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Primary care based guided self-help for depression provided by a nurse practitioner: a pilot evaluation.

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ABSTRACT

National Institute for Health and Clinical Excellence (NICE) guidelines for depression and anxiety recommend the provision of cognitive behaviour therapy (CBT)-based guided self-help interventions in primary care as part of a stepped care model.

Despite such guidance, some important questions remain, such as the nature of the guidance, who should provide the guidance within primary care, and the application of service delivery models in practice.

This paper describes and evaluates a pilot project involving guided self-help for depression provided by a nurse practitioner within primary care.

Clinical outcome measures showed statistical and clinically significant improvements in both anxiety and depression, although, as this was not a controlled study, one cannot definitely attribute improvements to the intervention. Issues about the provision of guided self-help in primary care and the implications for implementing NICE guidance and the role of nurse practitioners and other primary care staff are discussed.

Keywords: CBT, guided self-help, nurse practitioner, primary care mental health, stepped care

Introduction

Depression is a major public health problem and, according to the World Health Organization, by the year 2020 depression is predicted to be the most serious medical disease as reflected by global disease burden.[1,2] Depression is also the most common mental health problem and the third most common reason for consultation in general practice in the UK.[3] The economic cost of depression has been highlighted recently by Lord Layard, and most service users with common mental health problems, particularly anxiety and depression, are seen only in primary care.[4,5] Layard also pointed out that at present, only one in two people with depression receive any kind of treatment, just 8% see a psychiatrist and 3% a psychologist.[4]

The *National Service Framework for Mental Health* highlighted the need to develop the capacity of primary care services to assess and provide treatment

for people with mild-to-moderate common mental health problems, such as anxiety and depression.[6,7] National Institute for Health and Clinical Excellence (NICE) guidelines for depression and anxiety recommended the provision of cognitive behaviour therapy (CBT)-based guided self-help interventions in primary care as part of a stepped care model.[8,9] A stepped care approach advocates that the least intensive treatment likely to provide significant health gain is first offered, and more intensive treatment offered only if required, and the NICE guidance suggests guided self-help as step two for treatment of mild depression in primary care. A more recent NICE technology appraisal recommends that computerised cognitive behaviour therapy (CCBT)[10] is also made available as an option, 'Beating the Blues' for mild-to-moderate depression and 'Fearfighter' for panic and phobia.[10] Self-help approaches can also increase self-efficacy and self-reliance and provide a wider choice and range of options that can be accessed more easily, although care must be taken to develop service models and protocols that match self-help interventions appropriately to patient needs. Improving the range of therapeutic options available is important in view of the lack of availability of therapists, and the long waiting times for psychological therapy.

Meta-analyses of research into self-help interventions for anxiety and depression provide some support for their effectiveness.[11–14] Also, a recent review of research into self-help approaches for mental health problems reports evidence for the effectiveness of CBT-based self-help materials for anxiety, depression, bulimia nervosa and binge eating disorder.[15]

Despite the evidence and recommendations in NICE guidance, there is still a need for research into self-help interventions to clarify the amount and type of guidance required, models of provision such as stepped care, cost-effectiveness and which practitioners can and should provide guided self-help. Among the practitioners who could provide guided self-help interventions are graduate primary care mental health workers, assistant psychologists and primary care practitioners. Despite this, there is relatively little research on self-help interventions provided by such practitioners, and where controlled studies have been carried out the results have sometimes failed to demonstrate clear benefits.[16.17] *Liberating the Talents* encourages nurses with the skills and knowledge to work in new ways and providing guided self-help is one possible role.[18] The Enhanced Service Specification for depression under the new general medical services (GMS) contract also provides incentives and opportunities for developing primary care-based services for people with depression, including guided self-help, and recognition of depression in patients with chronic diseases such as diabetes and coronary heart disease is part of the quality and outcomes framework in the new GP contract.[19]

This paper describes a pilot guided self-help development, provided by a nurse practitioner in primary care, for patients with mild-to-moderate depression. The intervention developed and evaluated in this paper is consistent with NICE guidance and consistent with stepped care in that it provides a less intensive, briefer intervention. It is not a controlled study, but describes the development and implementation of the service, issues raised and the progress of patients.

