A feasibility study to assess the appropriateness and viability of training community pharmacists in Cognitive Behavioural Therapy (CBT)-based techniques to enhance patient consultations

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Background

NHS England commissioned the Academic Health Science Networks (AHSN’s) to align training and education, clinical research, informatics, innovation, and healthcare delivery. The primary goal of the AHSNs are to improve patient and population health outcomes by translating research into practice, and developing and implementing integrated health care services. They will support knowledge exchange networks to build alliances across internal and external networks and actively share best practice, whilst providing for rapid evaluation and early adoption of new innovations (1). At present, the Oxford AHSN is funding and supporting ten Clinical Networks which it has identified as initial priorities for driving improvements in health for our population and prosperity for our geography, which includes medicines optimisation.

In response to growing evidence of poor medicines management performance, the practice of ‘medicines optimisation’ has developed into a vitally important aspect of patient care. It requires all health professionals and healthcare organisations to work collaboratively to recognise and develop ways to address the causes of sub-optimal use of medicines by patients. Concerns have been growing over the need to reduce risks for patients and help them derive maximum benefits from their medicines, so that the best quality outcomes are achieved. Research has shown that:

- In primary care around £300 million per year of medicines are wasted (this is likely to be a conservative estimate) of which £150 million is avoidable and remains a largely untackled issue (2).
- Up to half of all patients do not take their medicines as recommended (3).
- Furthermore, only 16% of patients who are prescribed a new medicine take it as intended, experience no problems and receive as much information as they need (4).
- Ten days after starting a medicine, almost a third of patients are already non-adherent and of these, 55% do not realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent (4).
- When admitted to hospital, most patients have a medicine omitted or a wrong dose recorded. Patients taking several medicines for long term conditions are most likely to have experienced medication management errors (5).
- 5-8 per cent of all unplanned hospital admissions are due to medication issues, rising to 17% in the over 65’s (6) and at least 6% of emergency re-admissions are caused by avoidable adverse reactions to medicines (3).
- When patients don’t take their medicines in line with recommended advice it costs the NHS an estimated half a billion pounds a year in lost patient benefits (4).
- Overall, poor adherence to medication regimens is common, contributing to substantial worsening of disease, death and increased healthcare costs (7).
In response to increasing wastage, good practice guidance entitled ‘Medicines Optimisation: Helping patients to make the most of medicines’ was published by the Royal Pharmaceutical Society in May, 2013 (8). It represents a collaboration between patients and the health professionals that care for them, and sets out four principles of medicines optimisation:

- Aim to understand the patient’s experience.
- Use evidence-based choice of medicines.
- Ensure medicines use is as safe as possible.
- Make medicines optimisation part of routine practice.

The Oxford AHSN Medicines Optimisation Clinical Network response was to develop four themes partnering organisations within Oxford AHSN and beyond including representatives from primary care, community care, secondary care, healthcare commissioners, academia and industry. The four project themes are:

3. Medicines Reconciliation.
4. Transfer of Care between Hospital and Community Pharmacists.

The primary project within theme one ‘Effective Consultations with Patients’ is to reduce medicines wastage and improve patient outcomes through providing Cognitive Behavioural Therapy (CBT) training to community pharmacists to provide the opportunity for more timely and effective patient consultations. From a strategic perspective, enhancing the communication and consultation skills of pharmacists has been identified as a priority by Health Education England, and has been supported by the Chief Pharmaceutical Office, NHS, the Director for Pharmacy Postgraduate Education and the Director of Education and Quality, Health Education England (9).

As well as Ad Hoc opportunities, pharmacists are funded to provide face-to-face consultations about medicines through the Medicines Use Review (MUR) and the New Medicine Schemes (NMS). Recently the NMS has been nationally evaluated and it found that community pharmacists can improve adherence through the use of this service – furthermore that it was cost-effective to do so (10), however, a secondary evaluation uncovered that the NMS did not significantly change patient beliefs about their medicines and suggests that there is scope for improvement of the NMS (11).

CBT at the point of interaction through the MUR/NMS services will enable patients to consider factors that influence medication adherence and to identify barriers and solutions, which are directly tailored to their needs and their health beliefs. A recent meta-analysis of CBT-based techniques to improve adherence found them to be effective in improving adherence and that these techniques were effective beyond educational and behavioural interventions and, according to sub-group analysis, these could be delivered...
by routine healthcare professionals (10). Additionally, a case study example of the effectiveness of CBT in Human Immunodeficiency Virus (HIV) management, found that CBT increased medication adherence by 25% compared to those without CBT (12). This is a clinically significant outcome considering there are two studies suggesting that even a 10% increase in adherence is associated with medically significant HIV outcomes (13 & 14). Further evidence of the benefits to medication adherence among patients with psychiatric illnesses can be found in Rose et al., 2009 (15).

