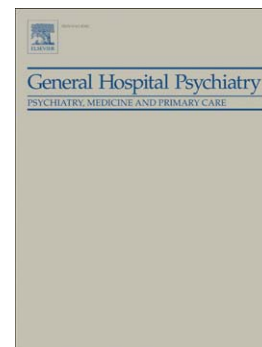# Accepted Manuscript

Selecting, training and supervising nurses to treat depression in the medically ill: Experience and recommendations from the SMaRT Oncology collaborative care trials

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Title: Selecting, training and supervising nurses to treat depression in the medically ill:

Experience and recommendations from the SMaRT Oncology collaborative care trials.

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Title: Selecting, training and supervising nurses to treat depression in the medically ill:

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ABSTRACT

Collaborative care treatment programs have been developed to improve the management

of comorbid depression in the medically ill. These programs are delivered by a team of

psychiatrists and care managers who work closely with the patient's general medical

providers. General nurses are often selected to be care managers because they understand

the patient's medical condition and its treatment but there is limited practical information

available on how best to select, train and supervise them.

We report our experience of selecting, training and supervising general nurses to deliver

'Depression Care for People with Cancer', a highly effective collaborative care treatment

program. We describe the problems that we encountered in each of these three areas and

the solutions that we adopted to address these. We provide practical recommendations to

those planning to set up similar programs.

Keywords: cancer, depression, collaborative, nurse, training

1. INTRODUCTION

Depression is a common complication of chronic medical conditions and substantially worsens both patients' quality of life and their adherence to medical treatments (1-3). However, such comorbid depression is often poorly managed, in part because the medical and psychiatric elements of healthcare are typically separate and delivered by different professionals working in different organizations (4). There is a clear need to integrate psychiatric and medical treatment to provide patient-centered care for people with chronic medical conditions and comorbid depression (5) One established way of achieving this is the collaborative care model (6). There is substantial research evidence showing the effectiveness of collaborative care models, particularly in improving depression outcomes (7).

Collaborative care treatment programs are delivered by a team of psychiatrists and care managers who work closely with the patient's general medical providers to deliver pharmacological and psychological treatments. Whilst care managers can be from any discipline, general nurses are often selected for this role (8). Unlike mental health nurses, they do not have extensive training in psychological care and therefore need to learn not only about the content of treatment programs (e.g. side effects of antidepressant drugs) but also new ways of working with patients (e.g. how to work with patients to identify solutions together in contrast to giving clinical advice). However, there is substantial benefit to be gained from training general nurses to be care managers because they understand the patient's medical condition and its treatment; depression management can therefore be fully integrated with the patient's medical care.

Reports of clinical trials of collaborative care programs have typically summarized descriptions of the training of general nurse care managers and some researchers have authored training workbooks (8, 9). However, there is limited practical information available on how best to select, train and supervise general nurses who take on the care manager role in collaborative care treatment programs. This is important to ensure the integrity of interventions in clinical trials and subsequently in everyday clinical practice.

We have developed a collaborative care based treatment program ('Depression Care for People with Cancer', DCPC) for people with cancer and comorbid major depression. DCPC is designed to be integrated with the patient's cancer care (10).

The DCPC team comprises cancer nurses (as care managers) and psychiatrists working in collaboration with the patient's oncology team and primary care physician (PCP). The treatment program is highly specified in a manual. As with most collaborative care programs, the nurse care managers have a number of roles: they need to establish a therapeutic and collaborative relationship with patients, provide education about depression and its treatment, deliver brief evidence-based psychological interventions (problem-solving therapy and behavioral activation) and monitor patients' progress (using the PHQ-9 depression severity scale) (11-13). The nurses are selected, trained and supervised by the team psychiatrists, who also advise PCPs on prescribing antidepressant medication (recommendations about antidepressant medication are conveyed in reports signed by both the nurses care manager and the psychiatrist and the psychiatrist discusses complex medication decisions with the PCP) and provide direct consultations to patients who are not improving. DCPC has been evaluated in three randomized controlled clinical

trials, which all found it to be substantially superior to usual care in improving depression (14-16).

This paper is based on our experience of selection, training and supervision of general (non-mental health) nurse care managers to deliver DCPC in our clinical trials (SMaRT, symptom management research trials, Oncology-1, 2 and 3) and on feedback from the nurses during and after training. We describe the issues to be considered in each of these three areas, the problems that we encountered, and the solutions that we adopted to address these. We conclude with recommendations for the selection, training and supervision of nurse care managers whose role it is to deliver depression care to the medically ill.

2. SELECTION OF NURSES

2.1 Issues to consider

When we started our trials, there were a number of issues which needed to be considered when selecting nurses for the care manager role. These included which nurses to recruit and what processes we should use to select them.