Method

Background to the pilot

The pilot to develop and evaluate guided self-help provided by a nurse practitioner was carried out by author FP as part of a thesis for an MSc for nurse practitioners. The project was supervised by author ML and the patient work supervised by author AW. The nurse practitioner set up the guided self-help pilot as a clinic within the general practitioner (GP) practice where she had been working for a number of years. Initially, she discussed the care of depressed patients with the primary care team members informally, to gain an insight into the problems of team members, gather opinions, identify problems and engage the team in the pilot. A meeting was then held looking at current practice and issues (via a strengths, weaknesses, opportunities and threats, SWOT, analysis) and, as a result, it was agreed by the whole team to support the pilot project.

Setting

This pilot took place in a semi-rural population of approximately 9700. There were nine GPs, all of whom were part time. The population was predominately white, with only about 1% from black and minority ethnic (BME) groups.

Patients and suitability criteria

Patients were selected as suitable for guided self-help following routine primary care consultations, six with the nurse practitioner and nine with one of the GPs. In assessing patients' suitability for guided self-help, guidelines from the graduate primary care

mental health worker training programme at the University of Huddersfield were used. Inclusion indicators included adequate literacy skills, motivation for a self-help approach, and ability to identify achievable goals. The following contra-indicators were considered: severe depression; obsessive-compulsive disorder; post-traumatic stress disorder; immediate requirement or request for counselling or more in-depth psychological therapy; serious risk of self-harm; and if patients were already receiving counselling or psychological therapy. Consecutive patients receiving the intervention were asked to give their consent for anonymous information to be reported in this paper. This request was made after the intervention was completed and sent by post.

The intervention

Structure and content

The plan was to provide the intervention over four sessions, the first 30 for minutes and subsequent sessions for 15 minutes. This fitted into the existing 15 minute appointment system in the practice. Although most were seen within this format, some were seen for more sessions and some sessions were slightly extended. For example, older patients were given more time to work through the self-help materials, because it was judged they needed more time to understand the CBT model and identify their negative thinking. Sessions were structured to identify key problems and realistic goals, to identify appropriate self-help materials and support the patients' progress in relation to their goals.

Sessions were provided at various times of the day, allowing patients to work around work and child-care commitments. Goals were identified and patients worked on homework assignments between sessions. They brought the booklets they had worked on with them to each session.

Self-help material

The primary self-help material used was *Overcoming Depression: a five areas approach*.[20] This is a self-help workbook and was developed to provide a relatively jargon-free and accessible model of CBT for use in busy clinical settings. Feedback from users and professionals has led to changes and improvements over the last two years, including extensive testing with patients to ensure clarity of content. However, more research is needed to determine the effectiveness of this material as a support for guided self-help. The 'five areas assessment' allows the range of problems and difficulties to be summarised within a single model. To tackle problems effectively, it is necessary initially to prioritise them and focus on changing just one area at a time. The clinician needs to discuss and jointly agree with the patient how to prioritise the problem.[21]

Training and supervision

The nurse practitioner had completed the Praxis CBT training programme.[22] Praxis is a CD-ROM-based CBT distance learning package offering introductory training for those starting out in the CBT field. It uses a step-by-step approach and is designed to be used in conjunction with regular clinical supervision. The programme is based on Beckian-style CBT, and emphasis is placed on the CBT model and the role of formulation in the assessment and treatment of clients with depression and anxiety, particularly panic disorder. A range of the key cognitive and behavioural strategies is demonstrated using illustrative case studies and video demonstrations. It therefore provides grounding in CBT knowledge and skills, and is perhaps most appropriate for clients with mild-to-moderate common mental health problems and therefore for practitioners working in primary care. The nurse practitioner had also attended a one-day workshop on guided self-help using the book *Overcoming Depression: a five areas approach*.[20] This covered use of the five areas CBT model and supporting patients using the self-help materials contained within the book. They received regular clinical supervision from a GP at the practice (AW), as part of the Praxis training and as ongoing supervision throughout the pilot. The GP had a diploma level qualification in CBT.

