delivered Cognitive Behavioural Therapy (rCBT) intervention was offered to a group of patients with severe health anxiety who used urgent care at a high rate.

The intervention involved:

- A carefully worded explanation for use by a clinician providing ongoing care to the patient, to explain the rCBT intervention (talking to someone over internet video conferencing software or over the telephone (if internet access is limited) about how to cope better with distress from their physical symptoms) and seek their consent for referral.
- Remote delivery of CBT through video calling. Similar to Skype, WebEx involves using an internet connection and web-cam to have a real-time, virtual face-to-face conversation. This addressed a number of barriers to engagement amongst patients with severe health anxiety: it increased accessibility, by providing care wherever patients wanted to receive it; it reduced the impact of stigma, by removing the requirement to attend mental healthcare premises, and it promoted continuity of care, by making attendance at a series of appointments as easy as possible for those likely to have co-morbid long-term health conditions. Furthermore, screen and application sharing facilities mean that activities can be very similar to face-to-face treatment.
- Delivery of 6-12 rCBT sessions with a CBT therapist, plus the offer of up to four booster sessions dependent upon clinical need, which brings the rCBT intervention in line with IAPT's offering up to 16 sessions.
- The same standardised assessments as those routinely used by IAPT services (PHQ-9, GAD-7) with an additional assessment of healthcare use to evaluate healthcare impact.
- Routine progress monitoring using software providing algorithm-based feedback on predicted outcome. This helps reduce treatment dropout, improve clinical outcomes and improve the efficiency of treatment (i.e. fewer sessions are needed).
- Recording of WebEx sessions as standard to enhance care quality and support consolidation of rCBT benefits by encouraging patients to review each session recording.
- Best practice procedures for enhancing clinical effectiveness, including clinical supervision focused on cases with little treatment response, using session recordings and outcome monitoring to inform improvements.
- Smart-messaging software for use after treatment to prevent relapse (already commissioned in some regions).



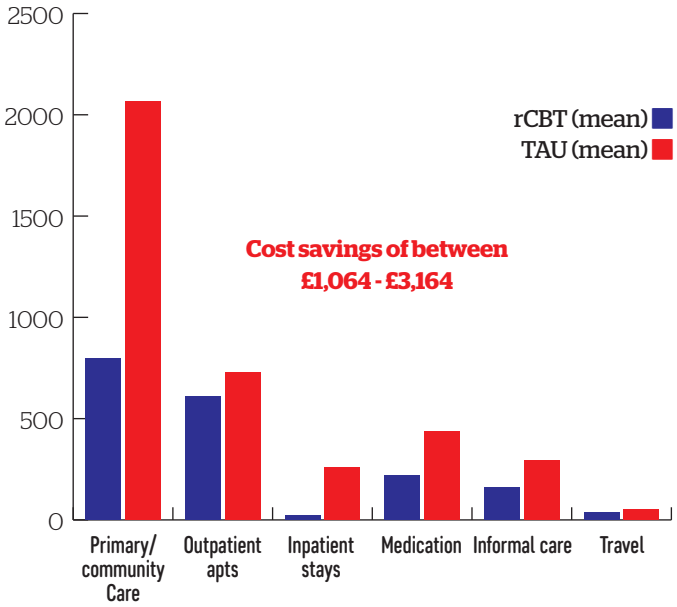
SO WHAT? - PATIENT BENEFITS:

- Physical and mental health improves as severe health anxiety is reduced and managed.
- Accessible and acceptable delivery of suitable treatment via web-based approach. Importantly, it reaches patients who do not, would not or cannot engage with more traditional treatment delivery. This includes those restricted by ongoing chronic health conditions, which may prevent them receiving similar care in existing services. It also removes the travel burden which might prevent access for some patients.
- Improves reach to rural-communities and those who have access problems, including patients who are housebound.
- Enhances self-management for patients with ongoing health problems and improves decision-making regarding when to access care or seek help.
- Provides a long-term treatment effect, lasting 5+ years (Tyrer et al., 2017).