To conclude, it is hoped that through the development and roll-out of this programme throughout the Oxford AHSN geography at the point of reporting (i.e. Bedfordshire, Berkshire, Buckinghamshire, Milton Keynes and Oxfordshire), will not only improve medication adherence but ultimately reduce wastage and increase value for money of NHS service provision within our geography. Therefore, the rationale of the present feasibility study is to test the CBT-based training programme to evaluate whether it is appropriate for community pharmacists, applicable for use in the clinical setting, fit for purpose and would be reviewed positively by course attendees.

Methodology

Course Design and Outline: Background to Development

Interventions to improve adherence are often expensive, ineffective and not based on the reasons behind non-adherence (16). There has been extensive research carried out on the reasons for non-adherence (17) and there have been psychological models and frameworks proposed and tested to explain this behaviour (18 & 19). The Necessity Concern Framework (NCF), for example, has been extensively tested and is consistently associated with non-adherence (20).

Community pharmacists are aware of the need to overcome non-adherence where possible. In addition to the provision of basic information on medicines at the point of dispensing, they remain available to answer questions and deal with problems. To help to further address the problem of non-adherence, community pharmacists can now offer new advanced services to eligible patients as follows;

- Medicines Use Review (MUR) which consists of accredited pharmacists undertaking structured adherence-centered reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered (http://psnc.org.uk/services-commissioning/advanced-services/murs/)

- The New Medicine Service (NMS) provides support for people with long-term conditions newly prescribed a medicine, to help improve medicines adherence; it is focused on particular patient groups and conditions (http://psnc.org.uk/services-commissioning/advanced-services/nms/)

Building on these services, it was recognised that community pharmacists have the opportunity to extend their role in medicines optimisation by spending more time with patients. Patient consultations are one of the key vehicles through which medicines optimisation and public health can be delivered and training in consultation skills is now available. This aims to help pharmacists and pharmacy technicians to enhance
their communication and consultation skills;
(http://www.consultationskillsforpharmacy.com/about6.asp?P=2)

This training aims to complement the consultation skills training received by pharmacy staff and the underlying principles of New Medicines Service (NMS) intervention (21). The NMS was based upon a theoretical model, the Self-Regulatory Model (22). This model recognises that an individual’s response to a health threat or intervention is influenced by pre-existing beliefs and perceptions, and that individuals will use these beliefs along with their experiences to develop a common sense understanding of their illness. The SRM model was subsequently enhanced by Horne et al with the addition of the NCF (18). The NCF posits the idea that individuals base their decisions on whether or not they take their medicines on two belief themes: the extent to which an individual believes they need the medication and extent to which they believe the medicine will do them harm. The New Medicines Service has already been shown to improve adherence (23), however, the evaluation also found that belief change was unaffected by the intervention. Given that negative beliefs about illness and medication are associated with poor adherence, this finding indicates the need for a more sophisticated approach.

As well as being grounded in theory, the CBT-based training provided in the present study has also been informed by recommendations made in Royal Pharmaceutical Society Medicines Optimisation paper (24), NICE Adherence Guideline (25), NICE Medicines Optimisation guideline (26) and the report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (27) and the NMS, which suggests that a successfully implemented adherence intervention influences 5 levels; cognitive, affective and behavioural systems, clinical outcomes and health care resource utilisation (23). These papers recommend an approach which develops a shared understanding of the problem of adherence; identifies both intentional and non-intentional barriers to adherence and addresses these appropriately; assesses and addresses the cognitive, emotional and behavioural aspects of adherence and does all these things in a collaborative and patient-centred manner.

CBT is a talking intervention, proven to help treat a wide range of emotional and physical health conditions in adults, young people and children. CBT examines how we think about a situation (cognitive component) and how this affects the way we act (behaviour). In turn our actions can affect how we think and feel. A CBT practitioner works with the patient to consider ways of changing their thoughts, behaviours and/or both, to promote mental well-being.