Measures

Hospital Anxiety and Depression Scale (HADS)[23]

The HADS consists of seven items for anxiety and seven for depression. The items are scored on a four-point scale from 0 (not present) to 3 (considerable). The item scores are added, giving scores on the anxiety and depression subscales from 0 to 21. In order to be valid in patients with somatic problems, the HADS items are based on the psychological aspects of anxiety and depression. Scores of 11 or more on either subscale are considered to be a significant 'case' of psychological morbidity, while scores of 8–10 represent 'borderline', and 0–7 'normal'.

Ethical considerations

All patients reported in this pilot gave written consent for anonymised information to be included in

this paper. The chair of the local research ethics committee advised the authors that formal research ethical approval was not required.

Results

Fifteen out of 24 patients seen during the pilot gave their consent, and all these are reported in this paper. All were white, there were 11 females and four males and the average age was 45 years, with a range of 27–82 years. Six presented initially with low mood, three with anxiety, three with general fatigue, two with work stress and one with irritability. Despite these various presenting problems, all reported experiencing significant problems with low mood.

At the beginning of the intervention five of the patients were working, six were off work due to their mental health problems and four were retired. All six patients who were off work due to ill-health before the intervention had returned to work by the end of the intervention.

Five of the 15 were taking antidepressants. The number of sessions provided ranged from three to seven. The total time spent by patients in all their sessions varied from 60 to 120 minutes, and 11 patients (73%) were seen for about 75 minutes over four sessions as planned.

Table 1 shows the means and standard deviations of HADS depression and anxiety scores before and after the intervention. In 13 cases the HADS was completed after the intervention, and paired *t* tests showed significant differences in pre and post scores on the HADS for depression, $t(12) = 8.2$, $P < 0.001$ and anxiety, $t(12) = 7.8$, $P < 0.001$.

Table 1 Mean pre- and post-intervention depression and anxiety scores on the HADS

	Pre-intervention, mean (SD)	Post-intervention, mean (SD)
HADS depression	11.6 (3.2)	2.1 (1.3)
HADS anxiety	13.7 (3.7)	5.3 (1.7)

Discussion

This pilot development of the provision of guided self-help by a nurse practitioner in primary care is clearly consistent with recent policy and best practice guidance, such as NICE guidance, stepped care, and 'Enhanced service specification' for depression under the new GMS contract. It set out to provide guided self-help as an early and accessible treatment option for patients with mild-to-moderate depression, and to determine the feasibility and effectiveness of the approach. In fact most patients had problems with anxiety as well as depression, and this is typical of patients seen in routine primary care services. The patients were all seen within one to two weeks of being identified as appropriate, so the treatment was accessible and contrasts with long waiting times for psychological therapies services. However, psychological therapies services appropriately tend to see patients with more complex and longstanding problems than those seen in this pilot, consistent with stepped care and NICE guidance.

It was interesting that all patients expressed concerns about the option of medication, so guided self-help really did increase their choice and access to a psychological intervention. The intervention was provided within the GP practice and by a primary care practitioner with whom most patients had already had some contact. It was, however, an 'add on' to the usual nurse practitioner's workload. Extra 'clinics' had to be set up to provide the interventions, which made it difficult to fit the commitment into the existing workload.

The number of sessions varied from three to seven, and total session time ranged from 60 to 120 minutes. Although 11 of the 15 patients were seen for four sessions and a total of 75 minutes as planned, the interventions were flexible to the different needs of the patients and they were certainly outside the traditional one-hour therapy sessions usually provided in psychological therapies services.