SO WHAT? - SERVICE BENEFITS:

- Provides a way of offering appropriate treatment to a traditionally seldom heard patient group, who are at risk of poor patient experience and long-term health outcomes.
- Is compatible with the requirement for clinical commissioning groups to offer IAPT services integrated with physical healthcare pathways. See IAPT Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms for details.
- Virtual delivery through web-based technology extends the reach of service provision.
- Easily spreadable, with extended reach due to the lack of a geographical anchor (i.e. the clinic location): in the study, 1 FTE therapist reached (virtually) across 15,600 square kilometres to deliver care and treatment. Enables services to expand to meet NHS England's IAPT commitment (www.england.nhs.uk/mental-health/adults/iapt/).
- Needs few therapists to cover a large geographical area; the intervention can be offered through a 'hub' approach at STP level, rather than duplicate services offered by individual service providers.
- The rCBT intervention saves money: Over one year, per patient, the treatment course saves between £1,064 - £3,164 through improvement in quality of life and reduction in unscheduled care (primary, secondary and emergency), in-patient stays and routine out-patient appointments.
- Effects of the intervention can be sustained for 5+ years, with potential for associated year on year savings (Tyrer et al., 2017).
- Provides a specialist service using an integrated care approach, ideal for delivery across a STP.
- Offers an evidence-based intervention for patients that clinicians may struggle to help. GPs, neurologists and endocrinologists have specifically reported satisfaction with the approach for this particular patient population.
- The rCBT intervention may fit within current national IAPT priorities of integration of care with long-term conditions. However, alternative pathways may also be possible, as the delivery can be adapted to fit organisational context.

Mean costs (£) per participant over 12 months



SO WHAT? - SYSTEM BENEFITS:

The rCBT intervention for severe health anxiety addresses many service level demands set out in STP plans and in the Five Year Forward View for Mental Health (FYFV). For example, adoption of the intervention will:

- Provide additional psychological therapies for those with anxiety and depression (FYFV). The rCBT intervention provides an alternative source of support/therapy that is unavailable elsewhere for this particular patient population.
- Improve productivity and variations in care (STP), by offering a standard approach to recognising and treating severe health anxiety across an STP area. The intervention is clinically effective in reducing care burden, resulting in better health service productivity by reducing the demand for repeated, same day appointments from this patient group.
- Develop IT and digital services (STP). The rCBT intervention is delivered remotely, and as such relies on the development of IT and digital services.

The rCBT intervention for severe health anxiety is clinically and cost effective:

- It reduces GP appointments, with patients requesting 12 appointments less per year (per patient).
- It reduces ED presentation / emergency appointments, with patients attending 3.5 times less per year (per patient).
- It reduces length of in-patient stays by 3 days (per patient).

A recent paper estimated 1% of the practice population experience anxiety-related healthcare use (Fink et al., 2010). In a typical GP practice with 10,000 patients, this means that 100 patients might fall into this group in any given year. If the rCBT intervention was given to 33% of them (as found in the study), in the subsequent year it would save:

396 GP visits (of which, 198 are unscheduled)

116 hospital contacts

99 in-patient admission days

Given the sustained effectiveness of the intervention over 5+ years, these savings grow:

2000 GP visits (of which, 1000 are unscheduled)

600 hospital contacts

500 in-patient admission days

- Remotely delivered rCBT for severe health anxiety has similar clinical effectiveness to face-to-face delivery.
- Patients receiving rCBT reported significant reduction in severe health anxiety, depression symptoms, general anxiety symptoms and general health 12 months after treatment was started.
- Treatment lasted a median of 8 sessions (equivalent to two months of weekly appointments), but health improvements were sustained at 12 month follow-up.
- There was a net monetary benefit to providing rCBT of £1,064 - £3,164 per patient when taking into account reduced overall healthcare costs and improvement in quality of life.

Given the accessibility and cost benefits, remotely delivered therapy may be a suitable delivery option for this patient group.