The CBT training programme adopted in this study was developed by the Oxford Cognitive Therapy Centre; a world-renowned institute in CBT training. Dr Lee David, a General Practitioner (GP) with a special interest and training in CBT, noticed that CBT techniques were useful in her routine GP consultations. The therapy enabled her to structure her conversations with patients in a more efficient manner and manage common mental health issues and long term conditions more effectively. Her suspicion was that medicine adherence was also improved.

The PPIPCare programme is an Royal College of General Practitioners (RCGP) accredited training programme which offers professional, evidence-based training and development opportunities in advanced primary care consultation skills and CBT techniques to GPs and other primary care health professionals to;
- Maximise their contact with patients and build resilience through supporting self-care and self-management.
- Support an integrated approach to physical and associated psychological distress in primary care consultations, including Long Term Conditions and Medically Unexplained Symptoms (MUS).
- Enable primary care staff to offer optimal Step 1 support to those suffering with mild to moderate depression and anxiety.

The programme consists of two types of training modules: short teaching sessions that offer useful techniques and frameworks (30, 60 or 90 minute sessions) and longer training sessions which focus more in-depth on how to use Cognitive Behaviour Therapy techniques in 10 minute consultations. For our feasibility study for use of the CBT model in community pharmacy, the most appropriate delivery of CBT was a tailored version of the '10-minute CBT Master Class' approach to patient consultations as part of her Psychological Perspectives in Primary Care (PPiPCare) programme.

In the design of the training, it was hypothesised that three components were essential: 1) Using the cognitive behavioural model to develop a shared understanding, which includes cognitive, affective and behavioural aspects, as well as addressing perceptual barriers using guided discovery and a collaborative and patient-centred approach, 2) Using Problem Solving to address practical barriers and 3) the use of motivational interviewing to facilitate change behaviour (Table 1).

**Table 1:** Demonstrates how the training addresses key recommendations in supporting adherence.

<table>
<thead>
<tr>
<th>Recommendation for Supporting adherence</th>
<th>Training element which covers this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit beliefs and perceptions about the illness</td>
<td>10 Minute CBT</td>
</tr>
<tr>
<td>Elicit beliefs about the concerns of medication</td>
<td>10 Minute CBT</td>
</tr>
<tr>
<td>Elicit beliefs about the need for treatment</td>
<td>10 Minute CBT</td>
</tr>
<tr>
<td>Develop a shared understanding (incorporating cognitive, affective and behavioural aspects) of the barriers to adherence</td>
<td>10 Minute CBT</td>
</tr>
<tr>
<td>Support motivation for change</td>
<td>Motivational Interviewing</td>
</tr>
<tr>
<td>Support shared decision making</td>
<td>10 Minute CBT and Motivational Interviewing</td>
</tr>
<tr>
<td>Identify and address practical barriers to adherence</td>
<td>Problem Solving</td>
</tr>
<tr>
<td>Foster self-efficacy</td>
<td>10 Minute CBT, Problem Solving and Motivational Interviewing</td>
</tr>
<tr>
<td>Remain Patient-centred and collaborative</td>
<td>10 Minute CBT, Problem Solving and Motivational Interviewing</td>
</tr>
</tbody>
</table>
Participants

It was decided that the scheme would open to pharmacists and nurses that routinely come into contact with asthma patients in the first instance i.e. Community and Hospital Pharmacists and Practice and Specialist Respiratory Nurses. Pharmacists and nurses who provided NHS services to patients in the Oxford AHSN geography were approached and invited to attend the course, in particular those pharmacists who had already successfully completed the CPPE Consultation Skills programme (https://www.cppe.ac.uk/programmes/l/consult-e-01/).

Results

Twenty pharmacists were either fully trained or partially trained in CBT-based techniques by professional coaches over two separate days, three weeks apart in March, 2015. Twenty trainees attended day one and eighteen of these trainees attended day two, therefore, there was an attrition rate of 10 per cent prior to the second day of training. The results of the course content evaluation survey was explored through both qualitative and quantitative methods.

Quantitative Results
Pre and post-Training Perceptions of CBT Models and Techniques

Before and after both training days, trainees were provided with a scenario based on a fictional patient with Asthma, called Mary. Trainees were then asked the following questions around the relevancy and appropriateness of the CBT model to support Mary with her difficulties;

1. How relevant do you think the CBT model and/or CBT techniques would be for this patient?
2. How could you help Mary to make sense of her problems using a CBT model?
3. Within the confines of a 10 minute consultation, describe TWO CBT skills or techniques that you could draw upon to help Mary with her difficulties.
4. Based on what you currently do (i.e. your current practice), how likely would you be to use the CBT model and/or CBT techniques with Mary?