In terms of effectiveness, the changes in HADS anxiety and depression scores were impressive overall, with highly statistically significant changes. In terms of clinically significant changes, taking HADS scores of 11 and above as significant indicators of anxiety and depression, 11 patients moved from above this threshold to below for depression, and 8 for anxiety. Taking the lower threshold of 8, the numbers are 11 for depression and 10 for anxiety who showed clinically significant improvement on this lower criterion. However, we must be very cautious in attributing these changes to the guided self-help, because this was not a controlled study, particularly given recent controlled studies that have failed to show significant benefits for guided self-help compared to controlled groups.[11,12] It is of course possible the patients in this pilot would have improved without the intervention, but the results are nevertheless very encouraging. It is also important to point out that patients reported significant attainment of the goals agreed at the beginning

of the intervention, expressed very positive views about the intervention, and opted for guided self-help as a choice not previously available. Also, all six patients who were off work due to ill-health at the beginning of the intervention had returned to work at the end. The return to work is particularly interesting given recent high-level policy developments to improve access to psychological services to enable people with mental health problems to return to work.[4]. However, it is important to note that the patients seen in this pilot had been off work for relatively short periods of time, 10 weeks in one case and between two and four weeks for five others. This suggests the patients were experiencing relatively acute problems of recent onset that resulted in time off work for some, and we were not studying those who had been off work in the longer term and receiving incapacity benefit.

The nurse practitioner found it relatively easy to assess the suitability of patients for the guided self-help intervention, and this was assisted with inclusion/exclusion guidelines. Guidelines are essential for such primary care-based interventions, but should not be applied too rigidly. An effective suitability assessment should combine such guidelines with clinical assessment. Other possible criteria would be questionnaire scores, but this was not used in this pilot. In fact, a significant number of the patients scored highly on depression and anxiety so had criteria based on questionnaire scores been used, some of the patients would have been excluded, despite the fact that they appear to have benefited from the intervention.

All patients were white, with none from BME groups and this reflects the very low BME population in the practice (approximately 1%). Initially, the majority of patients were identified as suitable by the nurse practitioner in her routine work, but GP referrals were increasingly made as the pilot developed. The nurse practitioner was also aware of her limited time to provide guided self-help, which inhibited her from promoting the service more widely.

It is useful to reflect on the nature of the guidance required to support a person to use self-help materials effectively, which has not been adequately described in the literature or guidance documents. It is clearly more than an informal discussion about progress. There are key skills and knowledge which guide the process and its potential effectiveness, and these include structuring sessions to identify key problems and realistic goals, identifying appropriate self-help materials and supporting and monitoring the patients' progress in relation to their goals.

Having established positive outcomes in terms of feasibility, prompt access and patient acceptability and progress, a key question is whether nurse practitioners are in the best position to provide this type of guided self-help for these types of patients and problems. Apart from the direct guidance to patients, it seems likely that an appropriately trained and supervised nurse practitioner in this role will also be a resource to the primary care team as a whole. There are others, such as primary care graduate mental health workers (GMHWs), who can also provide guided self-help and this has indeed become an important part of their training and practice.[24] However, the capacity of GMHWs is limited, as with any part of the workforce. Decisions on who is best placed to provide guided self-help depend on a number of factors such as availability of practitioners with the skills, and capacity and should be informed by cost-effectiveness considerations. Clearly, if nurse practitioners are to provide guided self-help in this way it needs to be prioritised. Alternatively, it may be possible to provide forms of guided self-help that are integrated into the routine work of primary care practitioners, for example to support chronic disease clinics. This approach would require creative approaches to practice-based training and ongoing supervision, and easy access to good-quality, brief self-help materials, for example via desktop PCs. It is also important to consider self-help in primary care in the broadest sense, incorporating a holistic approach and drawing on the wide range of strategies that help people manage their lives on a day-to-day basis.[25]

Finally, this pilot was considered very successful by the practice where it took place, and the provision of guided self-help by the nurse practitioner has continued. Such developments depend very much on the interests and skills of the existing practitioners working within practices, but we suggest other practices consider similar approaches, provided by nurse practitioners, primary care graduate mental health workers or others, which could ultimately lead to much better access to self-help materials and approaches for the many patients with depression and anxiety seen routinely in primary care.

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CONFLICTS OF INTEREST

None.

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