Wales Mental Health Primary Care (WaMH in PC) Bursary Application Form 2010

Proposal for: Pilot study of Telephone CBT for individuals experiencing common mental health problems in Swansea's Wellbeing Service

Application from:
Swansea Wellbeing Service, Psychological Services, ABMU
Mental Health Directorate
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Category for which the bursary is sought

Category 5 - Promoting mental health and wellbeing
Fulfils all 5 Attributes of WaMHinPC
Fulfils all 3 of the Hallmarks of WaMHinPC Gold Standards
*Meets NSF Standards: 1(*Social inclusion, health promotion and tackling stigma); 2 (Service user and carer empowerment); 4 (Providing equitable and accessible services); 7 (Effective client assessment and care pathways); and 8 (Ensuring a well staffed, skilled and supported workforce).

The Project Developers

The Swansea Wellbeing Service is the front line of the Stepped Care model of Psychological Services in Swansea (Abertawe Bro Morgannwg University Health Board Mental Health Directorate). It aims to promote self-help and act as a stepping stone to boost individuals on their own way to recovery from mild-moderate ('common') mental health problems and prevent individuals needing to enter secondary services. It does this through providing a range of psycho-educational courses that are cognitive behaviour therapy (CBT) based including the Directorate-wide 'Stress Control' stress management course and computerised CBT (CCBT). We are aiming to expand and provide treatment that targets service users experiencing common mental health problems who find the process of accessing services difficult and stigmatising.

Background

Between 2004 and 2007, NICE reviewed the evidence for the effectiveness of a variety of interventions and issued clinical guidelines (NICE., 2004a, 2004b, 2006) that strongly support the use of certain psychological therapies. CBT is recommended for depression and all the anxiety disorders. Some other therapies (interpersonal psychotherapy, couples therapy, counselling) are also recommended for depression, but not for anxiety disorders. Public attitudes towards psychotherapy are generally more favourable compared to views regarding anti-depressants (Hansen & Kessing, 2007). Most people with common mental health problems are diagnosed and treated within primary care. However, provision of CBT and other forms of psychotherapy within UK primary care is limited. In the light of evidence that some individuals respond well to "low intensity" interventions (e.g. guided self-help and CCBT) NICE has recommended that there be greater access to CBT. Although subsequent reports have called for the development of psychological treatment centres to improve access to CBT (Layard, 2006) many primary care services in the UK still have long waiting lists for CBT (Beattie, Shaw, Kaur, & Kessler, 2009).

Alternative measures in cutting down the waiting list for face-to-face CBT treatment can be seen in the form of CCBT. Research looking at the effectiveness of CCBT has shown similar outcomes as in face-to-face CBT (Kiropoulas et al., 2008). Although CCBT appears to be effective, it may only be suitable to people who are familiar with computers, feel comfortable writing their feelings down and are attracted to the anonymity of an online therapeutic relationship (Andersson, 2009).

Recently there has also been a growing interest in telephone administered psychotherapy as a means for overcoming specific client barriers to care, such as time constraints, distance from services in rural areas, medical illness, or disability (Mohr et al., 2006). Randomised controlled studies have provided evidence that telephone-administered psychotherapy is effective in reducing depression, anxiety and obsessive compulsive disorder (Beckner, Vella, Howard, & Mohr, 2007; Miller & Weissman, 2002; Mohr et al., 2005, 2000; Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004; Lovell et al., 2006). Despite this supporting evidence and the widespread familiarity of the telephone as a means of communicating, the healthcare system has been slow to use telephone delivered psychotherapy (Bee, Lovell, Lidbetter, Easton, & Gask, 2010).

Research has also explored service users' attitudes towards non face-to-face psychotherapy, as it is important that new interventions are service user centred (Bee et al., 2010). The majority of participants in the study agreed that the telephone was an acceptable medium for delivering CBT. The emphasis that was placed on task facilitation and client anonymity was at the forefront of many individuals' accounts. While some participants reported that a lack of visual information was a barrier to establishing a therapeutic relationship, others seemed much more open to building up a therapeutic alliance in the absence of physical proximity.

While these developments are promising it is important to note that there has been no research carried out regarding T-CBT in Wales, as most pilot studies tend to be set up in England such as Newham or Doncaster (Clark, Layard, Smithies, Richards, Suckling, & Wright, 2009). Therefore, it may prove useful to primary care services in Wales if a T-CBT pilot was carried out here in order to see if it could be effective in improving access to services and assisting people in managing their mental well being.

Purpose of Project

If successful in securing a bursary we would use the funding to employ a CBT therapist part-time who would deliver CBT by means of a telephone. The pilot project would run for a period of 6 months where it would then be evaluated to assess its feasibility within the wellbeing service. The program will include eight core sessions with the first two lasting approximately 30 minutes. The next 6 sessions will each last for one hour. Each session will operate on a weekly basis. When the 8 core sessions are complete, there will be one hour-long follow-up session after 4 weeks. The main content of the sessions will focus on psycho-education and cognitive behavioural experimentation. This approach is designed to help individuals explore and resolve ambivalence about behaviour change in a non-confrontational manner (Tutty, Spangler, Poppleton, Ludman, & Simon, 2010).