When trainees were asked to rate how relevant they thought the CBT model and/or CBT techniques would be for this patient on a scale of 0-7, whereby 0 indicated ‘not relevant at all’ to 7 indicating ‘highly relevant’ (question 1), there was a very large shift from training day one to training day two as demonstrated by line graph 1 below.
Line Graph 1: Pre and post-training ratings of how relevant trainees thought the CBT model and/or CBT techniques would be for ‘Mary’ (0 = ‘not relevant at all’ to 7 = ‘highly relevant’).

When trainees were asked question 2: ‘How could you help Mary to make sense of her problems using a CBT model?’ on training day one, the most common response was ‘I don’t know’ (13/20 respondents). Five trainees did supply an answer to this question, however, only two trainees reported CBT techniques in their answers, which included ‘discuss barriers’ and use the hot cross bun technique i.e. ‘Thoughts → Behaviour → Environment → Physical → Symptoms → Feelings’ model. The remaining trainees reported ‘giving suggestions that will aid compliance with medication’, ‘offer solutions regarding time management’, ‘give additional reminder material…to help her take meds in time’, all of which refer to ‘giving suggestions or material’ to help solve the problem rather than adopting and applying a CBT model and/or techniques to Mary’s non-adherence.

By the end of training day two, 14 of the 18 trainees reported they would adopt the hot cross bun technique and explore the patients’ thoughts, behaviour, environment, physical, symptoms and feelings’ and two trainees would adopt motivational interviewing techniques. The other two reported they would listen to the patient, discuss the costs versus benefits of non-adherence/adherence behaviours and provide feedback to the patient in the form of encouraging them to identify solutions to their perceived problems.

When trainees were asked question 3: ‘Within the confines of a 10 minute consultation, describe TWO CBT skills or techniques that you could draw upon to help Mary with her difficulties?’ only one trainee reported they would use motivational interviewing as a skill or technique they could draw upon to help Mary with her difficulties. The remaining trainees reported they either ‘didn’t know’ (16/20 trainees) or would listen to Mary and try to understand the problem from her perspective. By the end of training day two, only two
trainees did not provide an answer to the question. The remaining trainees provided the following skills or techniques they would draw upon in their consultation skills;

- Motivational Interviewing and exploring the patients’ thoughts and feelings around their medication regime.
- Enhanced listening skills using open questioning and summarising to gain a consensus of understanding between the pharmacist and the patient.
- Explore the costs versus benefits of a patients’ ‘as is’ situation versus a ‘should be’ scenario
- Explore resistance towards medication adherence.
- Being empathetic towards, and collaborating with, the patient to enable them to formulate their own solutions to their perceived problem.
- Discuss an action plan with the patient.

When trainees were asked question 4: to rate how likely the trainee would be to use the CBT model and/or CBT techniques with ‘Mary’ in their current clinical practice on a scale of 0-7 (0 = ‘not relevant at all’ to 7 = ‘highly relevant), there was a very large shift from training day one to training day two as demonstrated by line graph 2 below.

Line Graph 2: Pre and post-training ratings of how likely would the trainee be to use the CBT model and/or CBT techniques with ‘Mary’ in their current clinical practice (0 = ‘not relevant at all’ to 7 = ‘highly relevant’).

Line Graph 2 is in agreement with line graph 1 demonstrating that there had either been a large increase in the perception of how relevant the CBT model and/or techniques are for the treatment of Mary from the beginning of training day one compared with the end of training day two, or that those who were already
aware of the techniques and/or models, did not alter their opinion of how likely they would be to use CBT in consultation with this hypothetical patient.

Course Feedback

Training Day One

At the end of training day one, the twenty trainees were asked to rate the course on a ten-item satisfaction survey with Likert scale responses that ranged from strongly disagree (1) to strongly agree (5) and all 20 trainees responded. A copy of the satisfaction survey is located in Appendix 1 and the bar chart below demonstrates the overall results of the satisfaction survey at the end of training day one.

Bar chart 1: Mean ratings of agreement on all satisfaction survey items at the end of training day one (n=20).

Bar chart 1 demonstrates that, on average, trainees either ‘agreed’ or ‘strongly agreed’ with the ten survey items, indicating the majority of trainees were satisfied with the course content at the end of training day one.
Bar chart 2: The results of the ten-item satisfaction survey to evaluate responses to the course content statements (n=20).

