Who should deliver behaviour change or psychological therapy in Tier 3 weight management services?

Colette Boyden, RGN, RM, MSc Weight Management
Behaviour Change Therapist, Rotherham Institute for Obesity, and General Practice Nurse, Sheffield

In 2013, more than 62% of adults in the UK and Ireland were classed as overweight or obese (Public Health England, 2015). Behaviour change has become accepted as a necessary component in the management of weight loss (Cavill and Ells, 2010). This was further confirmed by a British Psychological Society (2011) report, which suggested that psychological issues can be linked to the causes and consequences of obesity, and that psychological techniques and therapies should be incorporated into weight management services to assist in maintaining a healthy weight. Stewart et al (2010) suggested that up to 30% of people who undergo bariatric surgery begin to regain weight after 2 years, as a result of binge eating, emotional eating, triggers, strategies and/or their environment. The National Confidential Enquiry into Patient Outcome and Death revealed that only 29% of bariatric surgery patients in the UK received any psychological input before or after surgery to address these issues (Martin et al, 2012).

These findings informed the formulation of the current NHS clinical commissioning policy for complex and specialised obesity surgery (NHS Commissioning Board, 2013). With the development of more Tier 3 weight management services, it appears prudent to discuss who should be involved in delivering the behaviour change aspect of weight management care. The question arises as a result of the following statement (NHS England, 2014):

> *"A Tier 3 obesity service is for obese individuals (usually with a body mass index ≥35 with co-morbidities or 40+ with or without co-morbidities) who have not responded to previous Tier interventions. A Tier 3 service is comprised of a multi-disciplinary team of specialists, led by a clinician and typically including: a physician (consultant or GP with a special interest); specialist nurse; specialist dietitian; psychologist or psychiatrist; and physiotherapist/physical activity specialist/physiology."*

This is reiterated by The Royal College of Surgeons of England (RCS, 2014) commissioning guide. However, the panel publishing that report recognised that having a psychologist or psychiatrist is aspirational and that flexibility is necessary in developing services. They also identified that "there is no literature to identify which professionals are best placed to provide mental health interventions in weight management, and further research is required." A similar structure is described by the NHS Commissioning Board (2013) for Tier 3 multidisciplinary team (MDT) services for people requesting surgery. However, the Commissioning Board recognise that there are different models of MDT structures, and they advise that the main aim should be to ensure that psychological factors relating to obesity, eating behaviour, physical activity and patient engagement are evaluated.

Talking therapies

Whilst recognising the value and importance of psychologists and psychiatrists, is there room for flexibility in the service delivery? The role of talking therapies has already evolved in general practice, with the introduction of the NHS's Improving Access to Psychological Therapies (IAPT) programme (available at: www.iapt.nhs.uk).

Talking therapists have delivered behavioural change and psychological therapy at the Rotherham Institute for Obesity (RIO) since 2009. RIO is a Tier 3 weight management MDT consisting of a GP with a Special Interest in obesity, Obesity Specialist Nurses (OSNs), Healthcare Assistants, a Dietitian, an Exercise Therapist, Health Trainers and Talking Therapists. Weight loss behaviour change is delivered by all members of the team utilising evidence-based principles of weight loss, such as setting realistic weight targets, creating a calorie deficit, becoming

consciously aware of their eating habits, triggers and incorporating physical activity into their daily life (Aldridge, 2014). More specific behaviour change is delivered by Health Trainers, who utilise motivational interviewing and coaching skills.

If patients are failing to lose weight, binge eating, comfort eating or requesting bariatric surgery, they are referred for talking therapy (Boyden et al, 2015). The therapeutic approach is solution-focused and includes cognitive behavioural therapy, motivational interviewing, neurolinguistic programming, hypnotherapy, life coaching and emotional freedom techniques. The behaviour change element follows the recommendations of NICE (2014) and includes the following:

- Self-monitoring of behaviour and progress.
- Stimulus control.
- Goal setting.
- Slowing the rate of eating.
- Ensuring social support.
- Problem solving.
- Assertiveness.
- Cognitive restructuring (modifying thoughts).
- Reinforcement of changes.
- Relapse prevention.
- Strategies for dealing with weight regain.

The patients' mental health is assessed initially by OSNs, and they are classed as unsuitable for RIO if they are unmotivated or if their mental health appears unstable. If psychological issues such as undiagnosed depression, suicidal intention or other mental health problems become apparent, the GP is informed to ensure that referral to psychological services or psychiatry occurs and that the patient will receive ongoing management.

