Northern IAPT Practice Research Network

Title:	**Practice guideline for Stress Control psychoeducational groups applied in IAPT services.**
Funding body:	West Yorkshire Clinical Commissioning Groups.
Contributors:	Clinicians, managers and academics affiliated to the Northern IAPT PRN; in consultation with IAPT service users.
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Background and aims

Stress Control (SC) is a six-session, group-based psychoeducational intervention designed to promote self-help for problems including stress, anxiety and low mood.[1] It is based on principles of cognitive behavioural therapy and delivered in a seminar style to large groups of people, with minimal interaction between facilitators and participants. SC is available in the National Health Service, usually through IAPT (*Improving Access to Psychological Therapies*) services. The low intensity and high volume nature of SC makes it a cost-efficient treatment for many patients, although it is also clear that some people drop out early and do not benefit from this approach.[2]

During 2014 – 2016, the Northern IAPT PRN conducted a multi-service evaluation of SC interventions,[3] funded by NHS Research Capability Funding from the West Yorkshire Clinical Commissioning Groups (Ref: RCF-2014-010) and approved by an NHS research ethics committee (Ref: 15/NE0062). The project included formal research and consultation meetings with patients and treatment providers to co-produce recommendations for IAPT services. The aims of the guideline are (a) to summarise the findings of this research; (b) to propose recommendations to services for best practice; and (c) to define possible future developments.

A multi-service evaluation of Stress Control

The SC study was based on the analysis of de-identified clinical records for 4451 patients, obtained from 5 IAPT services working across Cumbria, South and West Yorkshire, covering the period between 01/2013 – 01/2015. Primary outcomes data included patient-reported measures of anxiety (GAD7) and depression (PHQ9); secondary data included measures of functioning (WSAS), treatment attendance and socio-demographics. Treatment outcomes were statistically compared between services and compared to published benchmarks from controlled trials of guided self-help. Multilevel modelling was used to examine variables associated with treatment outcomes. A fuller description of methods is available in the source publication.[3]

Summary of findings

- Clinical effects of SC groups delivered by IAPT services were comparable to those reported in controlled trials of guided self-help interventions.
- Effectiveness was consistent across most services; except for 1 service that had poorer outcomes. This service had made modifications to the SC materials and reduced this to a 5-session intervention.
- Patients who attended more SC sessions tended to have better outcomes.
- Patients (a) living in deprived neighbourhoods, (b) with severe symptom severity and (c) severe functional impairment tended to have poorer outcomes across all services.
- Although SC is a highly standardised intervention, some groups were less effective than others. This is likely to be explained by variations in the competency of different group facilitators.

Key milestones of the Stress Control project

Sep 2014	Initial Practice Research Network meeting
Oct 2014	Research funding secured for SC study
Nov 2014	Initial SC project team meeting
Feb 2015	NHS ethical approval obtained
May 2015	NHS management permissions obtained
Jun 2015	Datasets obtained from 5 IAPT services
Sep 2015	Data analysis discussed at project team meeting
Nov 2015	Data analysis completed and paper submitted for peer review by a scientific journal
Feb 2016	Consultation with a group of SC patients
Jun 2016	SC study results presented at national conference - *British Association for Behavioural and Cognitive Psychotherapies (BABCP)*
Jun 2016	Consultation with Practice Research Network members to draft recommendations
Sep 2016	SC study published in *Behaviour Research and Therapy*
Oct 2016	Practice guideline published and disseminated

Practice guidelines co-produced by IAPT service providers, service users and academic researchers

Suitability

1. SC can be an effective and efficient way to improve the wellbeing of people who experience mild-to-moderate symptoms of stress, anxiety and low mood; with mild-to-moderate functional impairment.
2. SC should only be offered based on informed consent, after patients have had an opportunity to consider alternative treatment options, since patients' preferences influence their engagement with healthcare interventions.
3. SC may not be an effective first-line treatment in cases with: comorbidity of anxiety symptoms with major depression; severe-range symptoms (i.e. GAD-7 ≥ 15); severe functional impairment (i.e. WSAS ≥ 30); socioeconomic deprivation.
4. SC is not suitable for patients with acute risks of self-harm, given the limited availability of contact with practitioners.
5. SC is not suitable for patients who may find it difficult to engage with didactic materials without personalised support. For example due to impairments in sight, hearing, memory, concentration, or language barriers. These obstacles may not be obvious (i.e., in telephone assessments) and therefore it is important to check this prior to offering SC interventions.
6. In line with NICE guidelines,[4] disorder-specific treatment options should be considered prior to offering SC, in particular for cases with social phobia, eating disorders, post-traumatic stress and obsessive-compulsive disorder.

Accessibility

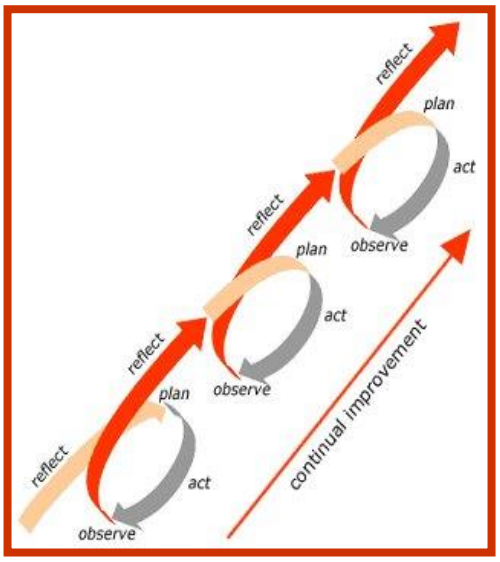
7. Patients appreciate having the option to attend SC sessions accompanied by family members or significant others.
8. Family and significant others appreciate hearing tips about what they could do to be supportive of improvement.
9. SC groups and/or materials could be translated to other languages to maximise accessibility and cultural sensitivity.
10. Running SC groups in community (non-healthcare) venues can help to put some participants at ease and to normalise experiences of mental health problems.

Effectiveness

11. SC classes should be delivered with fidelity to the original 6-session treatment protocol.
12. SC participants should be encouraged and supported to attend all 6 sessions, and information regarding the effectiveness and benefits of attendance could be included at session 1 to enhance expectations and engagement.
13. Patient-reported outcome measures should be implemented on a session-to-session basis to monitor response to treatment and to support risk assessment and management.
14. SC participants who do not show signs of reliable improvement in standardised outcome measures after having an 'adequate dose' (4-6 treatment sessions) should be offered more personalised and/or intensive treatment options.
15. IAPT services can use the method and benchmarks provided in the SC study[3] to evaluate the effectiveness of SC groups delivered in routine care.

Recommendations for future developments

16. The SC facilitator role should have a clearly defined job and skills development plan, separate to administrative roles and functions.
17. A competency framework and assessment method could be developed to support the practice development of SC facilitators.
18. Strategies to enhance attendance and prevent dropout could be developed and trialled.
19. Post-treatment follow-up may be a worthwhile addition to SC, for instance by planning 'booster sessions' as in traditional CBT interventions.
20. Qualitative research on patients' experiences of SC is needed to further our understanding of acceptability and mechanisms of change.
21. Research on the long-term effectiveness of SC is needed.
22. Research using SC as a preventative intervention could be developed.



Acknowledgements

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