Targeted interventions framework
Appendix A (24): Psychological Therapies for patients with Irritable Bowel Syndrome

NHS Leeds North Clinical Commissioning Group,
NHS Leeds South and East Clinical Commissioning Groups and
NHS Leeds West Clinical Commissioning Group

Version:	Final
Ratified by:	NHS Leeds West CCG Assurance Committee NHS Leeds North CCG Governance, Performance and Risk Committee NHS Leeds South and East CCG Governance and Risk Committee
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On behalf of NHS Leeds North Clinical Commissioning Group, NHS Leeds South and East Clinical Commissioning Group and NHS Leeds West Clinical Commissioning Group

1.0 Introduction

This policy is designed to clarify the agreements between Leeds Clinical Commissioning Groups (CCGs) NHS Leeds North CCG, NHS Leeds South and East CCG and NHS Leeds West CCG and providers regarding the commissioning of cognitive behavioural therapy, hypnotherapy, and psychodynamic psychotherapy for irritable bowel syndrome.

It serves to agree the conditions which are automatically commissioned and those that require exception permission before they can proceed.

There is an agreement that for commissioning to proceed, information must be provided by clinicians from levels 2, 3, or 4 (see below).

This document is intended as an aid to decision making. It should be used in conjunction with Leeds CCG policies on Individual Funding Requests and associated decision making frameworks.

Prior approval is not required, however the responsible secondary care clinician must confirm that patient meets the commissioning criteria in the case notes prior to referral, which must be available for commissioners to audit.

2.0 Definitions

Irritable bowel syndrome is a gastrointestinal disorder characterised by a chronic and relapsing symptom profile of abdominal pain or discomfort, with associated altered patterns of defecation. It is common, affecting up to 24% of women and 19% of men in industrialised countries (Drossman 1997). The aetiology is largely unknown, but IBS is increasingly recognised as a “biopsychosocial” disorder, with organic, psychological, and environmental contributions to its development (Webb 2007).

First line treatment, according to the management pathway developed by NICE, should consist of a combination of dietary and lifestyle changes, and pharmacological treatment of the predominant symptom. However, many patients do not have adequate alleviation of symptoms using such therapies (Webb 2007).

NICE has identified the term “*refractory* irritable bowel syndrome” to describe “people with IBS who do not respond to first line therapies after 12 months and who develop a continuing symptom profile” (NICE 2008). While this is not defined in much further detail, in the context of the NICE treatment pathway for IBS, it can be taken to refer to those individuals who have not had an adequate response to the suggested first line therapies (dietary changes, physical activity, pharmacological management of predominant symptom) despite 12 months of treatment.

For those with refractory IBS, NICE recommends that referral for psychological interventions should be considered. The psychological interventions covered by the guidance are cognitive behavioural therapy, hypnotherapy, and psychotherapy. NICE

has considered, for the purposes of the clinical guideline, that these three therapies are equivalent, as all three are cost effective and have similar levels of evidence.

Hypnotherapy uses hypnosis to induce states of altered awareness, in which the associated mental processes may be very effective in producing change. Gut-directed hypnotherapy has been specifically designed to improve symptoms of IBS, by utilising hypnosis to allow patients to change the way their brain influences the activity of their bowel, and its impact on their symptoms (NICE 2008).

Cognitive behavioural therapy is a psychological therapy that aims to alter behaviour by challenging and restructuring the thought patterns that may lie behind or support that behaviour. It can be delivered on an individual or group basis (NICE 2008).

Psychotherapy, as described in the NICE guidance on IBS, relates to dynamic (or psychodynamic) psychotherapy. This is a talking therapy, delivered over several sessions, which explores symptoms and emotions in depth, and examines links between the two (Naliboff 2008).

NICE does not include relaxation or biofeedback approaches under its definition of psychotherapy – these psychological therapies are considered separately, and do not have sufficient evidence of effectiveness/cost effectiveness.

The NICE clinical guideline does not make any recommendation that any one of the three treatments should be used preferentially to another, and recognises that patient and clinician choice, and availability of services locally, should be taken into account in local decisions over which treatments to provide.

As such, it is reasonable that local commissioning decisions will take into account existing local demand (as a proxy of physician choice), current funding arrangements, and individual patient factors, when deciding which, if any, of these psychological therapies to fund.