Eligibility under category 5

Taking note from the Welsh Declaration for Mental Health and Well-being, we are striving to influence and develop service provision so that people with mild

to moderate mental health difficulties are better able to access treatment more efficiently in order to manage and maintain their mental well-being.

Our proposal aims to produce outcomes which will lead to understanding and help people to manage their well-being in a more effective way. The intervention is structured and educational in tone whereby the service user does a lot of the work themselves as there are activity experiments, which are tested with the aid of activity worksheets. This highly structured approach may be appealing to adults who often lack the initiative for self care during a depressive episode.

We aim to evaluate this intervention, so as to provide an evidence base for this intervention in Wales. We will also strive to ensure that the intervention is service user centred by collecting qualitative data on the service users' and therapist's experience of the program.
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Proposed Methods

Referral: Service users will be referred to our service by their GP and assessed by a qualified member of staff. Based on this assessment, if the service user is considered to be experiencing mild to moderate common mental health problems then they will be asked if they would like to avail of T-CBT. As with everything we offer in the Well-Being Service, it will be made clear to the individual that it is completely their own choice if they wish to take part in the intervention. Unfortunately, as we can only afford to run this pilot using 26 service users, this intervention could only be offered to the first 26 suitable service users.

Participation: If a service user wishes to participate they will be sent a letter with an appointment time for the T-CBT to take place. A CBT workbook will also be posted out to the service user which is used for in session exercises, useful reading and written homework exercises for completion between sessions (Simon, Ludman, & Tutty, 2006).

Evaluation: Service users will be asked to complete pre and post anxiety and depression measures in order to assess outcome. Analysis will also look at the feasibility and acceptability of T-CBT, which will involve asking for feedback from both the service user and the therapist. Other analysis will look at participation, maintenance of contact, mean session time and lag between sessions.

Planned Outcomes

- To reduce referrals to Secondary Care. It is hoped that this will result in shorter waiting lists.
- More people accessing Primary Care Services especially individuals who live in rural areas or find it difficult (due to anxiety or depression) to get access to a one to one appointment.
- A user friendly intervention that will hopefully empower service users to manage their common mental health problems.

- A more informed view of the feasibility for the ongoing delivery of T-CBT from both the therapist and service user's point of view.

Supporting Evidence

CBT exists as an umbrella term for a range of interventions based on modifying unhelpful thoughts, behaviours and feelings. Central to the CBT model is the idea of collaborative problem solving through which therapist and service user work together in order for the service user to achieve agreed goals. Research has reported the effectiveness of CBT for conditions such depression, anxiety, post-traumatic stress disorder and panic (Butler, Chapman, Forman, & Beck, 2006). Despite the efficacy of face-to -face CBT, it appears that primary care service users do not get to avail of this treatment as resources are limited in the healthcare sector.

Less intensive and more economical intervention involving computerised feedback and T-CBT appear feasible. In one particular study looking at T-CBT for depression in a primary care setting, 80% of service users completed the core program (Tutty, Ludman, & Simon, 2005). It was suggested that this high participation rate may be related to the convenience and accessibility of the program. Instead of service users having to request time off from work or arrange transport, the psychotherapist delivered T-CBT to the service user at a time that was most convenient for them. It was also reported that there may be less therapist and service user bias over the telephone compared to in person, as no significant differences were observed in participation rates among services users of varying ethnic, marital, and educational status. It has been suggested that T-CBT can be used as a stand alone treatment (Tutty et al., 2010); however Ludman et al (2007) have argued that T-CBT significantly improves outcomes in depression along with the use of antidepressants. Taking into account the poor outcomes associated with standard primary care treatment for adult depression (Nutting, Rost, Dickinson, 2002; Gilbody, Whitt, Grimshaw & Thomas, 2003), T-CBT appears to offer a cost-effective alternative for providers and service users facing barriers to care (Wang, Berglund, & Kessler, 2000; Tutty et al 2010).

Financial Statement

Funding from WaHM in PC is being sought to fund:

1. The cost of employing staff to deliver T-CBT to 26 mild to moderate clients within the Well-Being Service.
2. The cost of CBT workbooks, which will be posted out to the service user.
3. Researching the feasibility of the course in a primary care setting.

Requirement	Unit cost	Whole Time Equivalent	Total 6 month cost
1 supervisor for CBT therapist (Band 7)	£25	8 hours	£200
1 qualified CBT therapist (Band 6)	£17	160 hours in total	£2720
Materials (CBT workbooks)	£4 (approx)		£80
Total			**£3000**

NB: The cost of telephone calls and evaluation of project will be absorbed within existing resources. (£45.12 in call charges for 160 Hours to landlines)

References

Andersson, G. (2009). Using the Internet to provide cognitive behaviour therapy. *Behaviour Research and Therapy, 47*, 175-180.

