A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH

Submitted in fulfilment of the requirements for the degree of Doctor of Counselling Psychology (D. Couns. Psych)

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Section A

Preface

Preface

Background

Throughout the development of my career as a counselling psychologist I see my clinical and research interests as fundamentally interconnected. The main focus of my undergraduate degree was cognitive psychology, with a rigorous empirical foundation. Following my undergraduate degree I worked as a research assistant, which again promoted my interest in psychology research. But it was also at this time that I was first introduced to the field of counselling psychology by Dr. Mike Scaife.

In the beginning of my exploration of counselling, I was initially drawn to the more Humanistic or "softer" approaches to therapy, finding the theories and concepts interesting and seductive. However I soon found that I became frustrated with what I perceived as a lack of empirical foundation. When I began my counselling psychology training at City University, this again stimulated my interest in research, approaching counselling as both a scientific and person focused process. I found that my growing interest in CBT could provide a balance in both these areas for me; it provides a theory and practice that are empirical based without loosing the focus on the individual person and their experiences. At this point it was that my clinical work that influenced my research interests; driven by my goal to better understand my clients' presentations and their responses to therapeutic interventions.

Whilst working in counselling psychology I, like many other counselling psychologists have had experience of working within a range of different settings; mainly within the NHS, schools and voluntary organisations. These different environments brought within them many valuable learning opportunities and experiences, but also highlighted for me the many

differences in the ethos's and the working models of the different settings. This portfolio addresses the role of psychology within a number of different settings i.e. schools, NHS primary care and secondary care. The settings of psychology services are of particular interest to counselling psychologists as they increasingly working within a wide variety of settings, e.g. various NHS settings, prisons, occupational health, educational etc. In comparison, traditionally clinical psychology training and practice focused on NHS services, primarily psychology departments in mental health hospitals. Now that psychology is branching out into more diverse settings, both inside and outside of the NHS, it is important that work is completed to explore the efficacy of psychology in these different settings. This portfolio aims gain a greater understanding of the effectiveness of and implications for psychological treatments in within different treatment settings.

The research component

Section B contains the research component, which questions how the setting of psychological treatment might effect the clients' outcome. Recently within the NHS there has been an increasing emphasis placed on providing psychology services within the primary care setting, as opposed to the more traditional hospital based service. This is based on the rationale that there are a number of possible advantages or benefits to basing mental health services within primary care, for both the clients and the professionals involved. Primary care is seen as more accessible to the client, with perhaps fewer stigmas attached. Mental health workers within primary care can also offer benefits to the services and professionals; there are increased possibilities for continuing of care, greater opportunity for consultation with and training of other primary care professionals, with possibilities of broadening the scope of the psychologist's role and the skills of the primary care team.

Much of the rationale behind the integration of mental health services in primary care is based on theories and speculation rather than empirical evidence. There have been a number of studies investigating the effectiveness of counselling in primary care, which have interestingly produced very mixed results, which overall question the effectiveness of primary care counselling services. The majority of psychological treatments have demonstrated some efficacy (e.g Roth and Fonagy 1996) but the research investigating the use of psychology in primary care has produced conflicting results. Overall the research seems to imply that clients receiving psychological treatment in primary care may respond differently to clients treated in secondary care or clinical trails. Therefore before considering any potential indirect benefits of primary care, the main priority for mental health services is to demonstrate that the primary care services can produce clinically significant improvements for clients.

This research aims to investigate differences in the clinical outcomes of a psychology service provided in two different settings; primary care and secondary care. Using a quasi-experimental design it compares the responses of clients receiving similar treatment, provided in either of the two settings. It uses quantitative methodology to examine the differences in the rate of reduction of psychological distress of participants receiving cognitive behavioural treatment in the two opposing settings. The study also uses qualitative methodology with the aim of identifying the contextual factors which might have impacted on the clients' response to treatment. The rationale being that further understanding of these features could potentially help in optimising the structure of psychological treatments.

The client study component

Section C of the thesis describes psychotherapeutic work within a school setting, with "Charlie", an adolescent with problem gambling. The work involved the use of a CBT model for the treatment of problem gambling (Sharp and Tarrier 1993) and the report reflects on the contextual factors which created difficulties in the application of this model.