Other examples of Tier 3 multidisciplinary weight management services are given in *Box 1.*

Box 1. Other examples of Tier 3 multidisciplinary weight management services in the UK.

- The Fakenham Weight Management Service is a similar Tier 3 weight management MDT to RIO. It utilises a Psychological Therapist and a Health Trainer to provide behaviour change and psychological therapy (Hughes, 2015).
- The Weigh Ahead Tier 3 weight management service (available at: http://bit.ly/1GK2YRs) is provided by the NHS Dorset Clinical Commissioning Group. Behaviour change and psychological therapy is provided by a Psychological Therapist.
- The More Life weight management MDT (available at: http://bit.ly/1GbpKLw) employ psychologically informed practitioners such as counsellors and psychotherapists in their adult Tier 3 service.

Conclusion

From a brief survey of Tier 3 adult weight management services, it appears that there is support for delivery of behaviour change or psychological therapy by a range of approaches, rather than relying on psychologists or psychiatrists, as outlined by the RCS (2014). This suggests that commissioners are being flexible in their approach on which practitioners deliver behavioural change and psychological therapy.

Michie et al (2013) have approached behaviour change from a different angle and concentrated on classifying behaviour change techniques by their effects on increasing physical activity and healthy eating. They have classified a taxonomy of 93 behaviour change techniques that are effective and replicable, which include goal setting, planning, habit reversal and self-monitoring. The aim is to enable future comparisons, analyses and systematic reviews of the specific techniques, rather than comparisons of studies that contain the ambiguous term of behaviour change, and reduce the number of limitations to studies. The taxonomy is presently being assessed for reliability and usability across different populations, disciplines and settings. A significant aspect of the research is to ensure that behaviour change is effective, irrespective of who delivers the change. ■

Aldridge S (2014) Losing it in RIO. In: *Diabetes Update*. Diabetes UK, London. Available at: http://bit.ly/1JV8f7N (accessed 16.06.15)

Boyden C, Wilson C, Capehorn M (2015) Retrospective analysis of subjective wellbeing and weight loss in patients receiving talking therapies at the Rotherham Institute for Obesity (RIO). *Obesity Facts* **8**(Suppl 1): 184 (poster T4:PO.019)

British Psychological Society (2011) *Obesity in the UK: A Psychological Perspective*. BPS, Leicester. Available at: http://bit.ly/1LdXmN1 (accessed 16.06.15)

Cavil N, Ells L (2010) *Treating Adult Obesity Through Lifestyle Change Interventions. A Briefing Paper for Commissioners*. National Obesity Observatory, Oxford. Available at: http://bit.ly/1IijZNl (accessed 16.06.15)

Hughes CA (2015) The rewards and challenges of setting up a Tier 3 adult weight management service in primary care. *British Journal of Obesity* **1**: 25–31

Martin IC, Smith NC, Mason M, Butt A (2012) *Too Lean a Service? A Review of the Care of Patients who Underwent Bariatric Surgery*. National Confidential Enquiry into Patient Outcome and Death, London. Available at: http://bit.ly/1ejSN9N (accessed 16.06.15)

Michie S, Richardson M, Johnston M et al (2013) The behavior change technique taxonomy (v1) of 93 hierarchically clustered techniques: building an international consensus for the reporting of behavior change interventions. *Ann Behav Med* **46**: 81–95

NHS Commissioning Board (2013) *Clinical Commissioning Policy: Complex and Specialised Obesity Surgery*. NHS Commissioning Board, London. Available at: http://bit.ly/1hhFEXM (accessed 16.06.15)

NHS England (2014) *Joined Up Clinical Pathways for Obesity: Report of the Working Group*. NHS England, London. Available at: http://bit.ly/RNNm7S (accessed 16.06.15)

NICE (2014) *Obesity: Identification, Assessment and Management of Overweight and Obesity in Children, Young People and Adults* (CG189). NICE, London. Available at: www.nice.org.uk/guidance/cg189 (accessed 16.06.15)

Public Health England (2015) *Adult Obesity: UK and Ireland Prevalence and Trends*. PHE, London. Available at: http://bit.ly/1PYojaC (accessed 16.06.15)

Royal College of Surgeons of England (2014) *Commissioning Guide: Weight Assessment and Management Clinics (Tier 3)*. RCS, London. Available at: http://bit.ly/1MHKmjg (accessed 16.06.15)

Stewart KE, Olbrisch ME, Bean MK (2010) Back on track: confronting post-surgical weight gain. *Bariatric Nursing and Surgical Patient Care* **5**: 179–85