Commissioner – Leeds CCGs
Providers – any hospital/clinic/centre with a commissioning agreement with NHS Leeds CCGs, (including NHS and independent sector providers).

Level 2 – Primary care
Level 3 – Extended primary care intermediate services or providers or psychological services including hypnotherapy
Level 4 – Hospital services

3.0 Commissioning position

Gut-directed hypnotherapy, Cognitive behavioural therapy or dynamic psychotherapy for irritable bowel syndrome will be routinely commissioned for selected patients who satisfy all of the following criteria:

- Diagnosis of irritable bowel syndrome
- Have developed continuing symptom profile

- Inadequate response to one or more pharmacological agents over 12 months of treatment
- Identified by secondary care physician as appropriate for psychological referral

3.1 Rationale

Hypnotherapy, cognitive behavioural therapy, and dynamic psychotherapy are considered equivalent by NICE in terms of their role in the management pathway of patient with Irritable Bowel Syndrome. There is no more recent high quality evidence or guidance to suggest that any one of these three treatment options is preferable to another in terms of effectiveness or cost-effectiveness. Locally, CBT and psychotherapy services for other defined conditions – though not Irritable Bowel Syndrome – are provided as part of existing commissioning arrangements through IAPT. The IAPT service also already accepts referrals for CBT for those with IBS and co-existing common mental illness. However, hypnotherapy for IBS is only provided locally on a patient by patient basis, by a private practitioner. Where the potential interventions on offer are equivalent, as in this case, it is preferable to develop existing commissioning arrangements than to organise and pay for treatment on an individual patient basis. As such, it is reasonable to routinely commission IBS treatment through IAPT (most likely CBT, but to be determined by the IAPT service), but not hypnotherapy as in previous arrangements. For individual funding requests for hypnotherapy, it should be demonstrated why the proposed treatment should be funded, rather than CBT or psychotherapy through IAPT, given that CBT and psychotherapy are part of an established and affordable local service, and are considered equivalent to hypnotherapy for the purposes of the NICE guidance.

4.0 Background

The most recent NICE guidance on the management of irritable bowel syndrome was released in 2008. There is a 2007 Cochrane systematic review on hypnotherapy for IBS, and a 2009 Cochrane systematic review on psychological therapies for IBS (including evidence up to 2008). The NICE guidance is due to be updated, so this commissioning statement may need to be altered in light of this guidance when released. However, based on a recent literature search of papers published since 2008, it appears unlikely that the guidance relating to psychological interventions, including hypnotherapy, will be altered significantly.

5.0 References

This policy is based on the following evidence-based guidelines:

Drossman D.A., Whitehead W.E., Camilleri M. Irritable bowel syndrome. A technical review for practice guideline development. Gastroenterology Volume 112, 1997

Naliboff B.D., Frese M.P., Rapgay L. Mind Body Psychological Treatments for Irritable Bowel Syndrome. Evidence Based Complementary and Alternative Therapy, Volume 5, Issue 1, 2008.

National Institute for Health and Care Excellence, 2008. NICE Clinical Guideline 61: Irritable Bowel Syndrome in Adults. Accessed April 2014.

National Institute for Health and Care Excellence, 2013. NICE Pathways: Irritable Bowel Syndrome in Adults overview. Accessed April 2014.

National Institute for Health and Care Excellence, 2013. NICE Pathways: Managing irritable bowel syndrome. Accessed April 2014.

Webb A.N., Kukuruzovic R., Catto-Smith A.G., Sawyer S.M. Hypnotherapy for treatment of irritable bowel syndrome (Review). Cochrane Database of Systematic Reviews. Issue 4, 2007.

Zijdenbos I.L., de Wit N.J., van der Heijden G.J., Rubin G., Quartero A.O. Psychological treatments for the management of irritable bowel syndrome (Review). Cochrane Database of Systematic Reviews. Issue 1, 2009.

Appendix A: Equality Impact Assessment

This commissioning position statement has been considered as to its effect, or likely effect, on people with Equality Act protected characteristics – age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. On this occasion no adverse impact has been identified. It is considered that the commissioning position demonstrates due regard to reducing health inequalities, addressing discrimination and maximising opportunities to promote equality.

Appendix B; Version Control Sheet

Version	Date	Author	Status	Comment
0.1	7.10.14	Matthew Nielson, Fiona Day	draft	