2.2 Initial problems encountered

Our experience in the first trial indicated that some of the nurses we selected found it very hard to learn how to deliver DCPC even after extensive training. This highlighted that an interview on its own might not best predict the ability of a nurse to deliver the DCPC. It also brought to our attention that senior nurses might have performed better in the interview,

but when delivering intervention, they found it difficult to adhere to the treatment manual and to receive supervision.

2.3 Solutions adopted

Based on this experience, we developed a two-stage interview process intended to assess the nurses' aptitude for delivering DCPC. In the first stage of the interview process, we conducted a standard interview in which we asked applicants about their prior experience and reasons for applying for the post. In the second stage, we asked the nurses to participate in a brief video-recorded role play, in which a researcher acted as a distressed cancer outpatient. Nurses were tasked with finding out specific information about the patient such as "find out about the patient's main concerns about their illness". This exercise was intended to assess the applicants' ability to interact with a distressed patient. We gave applicants prior warning of this element of the selection process and explained that the training of successful candidates would include similar techniques. Two psychiatrists assessed the nurses' performance in role play using a scoring sheet that included: ability to establish a rapport; ability to communicate effectively; and meeting the objectives set for the scenario.The inclusion of role play confirmed that simply giving good answers to standard interview questions did not necessarily indicate the ability to communicate well with distressed patients and hence should be part of the selection process.

2.4 Further problems encountered

We also observed that when the psychiatrists informally asked an applicant how they had found the role play experience, there was a wide range in the nurses' ability to reflect on

their performance. Greater clinical experience did not seem to relate to ability to reflect; senior nurses did not perform better than more junior colleagues.

2.5 Solutions adopted

As a result of this experience, we decided to further modify our two stage-interview process to include an assessment of the nurse's ability to reflect on the role play in the selection process. We therefore required that nurses performed sufficiently well in the role play and were also able to reflect on their performance, identifying areas for improvement.

3. NURSE TRAINING

3.1 Issues to consider

It was also important to consider how we might best facilitate nurses' learning and how we should assess their competency. Our care manager training manual is specific to the DCPC program and was designed by the team psychiatrists, a psychologist with expertise in staff training and a senior academic nurse. The manual describes a series of learning objectives and competencies required to deliver DCPC which are organized in modules: basic psychiatry, basic oncology, advanced communication skills, depression assessment (including suicide risk), patient education about depression (including antidepressant medication) and problem solving treatment. We set out to use a variety of training methods including tutorials led by the team psychiatrists, role play sessions, self-directed learning resources, and seminars by external experts on specific aspects of treatment. During the training period nurses also spent time with PCPs and oncologists to learn about collaborative working for patients with cancer and depression.We assessed competency

using multiple choice and short answer questions, role plays and supervised DCPC treatment sessions with researchers acting as patients.

3.2 Problems encountered

Our initial experience indicated a number of problems: First, the nurses were not used to structuring their own time to effectively consolidate the new knowledge and skills that they learned during formal training sessions, they often felt that they did not know what goals they should achieve on their own. Second, in the training to deliver problem solving therapy, nurses found it challenging to stop their usual practice of giving information and instead to focus on enabling the patient to clarify their problems themselves and to generate their own solutions. Third, it was clear that the nurses had differing skills and experience at the outset of training and some struggled with the process of assessment: our use of competency assessments provoked a great deal of anxiety in senior nurses who regarded these as procedures that occurred only when a nurse's competency was in doubt, rather than as a normal part of training. Fourth, it became apparent from the nurses' feedback, that external trainers sometimes provided information that was confusing, partly due to the nurses' inexperience in depression treatment and partly because the information provided was not specifically tailored to DCPC delivery. Whilst all these problems were important, the main training challenge was the need for nurses to change their way of working: from providing the patient with advice to enabling the patient to find their own solutions.

3.3 Solutions adapted

We redesigned the training, taking these problems into account: we gave clearer instructions regarding self-directed learning timeslots, listing not only resources to be used (such as videotapes of real treatment sessions, selected for especially good use of skills or to demonstrate difficult situations) but also specific tasks to be carried out, for example a videoed role play to practice a particular skill. We made a highly structured training timetable to be completed, including treatment of simulated patients, over two to three months and ensured that all training sessions, including those on the delivery of psychological interventions, were delivered by our own team. As well as addressing the problems that we had encountered, this approach allowed the nurses and psychiatrists to work together more closely, having the effect of forming a cohesive team essential to subsequent successful treatment delivery. On the other hand, it did place greater burden on the team psychiatrists, who were also involved in delivering clinical care. We reconsidered the use of competency assessments but after discussion with the second less senior group of nurses we trained, who felt less threatened by assessments, we decided to retain these as an essential component to ensuring and demonstrating the quality of treatment. Finally, based on nurse's anxieties about assessment, we emphasized the achievement of competency, rather than simply completion of training.