Beattie, A., Shaw, A., Kaur, S., & Kessler, D. (2009). Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: A qualitative study. *Health Expectations, 12*, 45-59.

Beckner, V., Vella, L., Howard, I., & Mohr, D.C. (2007). Alliance in two telephone administered treatments: relationship with depression and outcomes. *Journal of Consulting and Clinical Psychology, 75*, 508-512.

Bee, P.E., Lovell, K., Lidbetter, N., Easton, K., Gask, L. (2010). You can't get anything perfect: "User perspectives on the delivery of cognitive behavioural therapy by telephone". *Social science & Medicine*, 71, 1308-1315.

Butler, A.C., Chapman, J.E., Forman, E.M., & beck, A.T. (2006). The empirical status of cognitive behavioural therapy: A review of meta-analyses. *Clinical Psychology Reviews, 26*, 17-31.

Clark, D.M., Layard, R., Smithies, R., Richards, D.A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy, 47*, 910-920.

Gilbody, S., Whitt, p., Grimshaw, J. & Thomas, R. (2003). Educational and organisational interventions to improve the management of depression in primary care: a systematic review. *JAMA, 289*, 3145-3151.

Hansen, H.V., Kessing, L.V. (2007). Adherence to antidepressant treatment. *Expert Review of Neurotherapeutics, 7*, 57-62.

Kiropulas, L.A., Klein, B., Austin, D.W. (2008). Is internet-based CBT for panic disorder and agoraphobia as effective as face-to face CBT? *Journal of Anxiety Disorders, 22*, 1273-1284.

Layard, R., Bell, S., Clark, D.M., Knapp, M., Meacher, M., & Priebe, S. et al. (2006). The depression report: A new deal for depression and anxiety disorders. London School of Economics. Available at **http://cep.lse.ac.uk** Centre fpr Economic Performance Report.

Lovell, K., Cox, D. Haddock, G. et al. (2006). Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomised controlled non-inferiority trial. *British Medical Journal, 333*, 883-887.

Ludman, E.J., Simon, G.E., Tutty, S., & Von Korff, M. (2007). A randomised trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *Journal of Consulting and Clinical Psychology, 75*, 257-266.

Miller, L., & Weissman, M. (2002). Interpersonal psychotherapy delivered over the telephone to recurrent depressives. A pilot study. *Depress Anxiety, 16*, 114-117.

Mohr, D.C., Hart, S.L. Julian, L., Catledge, C., Honos-Webb, L., Vella, L. et al (2005). Telephone administered psychotherapy for depression. *Archives of General Psychiatry, 62*, 1007-1114.

Mohr, D.C., Hart, S.L. & Marmar, C. (2006). Telephone administered cognitive behavioural therapy for the treatment of depression in a rural primary care clinic. *Cognitive Therapy and Research, 30*, 29-37.

Mohr, D.C., Likosky, W., Bertagnolli, A., Goodkin, D.E., Van Der Wende, J., Dwyer, P., et al. (2000). Telephone administered cognitive behavioural therapy for the treatment of depressive symptoms in multiple sclerosis. *Journal of Consulting and Clinical Psychology, 68*, 356-361.

NICE. (2004a). Depression: Management of depression in primary and secondary care (clinical guide 23). London, UK: National Institute for Clinical Excellence.

NICE. (2004b). Anxiety: management of anxiety (panic disorder, with and without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care (clinical guidance 22). London, UK: National Institute for Clinical Excellence.

NICE. (2006). Computerised cognitive behaviour therapy for depression and anxiety: Technology appraisal 97. London, UK: National Institute for Clinical Excellence.

Nutting, P.A., Rost, K., Dickinson, M. (2002). Barriers to initiating depression treatment in primary care practice. *Journal of General Internal Medicine, 17,* 103-111.

Simon, G., Ludman, E.J., Tutty, S. (2006). *Creating a balance: A step by step approach to managing stress and lifting your mood.* Victoria, British Columbia, Canada: Trafford Publishing.

Simon, G.E., Ludman, E.J., Tutty, S., Operskalski, B., & Von Korff, M. (2004). Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: A randomised controlled trial. *Journal of the American Medical Association, 292*, 935-942.

Tutty, S., Ludman, E.J. & Simon, G. (2005). Feasibility and acceptability of a telephone psychotherapy program for depressed adults treated in primary care. *General Hospital Psychiatry, 27*, 400-410.

Tutty, S., Spangler, D.L., Poppleton, L.E. Ludman, E.J., & Simon, G.E. (2010). Evaluating the effectiveness of cognitive behavioural teletherapy in depressed adults. *Behaviour Therapy, 41,* 229-236.

Wang, P.S., Berglund, P. Kessler, R.C. Recent care of common mental disorders in the United States: Prevalence and conformance with evidence based recommendations. Journal of General Medication, 15, 284-292.