During my training I was fortunate in having the experience of working within a school environment. Working within the school context was a very interesting and rewarding experience, but also provided me with many challenges. These challenges were both inherent to the setting, but also connected to my experience of working with the new client group. In the client study I reflect on the contextual factors of the school setting that impacted on the course of treatment. Firstly there were generic aspects of the school setting that needed to be considered in the development and maintenance of the therapeutic relationship. Secondly, in working with Charlie, factors existed within the school settings that were critical in the maintenance of Charlie's problem, which greatly impacted on the course of therapy. The challenges of working with these contextual factors are considered in the report. In addition, the report considers issues regarding adapting the CBT model to work more collaboratively and creatively with adolescents.

The literature review

Section D comprises of a critical literature review of the CBT treatment for school refusal, which again this work was influenced by my experience of working within a school setting. One of the differences I experienced when working in the school setting was a reduced focus

on evidence based practice and this was highlighted in my experience of working with adolescents with school refusing behaviour. I encountered a number of students who presented with school refusal and at the time was surprised to find very little research around the effectiveness of treatment interventions. School refusal is becoming an increasingly recognised problem, which is very heterogeneous in both its presentation and its aetiology. It also has a number of potential serious short and long term consequences for young people, which further highlights the importance of providing effective treatments. The published literature on the subject is mainly anecdotal or describing case studies, with a small number of very recent controlled trials, which have produced conflicting results. This highlights how different settings can have different focus within both their clinical practice and their research and literature. Section D reviews the literature on the treatment of school refusal, accentuating the need for further research in this area.

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Section B

Research

Abstract

Background: Within the NHS there has been an increasing emphasis placed on the integration of mental health service within primary care. It is suggested that mental health services within primary care can offer more benefits to the patient and the professionals involved. Research into the effectiveness of mental health services in primary care has produced equivocal results, the most positive outcomes have been in CBT treatment for depression, with one RCT implying that primary care treatment may produce more rapid recovery than secondary care treatment.

Aim: The aim of this study was to compare a primary care CBT service with a similar secondary care service, to investigate differences in the rate of recovery and participant satisfaction.

Method: The study was carried out in a primary care psychology service that provides treatment within 6 GP surgeries and one psychiatric hospital in south London. A quasi experimental design was used to compare 52 participants who received CBT treatment for a variety of psychological problems in either a primary care or secondary care setting. A range of psychological measures were taken at baseline and over the first six treatment sessions, to compare the rate of change in psychological symptoms. Consumer satisfaction was also measured at week 6 and a follow up questionnaire was used to explore the participants' attitude towards the contextual differences of the settings.

Results: Both groups demonstrated improvement over the period of the study but the participants from the Primary Care group showed a more rapid rate of recovery during the first six sessions. The Primary Care group also reported significantly higher levels of satisfaction than the secondary care group. The follow up questionnaire demonstrated that the primary care setting was associated with increased acceptability and accessibility and less stigma than the secondary care setting.

Conclusions: Patients receiving CBT may respond more rapidly to treatment provided in primary care rather than secondary. Providing a service in primary care might also increase patient compliance with treatment. But further research is needed to investigate the longer term outcome.

Chapter 1: Introduction

1.1 Review of Psychology in Primary Care

The focus of the study is the effectiveness of psychology services within NHS primary care settings. Primary care is often the first point of contact for people with mental health problems, and the management of a large proportion of these problems remains exclusively in primary care (Goldberg and Huxley 1992). Recent changes in the NHS reflect these facts by acknowledging the need for changes in the provision of primary care mental health services. The proposed changes include an increase in the management of mental health problems within primary care and an increase in the variety of primary care health professionals to implement that provision. However the research into the effectiveness of primary care mental health services is equivocal. Random controlled trials of primary care counselling services have been unable to demonstrate that counselling is any more effective than routine GP care. While the random controlled trials of psychology services within primary care have produced positive results, it is only the effectiveness of Cognitive Behavioural Therapy (CBT) for depression that has provided any conclusive results. One study compared the effectiveness of mental health services based in secondary care to those based in primary care, in the CBT treatment of depression (Blackburn et al. 1981). Their results demonstrated that the primary care treatment group recovered more rapidly than the secondary care treatment group, implying that the setting of the service may influence treatment outcome. Although the current trend is to concentrate more mental health services within primary care, the current research does not unequivocally support this hypothesis.