Bar chart 2 delineates the overall course content ratings and highlights the responses to each individual item on the survey. The results indicates that the majority of trainees either ‘agreed’ or ‘strongly agreed’ with the statements in the survey indicating that they were satisfied and enjoyed the course, they found the training useful, and that the information provided was appropriate and pitched at the right level. Where trainees disagreed with the satisfaction statements was around the time allocated for discussion and whether the handouts were appropriate or not, which may have influenced the overall satisfaction with the training.

Training Day Two

At the end of training day two, the eighteen trainees were asked to repeat the course satisfaction survey in the same manner as at the beginning of training day one (from strongly disagree (1) to strongly agree (5) and eighteen trainees responded. The bar chart below demonstrates the overall results of the satisfaction survey from day two.
Bar chart 3: Mean ratings of agreement on all satisfaction survey items at the end of training day two (n=18).

Bar chart 3 demonstrates that, on average, trainees either ‘agreed’ or ‘strongly agreed’ with the ten survey items, indicating the majority of the trainees were satisfied with the course content by the end of day two. Satisfaction survey responses such as ‘disagree’, ‘neutral’ and ‘strongly agree’ had fallen since the end of day one and agreement ratings of satisfaction with the course content had increased since the end of day one, on average.
Bar chart 4: The results of the ten-item satisfaction survey to evaluate responses to the course content statements (n=18).

As per training day one, bar chart 4 reports the overall course content ratings and highlights the responses to each individual item on the survey. In accordance with training day one, the results indicate that the majority of trainees either ‘agreed’ or ‘strongly agreed’ with the statements in the survey demonstrating satisfaction and enjoyment of the course, indicating they found the training useful, and that the information provided was appropriate and pitched at the right level. The majority of trainees also reported that they felt confident using the techniques, and moreover, 17 of the 18 respondents reported that they planned to use the techniques in future clinical practice with patients.

Whilst the results indicate the training was reported as enjoyable and fit for purpose, the areas for development include the quality of the theoretical information provided and the appropriateness of the handouts, whereby one respondent disagreed with both the survey satisfaction statements.

Qualitative Results
Qualitative analysis methods were adopted to investigate the course content evaluation further through open-ended questions within the satisfaction survey. Broadly, qualitative feedback from the course was consistent with the quantitative data highlighting that trainees found the course useful, pitched at the right level and that they felt confident to use the techniques would adopt them in future clinical practice.
When trainees were asked to list the three things they had learnt from the first days’ training, a number of themes emerged. By far the most common emergent themes were around how to apply the CBT in practice, being more patient-centred and parking your own agenda, using active listening skills, and how to define the problem using a different approach to extract information from the patient. Table 1 highlights the number of times a theme was reported within the satisfaction survey.

**Table 2: The emergent themes from qualitative data reported at the end of training day one (n=20).**

<table>
<thead>
<tr>
<th>Emergent Themes: End of Training Day One</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT Model</td>
<td>13</td>
</tr>
<tr>
<td>Parking your own agenda and practicing with a patient-centred focus</td>
<td>8</td>
</tr>
<tr>
<td>Active listening skills and demonstrate empathy, particularly towards resistance</td>
<td>7</td>
</tr>
<tr>
<td>Defining the problem including using open-ended and alternate questioning techniques to extract information</td>
<td>6</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>5</td>
</tr>
<tr>
<td>Explore the patients thoughts/ feelings to empowering discussions and supporting patients to identify their own solutions</td>
<td>5</td>
</tr>
<tr>
<td>Depression/ anxiety identification</td>
<td>4</td>
</tr>
<tr>
<td>Reflect, summarise and feedback to patients</td>
<td>4</td>
</tr>
</tbody>
</table>

By the end of training day two, the emergent themes had consistently reported adopting the CBT model, however, the themes shifted towards a focus on being able to apply the model and techniques in clinical practice. New themes that emerged by the end of training day two included how to close the session and apply two additional techniques; hot cross bun and visualisation, as demonstrated by Table 2.
Table 3: The emergent themes from qualitative data reported at the end of training day two (n=18).

