## SHORT REPORT: HEALTH PSYCHOLOGY IN ACTION

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**Suzanne is a Chartered Health Psychologist practitioner who completed her training in the UK in the 1990's. A founding member and former Chair of the Division of Health Psychology, Suzanne is a member of the Clinical Supervisor's register of PSI, and a member of the Heads of Psychology Services Ireland (HPSI) group of PSI. Suzanne left the HSE in 2003 to take up a psychologist post in NLN and is currently job-sharing the Principal Psychologist post in Rehab Group.**

As a health psychologist I am acutely aware of the complex issues effecting the recruitment of many sub-disciplines of psychology to the health services. I come across individuals who are on waiting lists and I know many psychologists who work in the health services who are under pressure, while other early career psychologists cannot move forward in their careers. As part of the PSI Division of Health Psychology (DHP), I am an advocate for the expansion of the recruitment criteria for psychology posts in the health services. In writing this piece I plan to illustrate the applicability of practitioner health psychologist's competencies to a rehabilitation service setting – which I would like to think will bring hope to health psychology graduates.

Before discussing the competencies, I will outline RehabGroup's services. RehabGroup is a Section 39 organisation offering services to children and adults with disabilities via its Care Division (Rehabcare) and its Learning Division (National Learning Network/NLN). The Care Division offers residential, day and respite services for children and adults with disabilities and is funded by the Health Service Executive (HSE). The Learning Division provides specialist rehabilitative and vocational training services to persons aged 16-65 years who have a disability and is funded by the HSE and the Education Training Boards.

Our definition of disability is broad and covers many care groups including adult mental health, adult intellectual disability (including autism spectrum disorders) and adult physical and sensorial disability including acquired brain injury (and the adolescent equivalent groups in small numbers). We also provide services to people with addiction issues, people who have suffered major medical setbacks and people from minority groups. Service outcomes include increased independence, greater community integration, improved quality of life, improved mental and physical health and progression to higher level training or employment.

Twenty-two psychologists work in RehabGroup as part of a multi-disciplinary team alongside social work, behaviour therapy, advocacy, social care staff and teaching staff. RehabGroup has services in every county all of which are serviced by the psychologists. Twenty years ago, RehabGroup were ahead of their time, using competency-based interviewing to recruit psychologists. For this reason, and because our client base is extremely broad, RehabGroup attracts psychologists from a wide variety of sub-disciplines, (including a number of health psychologists) bringing great diversity to the team.

### Competencies in Health Psychology

Health psychology has been defined as the study of psychological and behavioural processes in health, illness, and healthcare (Johnston, 1994). There are five core health psychology competencies (Allen at al., 2014):

- Health psychology interventions competence
- Generic professional competence
- Consultancy competence
- Teaching and training competence
- Research competence

I now outline how each competence maps onto the role demands in a rehabilitation setting.

***Health Psychology Interventions Competence***

One of the most influential models of understanding health, illness and disability is the biopsychosocial model. This model, rooted in health psychology, outlines the biological, social and psychological factors which interact to determine a person's rehabilitation progress (Engel, 1977). In my experience this is one of the most useful models – which is rooted in health psychology – within rehabilitation.

As mentioned above, the people who use our service come from many different care groups, yet in my practice I see people presenting with common issues resulting from varying disabilities/conditions. This view is supported by Lorig et al. (2012), who notes "although the biological causes of chronic illnesses [and conditions] differ, the problems they cause for people are similar", as is capture in in Table 1 below.

*Table 1.* Common Problems Caused by Varying Chronic Conditions

| **Chronic condition** | **Pain** | **Fatigue** | **Physical Function** | **Difficult Emotions** |
|---|---|---|---|---|
| Anxiety Disorders | | √ | √ | √ |
| Depression | | √ | √ | √ |
| Arthritis | √ | √ | √ | √ |
| Cancer | √ | √ | √ | √ |
| Chronic Pain | √ | √ | √ | √ |
| Diabetes | √ | √ | √ | √ |
| Multiple Sclerosis | √ | √ | √ | √ |
| Stroke | | √ | √ | √ |
| Heart disease | √ | √ | √ | √ |

Due to the medical, environmental and functional implications of disability being broadly similar despite varying backgrounds, a number of key constructs (linked to Engel's model) are assessed at intake, including those detailed in Box 1. These factors are explored through a needs/strengths assessment from which the identified needs and strengths are fed into a person-centred process that facilities the tracking of a person's journey through our service.

*Box 1. Assessment Constructs*

- Medical factors (biological):

- Diagnosis and symptoms,
- Chronic pain/injury management,
- Compliance with medication/medical regime.

- Psychomotor factors (biological):
  - Movement/mobility issues,
  - Gross and fine motor skills.
- Psychosocial factors (psychological and social):
  - Adjustment to disability,
  - Lifestyle factors,
  - Quality of life & personal network of support.
- Environmental factors (social):
  - Housing issues,
  - Aids and adaptations.
- Cognitive factors (psychological):
  - Thinking styles and errors, Information processing,
  - Concentration and attention issues.
- Educational factors (psychosocial):
  - Education history and learning issues.
- Vocational factors (psychosocial):
  - Career history and goals.