4. NURSE SUPERVISION

4.1 Issues to consider

Supervision is an essential part of treatment delivery. In DCPC, we used group supervision, initially supervising all care managers in one group. We used a standardized structure to review the progress of all patients being treated by the team supplemented with review of video recordings of sections of treatment sessions. The care managers first presented each

of their new cases in detail, and then the team discussed those patients who had not yet responded to treatment. The team then watched selections from individual treatment sessions in the final part of each supervision meeting. The aims of supervision sessions were: to ensure consistent treatment delivery; to optimize treatment delivery (both antidepressant drugs and psychological treatments); to discuss the best approaches to addressing difficult clinical problems; and to ensure that the care managers maintained their knowledge and skills and were supported in their role.

4.2 Problems encountered

Although most of the nurses had previous experiences of supervision, it emerged that this 'supervision' was mainly in the form of emotional support, either as regular sessions with a more experienced nurse or ad hoc sessions to review practice when aspects of a patient's care had gone badly. The experience of regular structured clinical supervision, including detailed review of their work, was new to them and perceived by some as critical. In addition, some nurses took the view that systematic review of all the patients' in their care, not just ones that they realized they needed help with, meant that they were not being trusted to manage their own caseload.

Leading the supervision of nurses was also new to some of the less experienced psychiatrists, who found it hard to deliver feedback that was not wholly positive and to clarify when nurses should contact them urgently and when they should wait to discuss patients in supervision; some nurses sought detailed advice from a psychiatrist after every patient session, whereas others failed to discuss even urgent issues such as suicide risk.

4.3 Solutions adopted

Following this experience we altered our supervision system: a senior psychiatrist with experience of clinical supervision led the case discussions in smaller groups, assisted by a second more junior psychiatrist. This allowed more time for discussion of each case and also supported the less experienced psychiatrists. Selected video-recordings were then viewed by the whole team (groups came together using video-conferencing), and all team members (both nurses and psychiatrists) were asked to comment on these, not flinching from criticism where appropriate but always starting with positive comments. At the end of each supervision session the nurses had an opportunity to see one of the psychiatrists individually to addresses issues that had arisen in supervision or to prepare for potentially difficult upcoming treatment sessions through discussion and role play. The new supervision format was preferred by both nurses and psychiatrists.

5. DISCUSSION

As far as we are aware this is the first detailed description of the processes of selecting, training and supervising general nurses to be care managers in a collaborative care program for the treatment of depression comorbid with a general medical condition. Whilst other publications have described nurse training, these have focused on the evaluation of treatment programs and have not discussed the issues to be considered in selection, training and supervision.

Our report is based on the experience of psychiatrists and nurses who delivered DCPC to patients with cancer and depression in three clinical trials. There are potential limitations to the generalizability of our findings. We describe the experience of only a small number of clinicians, working in a single collaborative care treatment program, delivered in a research

setting. Collaborative care programs can be used to treat a number of other conditions (such as anxiety or pain) in patients with a range of medical disorders. The program is, however, similar to others based on the collaborative care model and the psychiatrists and nurses we employed were selected on the basis of their clinical rather than research skills. Furthermore, we anticipate that the challenges of selection, training and supervision that we have described could be applied broadly to collaborative care programs. For example, selecting nurses that have an understanding of the relevant medical condition who can also be trained to treat psychiatric disorder and to enable rather than to advise patients.

Our recommendations should be applied with regard to the specific context of the collaborative care program. DCPC includes psychological treatment but in some collaborative care programs the nurse care manager focuses instead on medication adherence and progress monitoring; and consequently requires less intensive training and supervision. Regular team supervision may not be easily delivered in all settings and group learning may therefore require less frequent team sessions or information technology such as video-conferencing might be used creatively when implementing the program. Similarly, whilst it may not be feasible for junior psychiatrists to always jointly supervise with a senior colleague, it is important they get training and supervision in this new way of working. These issues are crucial to consider in order to ensure a successful implementation of the collaborative care programs (17).

Our experience over ten years and the positive results of our clinical trials strongly indicates that general nurses can be trained as depression care managers in collaborative care programs and can deliver highly effective treatment. However, our experience also suggests that it is important to carefully select, train and supervise general nurses so that they can provide optimal care.

RECOMMENDATIONS AND CONCLUSIONS

We recommend that those setting up collaborative care teams use role play scenarios in their selection process along with the opportunity to assess capacity for self-reflection. We also suggest that recruiters consider selecting less senior nurses, who may be more comfortable being trained in a completely new way of working. We recommend that the training should be structured, delivered in a way that closely mirrors the treatment manual and includes simulated practice. Finally, we recommend that supervision will be most effective when it is led by senior psychiatrists with access to detailed information about patients' progress. The summary of recommendations is provided in Table 1.

[Insert Table 1 here]

Meeting both the physical and mental health needs of patients is crucial to achieving the best clinical outcomes. As we have shown, general nurses can play a critical role in delivering integrated treatment as part of a collaborative care team. Whilst our experience has centered on the treatment of depression in patients with cancer, the recommendations set out in this article could be applied to collaborative care provision across different comorbidities.

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