<table>
<thead>
<tr>
<th>Emergent Themes: End of Training Day Two</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT model to support consultation skills in clinical practice</td>
<td>15</td>
</tr>
<tr>
<td>Defining the problem (e.g. using alternative questioning techniques and active listening to extract information and break things down)</td>
<td>13</td>
</tr>
<tr>
<td>Problem solving techniques including how to break down the problem initially</td>
<td>11</td>
</tr>
<tr>
<td>Support patient outcomes and decision-making</td>
<td>9</td>
</tr>
<tr>
<td>Closing the session and supporting behaviour change (e.g. using goal setting, handover and empowering techniques)</td>
<td>5</td>
</tr>
<tr>
<td>Hot-cross bun technique</td>
<td>5</td>
</tr>
<tr>
<td>Visualisation technique</td>
<td>5</td>
</tr>
</tbody>
</table>

Post-Course Behaviour Change

When trainees were asked ‘What (if anything) will you do differently as a consequence of this training?’ the emergent themes from days’ one and two were also evident within trainee answers. For instance, the application of the CBT model, being more patient-centred and parking your own agenda, using active listening skills, and how to define the problem using a different approach to extract information from the patient was reported by trainees in the following examples;

‘Listen to patient and use CBT model’

‘Focus on patient feelings, thoughts and physical symptoms’

‘Probe patient more on medicine use/behaviours’

‘Establish reasons for non-compliance before offering solutions’

By the end of training day two, trainees were reporting how they would apply the model and techniques in clinical practice, reflect on their professional development and consider how to develop their skills further beyond the training.

‘Look at the bigger picture. Ask open-ended questions. Reflect on my current consultation skills and build what I have learnt into my skill set.’

‘Change my thinking and approach when in consultations with patients and encourage them to talk more’

‘Use aspects from 10 min CBT. Listen more. Let patients come to final decisions. It is helpful to be given the tools to explore different techniques and improve patient care’
New themes that emerged by the end of training day two included how to close the session and apply two additional techniques; hot cross bun and visualisation. The latter theme is succinctly reflected by the following quotes;

‘[I will adopt the] Hot cross bun and externalisation/ visualisation techniques’

An additional attitudinal shift was highlighted in the trainee plans to use the model and techniques in their routine clinical Medicines Use Reviews (MURs) to enhance the service and even use the skills in their private lives;

‘Reflect patients’ needs when doing MUR rather than just preaching advice’

‘Try to take time to consider using CBT where appropriate for a patient doing MURs and where appropriate in every day considerations’

‘Conduct my MUR and NMS consultation differently including the CBT model’

‘Skills that will not only benefit our patients but will enrich and empower us in life - amazing. Thanks’.

**Impact on Clinical Practice**

Following the course, practitioners expressed they were clear about how they thought their clinical practice would change as a result of the training. Within two training days, attendees showed clear evidence that they were able to incorporate psychological approaches within routine clinical consultations. Some of feedback received included the following;

“I did find the CBT course useful, especially coming quite soon after the consultation skills course. Together they helped me to help patients identify their own problems in a more efficient manner.”

“During a recent MUR with a customer experiencing problems with pain control we found, after careful questioning, that his problems were much exacerbated by an underlying undiagnosed depression. He was reluctant to admit to this, but would now be more open to discussing with his GP and was looking to get in touch with the talking therapies service.”

“Another customers’ asthma was not being controlled adequately and during the consultation admitted to a recent episode of abuse by a close relative. I really feel that the CBT course helped me to help her admit and cope with this. It also reinforced my signposting resources and helped me personally by being available to support me during something I found quite difficult.”
Course Improvement

When trainees were asked what they thought we could do to improve the training, the following ideas and suggestions were provided;

- Provide pre-course material on CBT
- Reduce the number of power point slides
- More practical and role play sessions
- Change the case studies/scenarios for each session
- Explicit session on how CBT can be incorporated into MUR/NMS
- Videos to demonstrate how CBT can be implemented by a professional cognitive behavioural therapist.
- Condense even more information into the course on and around CBT principles/models and techniques;

‘More detail - I feel we have just scratched the surface - fascinating - so much to discover.’

Discussion

The background literature pointed to a need to work collaboratively to recognise and develop ways to address the causes of sub-optimal use of medicines by patients as concerns have been growing over the need to reduce risks for patients and help them derive maximum benefits from their medicines, so that the best quality outcomes are achieved. In the present feasibility study, an overview has been presented of an evaluation of an Oxfordshire-based CBT-based training programme that was designed to align the theoretical underpinnings of the Cognitive Behavioural Therapy approach to enhance consultation skills with patients within the community pharmacy setting.

