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

Marta Wanat, M.Res. [a,*], Jane Walker, Ph.D. [a], Laura Hodges, Ph.D. [b], Alison Richardson, Ph.D. [c], Michael Sharpe, M.D. [a]

[a] Psychological Medicine Research, University of Oxford Department of Psychiatry, Warneford Hospital, Oxford, UK
[b] Division of Psychiatry, University of Edinburgh, Edinburgh, UK
[c] Faculty of Health Sciences, University of Southampton, UK; University Hospital Southampton NHS Foundation Trust, Southampton, UK

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ABSTRACT

Objective: Collaborative care programs to treat comorbid depression in the medically ill often have general (non-psychiatric) nurses care managers. In this paper, we aim to provide practical recommendations for their selection, training and supervision.
Methods: Based on more than 10 years of experience of selecting, training and supervising general nurses to deliver a highly effective collaborative care programme called "Depression Care for People with Cancer," we describe the problems encountered and the solutions adopted to optimize the selection, training and supervision of nurse care managers.
Results: To select nurses for the role of care manager, we found that role plays enabled us to assess nurses' ability to interact with distressed patients and their capacity for self-reflection better than simple interviews. To train the nurses, we found that a structured program that mirrored the treatment manual and included simulated practice was best. To achieve effective supervision, we found that having sessions led by senior psychiatrists facilitated both constructive feedback to the nurses and effective review of the management of cases.
Conclusions: We recommend that the selection, training and supervision of general nurses use the strategies outlined if they are to maximize the benefit that patients achieve from collaborative care programs.

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 programmes 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. While 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, they need to learn about not only the content of treatment programmes (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 summarised 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 programmes. 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 programme (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].

* Corresponding author at: Psychological Medicine Research, University of Oxford Department of Psychiatry, Warneford Hospital, Oxford, OX3 7JX. Tel.: +44-1865-226477; fax: +44-1865-793101.
E-mail address: marta.wanat@psych.ox.ac.uk (M. Wanat).

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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 behavioural 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 randomised 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 (nonmental health) nurse care managers to deliver DCPC in our clinical trials (symptom management research trials, SMaRT, 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 applicants 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 programme 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 organised 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. While 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.

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