As a psychology service we are not constrained by being assigned to one care group. By the time a person arrives in our service, that person has moved beyond the acute phase of the condition (if applicable) and been deemed by their GP or mental health team (via a health report/referral form) to be well enough to engage full-time. We do not provide clinical treatment in the acute phase – we have a broad rehabilitation remit, taking a case management approach with each person. We have the freedom to provide the person with a wraparound psychology service which looks at their life holistically. We identify barriers to progression and formulate rehabilitation strategies to address these. Allow me to illustrate with an example.

One group of people we work with is those who have experienced major medical setbacks and have to engage in a process of rehabilitation and/or vocational training in order to adjust. Individuals in this group could have suffered an accident or the onset of chronic illness resulting in them experiencing difficulty returning to a previous life. These people may have to retrain towards a new career while managing a medical regime with challenging symptoms. Often these people feel they do not have a voice and have difficulty navigating healthcare systems. All these factors influence their adherence to health behaviours. As a certified leader in the Chronic Disease Self-Management Programme (Lorig et al., 2012), I am an advocate for self-management but in my experience, people typically require front-loaded interventions – the most frequent of which are captured in Box 2.

*Box 2. Most Frequent Psychological Interventions*

- Stress/anxiety and low mood
- Treatment adherence
- Finding resources/navigating healthcare systems
- Advocacy/communicating with healthcare professionals
- Communicating effectively with family/friends/employers
- Healthy lifestyles including diet and physical activity

- Sleep hygiene
- Pain management
- Substance and behavioural addictions
- Risk behaviours
- Increasing autonomy/independence
- Disability awareness and adjustment to disability/chronic conditions
- COVID-19 related stress/coping

***General Professional Competence***

This competence covers a host of areas, but I will focus on working autonomously and communicating effectively. Due to the geographic spread of our services each psychologist must work on their own initiative within a specific region but know when to seek clinical supervision. In RehabGroup, clinical supervision groups are PSI-accredited and held every six weeks regionally. Every member contributes a clinical piece, research piece or a case and all members are encouraged to act as peer-supervisors. Given the diversity in sub-specialisms of psychology, these supervision groups have a particular richness to them. All twenty-two psychologists also meet bi-monthly at national meetings facilitated by the principal psychologist/s.

To be effective communicators we need to tailor our way of communicating to different target groups. To support the people who use our service, we created an online psychology hub on our eLearning platform which has been a very effective way of supporting people during COVID-19. Another example of targeting information that we found to be effective is developing guidelines for staff. Recently I contributed to the development of a national guideline for frontline staff in residential services. These guidelines were tailored to guide staff in supporting people with an intellectual disability to make an informed decision about getting vaccinated. Whilst being underpinned by the Assisted Decision-Making Capacity Act (2015), this guideline had to remain user friendly for easy implementation.

***Research Competence***

As most practitioner psychologists will know, finding protected time for conducting research is a challenge. We focus on two areas, one of which is carrying out small-scale research projects with the help of assistant psychologists. These address service questions, like "What are the barriers to completion of rehabilitation/vocational training programmes?" and "What is the level of reduction in HSE service utilisation following completion of one of our programmes?"

A second area is the continuous collection of practice-based evidence, where data are collected from all psychologists on assessments, interventions and consultancy carried out. Data analysis facilitates us in responding to trends in presenting needs, staff training requirements and the development of training modules.

***Consultancy Competence***

In RehabGroup, psychologists' expertise is called upon for consultancy on many levels, one being the development/review of policies. Many of these policies draw heavily on psychological knowledge such as include the Policy on Consent or the Policy on Suicide and Self-Harm. Psychologists also receive requests for consultancy in terms of contributing to the strategic direction of the organisation – the input of psychology at all levels of the organisation

is given a high value. The Research Strategy and the Autism Strategy in particular are two areas where psychologists provide expertise and guidance.

### *Teaching and Training Competence*

Psychologists in RehabGroup respond to the needs identified by staff and service users by designing and delivering training workshops. Workshops developed for people who use our service include stress management, health and hygiene, goal setting, introduction to cognitive behavioural principles and coping with COVID19. Psychologist-led staff training forms a large part of all the training delivered for frontline staff. Psychologists are involved right from the outset by conducting a training needs analysis, designing the staff training programmes and delivering them to staff. Staff training is another area where diversity in sub-disciplines is an advantage.

Training is then evaluated and reviewed accordingly. Training programmes are then standardised nationally, resulting in shared knowledge and expertise amongst the psychology team. Psychologist-led staff training includes disability awareness, principles of goal setting/motivational theory, self-care/resilience, promoting autonomy and boundary management.

I hope that this article has illustrated the match between the competencies of practitioner health psychologists and rehabilitation/specialist training settings. My vision is to see health psychologist's practitioner skills being utilised to their full potential in all health service settings. I am proud to be part of the growing health psychology community and thoroughly enjoy being part of the diverse team of psychologists in RehabGroup.

## References


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