The specific aims of this work were to test the training programme and evaluate whether it was deemed appropriate for community pharmacists, applicable for use in the clinical setting, fit for purpose and was reviewed positively by attendees. Through qualitative and quantitative data collection, the course does appear to be appropriate, applicable, fit for purpose and has been reviewed positively by all but one attendee. One of the most striking results of the study was the difference in opinion of how applicable the CBT model could in helping resolve difficulties in Asthma management between training days one and two, with trainees reporting a lack of understanding of the model and rating it as ‘not applicable to the course scenario’ compared with the same question at the end of day two, whereby trainees reported the CBT model was very applicable to the management of the patient.

The quantitative results indicated that the trainees were satisfied with the training delivered across both days, whilst the qualitative results highlighted a number of emergent themes between days one and two that reflected the course material had been considered and understood. Trainee reports of how to assimilate the information into clinical practice ventured beyond the material to suggest that the trainees
would adopt the model and specific techniques in clinical practice with their patients. In addition, a number of trainees informed us of specific cases whereby the model had been applied to the benefit of their patients.

The Medicines Optimisation Clinical Network team acknowledge a limitation to the anecdotal results owing to the small sample size and the inability to follow-up direct with the patients seen by this cohort of CBT trainees. Prior to further exploration of this work to a wider cohort of community pharmacists, the Clinical Network will modify the course content to improve the delivery and individual/group working exercises in response to the detailed feedback provided by this first cohort of trainees and establish a more detailing approach to evaluation that follows patient outcomes beyond the consultation.

Future work in this area includes seeking funding to expand the ‘10-minute CBT’ training to 150 community pharmacists and other health professionals within the Oxford AHSN geography that could facilitate medicines adherence e.g. hospital pharmacists, practice nurses and GPs would also be eligible to attend the training. 200 HCPs will be approached and invited to take part in the project, with a view to recruiting 150 CBT trainees for a larger, more detailed exploration of the effects of CBT-based training techniques on consultation skills and patient outcomes, including medication adherence.

In consideration of the objectives of the good practice guidance entitled ‘Medicines Optimisation: Helping patients to make the most of medicines’ (8), the present piece of work appeals to the principles of medicines optimisations to understand the patient’s experience, ensure medicines use is as safe as possible based on the information gathered and interpreted by the community pharmacist, and that medicines optimisation becomes a part of routine practice, particularly through an enhanced MUR/NMS.

As the NMS has been nationally evaluated and was found to improve adherence through the use of this cost-effective service, it is encouraging to demonstrate here that the present cohort of trainees planned to incorporate CBT-based techniques routinely into their MUR/NMS. This is particularly important as CBT at the point of interaction through the MUR/NMS services could enable patients to consider factors that influence medication adherence and to identify barriers and solutions, which will be explored further by the Medicines Optimisation Clinical Network work stream as part of the Oxford AHSN.
References

Appendix 1  Course Outline (Day 1)

COGNITIVE BEHAVIOURAL THERAPY - A TOOL FOR DELIVERING BETTER MURs

CBT pilot training event - Day 1
Wednesday 4th March 2015; 10:00 to 17:00

Holiday Inn (Maidenhead), Manor Lane, Maidenhead, Berkshire SL6 2RA

Day 1 Programme

<table>
<thead>
<tr>
<th>Session</th>
<th>Aim and learning objectives</th>
<th>Content</th>
</tr>
</thead>
</table>
| 10.00 Introduction to each other and the day | Getting to know fellow students and overview of the 2 days | • Agenda and learning objectives  
• Intros to each other |
| Introduction to 10 CBT | To develop knowledge and skills in application of brief CBT skills in primary care | Evidence base  
Basic CBT principles  
Changing unhelpful thoughts  
The role of behaviour  
The Cognitive Behavioural Model (CBM)  
Using CBM in primary care consultations |

By the end of these training sessions you should know:
• Basic principles of CBT and a five-areas or cognitive-behavioural model (CBM)  
• How to apply these principles to common primary care problems (e.g. depression, anxiety, chronic disease)  
• How to communicate effectively with patients using the approach  
• Some strategies for managing time pressures
<table>
<thead>
<tr>
<th>CBT Communication skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useful strategies for time management</td>
</tr>
<tr>
<td>Handover questions</td>
</tr>
</tbody>
</table>

**LUNCH**

**Detecting Anxiety and depression**
To reflect upon and enhance current practice by highlighting some of the difficulties associated with detecting and diagnosing anxiety and depression

**By the end of this module the learner should know:**
- Issues surrounding the diagnosis of depression and anxiety
- Diagnostic criteria and assessment tools for depression and anxiety