WHAT IS NEEDED TO USE THE RCBT INTERVENTION?

In order to deliver the rCBT intervention, the following resources are required. All are included in the above costings.

- Therapist to deliver the rCBT intervention to patients.
- Computer for therapist to use.
- Strong, reliable internet connection with available bandwidth.
- A videoconferencing software system offering N3 connection security, secure cloud storage, reliable connectivity and essential file and screen sharing facilities, as found on WebEx.
- A contingency management protocol (available from CLAHRC if there is no organisational version).
- Text-based resources (manuals / learning materials) that can be emailed to patients (available from CLAHRC).
- Headsets / webcams for patients.

Prior to roll out, a few practical considerations should to be considered:

- This is not a solution for all mental health issues, nor for all patients experiencing health anxiety.
- IT security concerns need to be addressed and illustrative consent forms have been developed within the study, which can be shared for wider use.

GETTING STARTED

The rCBT intervention for health anxiety is available to use now. The package includes:

- The rCBT intervention with supporting user manual and contingency management protocol.
- A range of tried and tested recruitment methods for participating sites to use and/or adapt to local need. Suggested scripts for clinicians to use to introduce the service to patients, and pointers for what not to do or say!
- A tailored, text-based relapse prevention tool that aims to maximise therapeutic benefits after therapy is complete which was developed using the Florence (Flo) telehealth system. Flo has been designed by NHS professionals to support people to manage their health; there may be a charge to use Flo in some locations.

WHAT NEXT?

The rCBT is being used now; a pilot-roll out will shortly commence in Northamptonshire, and discussions are ongoing in Nottinghamshire. Further demonstrator sites are being actively sought.

If you are interested in commissioning the rCBT intervention for severe health anxiety and/or using it clinically, details can be found on the CLAHRC website: www.clahrc-em.nihr.ac.uk/clahrc-store. If you have any questions about the rCBT intervention for health anxiety please contact:

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- Sam.Malins@nottingham.ac.uk
- Helen.Tyrer@imperial.ac.uk

FURTHER RESOURCES

- Bermingham S., et al., The cost of somatisation among the working-age population in England for the year 2008-2009. Ment Health Fam Med. 2010; 7: 71–84.
- Fink P, Ørnbøl E, Christensen KS. The outcome of health anxiety in primary care. A two-year follow-up study on health care costs and self-rated health. PLoS One, 2010;24:e9873. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0009873
- Tyrer P., et al., Cognitive-behaviour therapy for health anxiety in medical patients (CHAMP): a randomised controlled trial with outcomes to 5 years. Health Technology Assessment 2017;21(50) https://www.journalslibrary.nihr.ac.uk/hta/hta21500#/abstract
- Tyrer, P., et al., Prevalence of health anxiety problems in medical clinics. Journal of Psychosomatic Research 2011;71(6), 392-394. https://www.jpsychores.com/article/S0022-3999(11)00211-X/fulltext
- Patel, S., et al. Protocol investigating the clinical outcomes and cost-effectiveness of cognitive-behavioural therapy delivered remotely for unscheduled care users with health anxiety: Randomised controlled trial. BJPsych Open, 2016;2(1), 81-87. doi:10.1192/bjpo.bp.115.002220. https://www.cambridge.org/core/journals/bjpsych-open/article/protocol-investigating-the-clinical-outcomes-and-costeffectiveness-of-cognitivebehavioural-therapy-delivered-remotely-for-unscheduled-care-users-with-health-anxiety-randomised-controlled-trial/1C0DAE665EF9ED8558E8967F0BFB43B5
- For more about the study, and patient experience films, please visit: http://www.clahrc-em.nihr.ac.uk/research/urgent-care-study
- NHS England: https://www.england.nhs.uk/mental-health/adults/iapt/
- NHS: Health Anxiety. https://www.nhs.uk/conditions/health-anxiety/
- NICE: Eyes of Evidence – cognitive behavioural therapy for health anxiety (2014). http://arms.evidence.nhs.uk/resources/hub/1036522/attachment

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