**Core clinical features**
- Questions to ask
- Screening tools
- Signposting

**Break**

**Motivational Interviewing Skills**
To develop knowledge and understanding of Motivational Interviewing (MI) and its use in primary care

**By the end of this module the learner should know:**
- What Motivational Interviewing is and where it is appropriate to use it

**Evidence base**
- What is MI?
- Extrinsic vs Intrinsic
- Practising the skills involved
<table>
<thead>
<tr>
<th><strong>Wrap up and close</strong></th>
<th><strong>How to use Motivational Interviewing techniques in primary care</strong></th>
<th>The 4 general principles of MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Action planning: what will I do to apply the learning back in the workplace?</td>
<td>What does MI look like in clinical practice?</td>
</tr>
<tr>
<td></td>
<td>Supporting each other to practice new skills: find a buddy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feedback</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 Course Outline (Day 2)

COGNITIVE BEHAVIOURAL THERAPY - A TOOL FOR DELIVERING BETTER MURs

CBT pilot training event - Day 2
Wednesday 25th March 2015; 10:00 to 17:00

Holiday Inn (Maidenhead), Manor Lane, Maidenhead, Berkshire SL6 2RA

Day 2 Programme

<table>
<thead>
<tr>
<th>AM Session</th>
<th>Aim and learning objectives</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the learning</td>
<td>Consolidate the learning</td>
<td></td>
</tr>
<tr>
<td>Problem solving</td>
<td>Identify challenges and obstacles and problem solve these together</td>
<td></td>
</tr>
<tr>
<td>Problem solving techniques</td>
<td>To develop knowledge and understanding of Problem Solving techniques and their use in primary care</td>
<td>Evidence base</td>
</tr>
<tr>
<td></td>
<td>By the end of this module the learner should know:</td>
<td>The problem solving approach to depression.</td>
</tr>
<tr>
<td></td>
<td>• Which techniques from problem solving therapy may be used in the primary care setting, and how this can best be achieved</td>
<td>Useful techniques for those working in primary care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Case examples.</td>
</tr>
<tr>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 minute CBT - Working with Long Term Health Conditions</td>
<td>By the end of this module the learner should know:</td>
<td></td>
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<tr>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>• How to use psychological, physical and cognitive strategies with patients suffering with long term health conditions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Know how to support patients to increase functional activities and control their symptoms</td>
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</tr>
<tr>
<td></td>
<td>• Support patients towards self-management</td>
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</tr>
<tr>
<td>There will be a break mid-afternoon</td>
<td>Evidence base</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT Strategies in asthma and other Long Term Conditions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting goals according to individual values</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Changing behaviours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Role play</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wrap up and close</th>
<th>Action planning: what will I do to apply the learning back in the workplace?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Who can I turn to for support?</td>
</tr>
<tr>
<td></td>
<td>How will I keep going?</td>
</tr>
<tr>
<td></td>
<td>Mentors</td>
</tr>
<tr>
<td></td>
<td>Feedback</td>
</tr>
</tbody>
</table>

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**Evidence base**
- CBT Strategies in asthma and other Long Term Conditions
- Setting goals according to individual values
- Changing behaviours
- Role play

---

**Wrap up and close**
- Action planning: what will I do to apply the learning back in the workplace?
- Who can I turn to for support?
- How will I keep going?
- Mentors
- Feedback
## Appendix 3  Training Feedback Form (Days 1 & 2)

<table>
<thead>
<tr>
<th>MODULE CONTENT</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with the training</td>
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<tr>
<td>I enjoyed the training</td>
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<tr>
<td>The training was useful</td>
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<tr>
<td>The quantity of theoretical info was appropriate</td>
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<tr>
<td>The quantity of practical info was appropriate</td>
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<tr>
<td>There was enough time for discussion</td>
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<tr>
<td>The training was pitched at the right level</td>
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<tr>
<td>The handouts were appropriate</td>
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<tr>
<td>I feel confident in the use of these techniques</td>
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<tr>
<td>I plan to use these techniques in future practice</td>
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</tbody>
</table>

Please list three things that you have learnt from today’s session:

1.  
2.  
3.  

What (if anything) will you do differently as a consequence of this training?
What could we do to improve the training?

Would you recommend this course to a colleague?  Yes / No

Would you be interested in attending any future training in CBT?  Yes / No

Please include your email address if you’d like to know about future training:

Thank you so much for taking the time to give us your feedback