The recent changes in the NHS shall be described followed by the rationale behind providing mental health services within primary care, with a discussion of the possible advantages and disadvantages. This is then followed by a review of the literature into the effectiveness of mental health services within primary care.

Primary Health Care within the Changing NHS

Primary care is usually the first point of contact people have with medical services. Its purpose is to provide the local community with a comprehensive, integrated health service, using a variety of staff; largely general practitioners (GPs) and nurses. It aims to provide continued care for a wide range of health problems; physical, psychological and social whilst also acting as a filter for referrals to other secondary or specialist health services.

Over the last decade there have been many changes in the provision of NHS primary care services. Beginning with the introduction of GP fundholding in the early nineties and more recently the development of Primary Care Groups and Primary Care Trusts. The introduction of fundholding led to opportunities for increased collaboration between GPs and other health professionals. The change in GP's purchasing powers allowed a greater number and range of staff within the Primary Care Team. With the advent of fundholding came a substantial increase in the number of mental health professional working within general practice (Corney 1996, Green 1994). However 1990 also saw the introduction of the Care Programme Approach (DoH 1990), which focused more attention and services on patients with severe and enduring mental health problems. This led to competing demands between the needs of this population and the

patients with less disabling but common neurotic disorders e.g. anxiety and depression (Paxton et al. 2000).

More recently there have been two important developments within primary care in the NHS, which have implications for mental health provision. Firstly April 1999 saw the beginning of Primary Care Groups (PCGs) (DoH 1997); PCGs are groups of local health and social care professionals, which take responsibility for the healthcare of their local community. They are made up of a number of stakeholders, including: GPs, nurses, social services and patient and Health Authority representatives, who have a lead role in the planning and development of local health services. Their aim is to develop the highest quality service for all patients, with the most efficient use of resources available to them. The development of PCGs has led to responsibility for decision making and commissioning of services being made at a local level. This means that the local professionals are provided with new incentives and sanctions to improve service quality and efficiency, based on clinical need of their local community. From April 2000, PCGs begun to further develop into Primary Care Trusts (PCTs), which are statutory NHS bodies accountable to the health authority. They serve the same functions as PCGs but purchasing power is transferred from the Health Authority providing the PCT with more resources to develop and implement health and social services.

Along with the increased purchasing power comes an increase in responsibility to ensure good practice. This means that primary care services must be based on evidence of clinical effectiveness and ensure the most efficient use of the resources available. In relation to mental health services in particular, the NHSE review of psychotherapy services in England (NHS Executive 1996) endorsed a range of psychotherapies for

mental health problems, but highlighted a need for further work on evidence based practice.

Secondly, National Service Frameworks (DoH 1999) were set up by the government to improve the quality of healthcare and reduce variations in health and social services. The National Service Framework for Mental Health targets a number of areas. One of these areas is "Primary Care and Access to Service". Recognising that primary care is often the first point of contact for many people with mental health problems, the framework stresses the importance of having mental health needs identified and assessed within primary care, leading to the implementation of effective treatment if required. The framework also suggests that the Primary Health Care Team (PHCT) themselves should develop the capacity and the capability to manage common mental health problems with the support of specialist services when appropriate.

In relation to Psychology services the National Service Framework and advent of PCTs mean that there is an increased acknowledgement of the importance of recognising and managing mental health services within Primary Care. Also as they have developed, the PCGs and PCTs have been given more autonomy and resources to enable them to provide effective mental health services to suit the needs of their community.

The need for psychological treatments within primary care

Epidemiological studies from both Britain and the United States suggest that the rate of mental illness in the general population at any point in time is in the range of 10-15% (Mann 1993). The British Psychiatric Morbidity Survey, performed in 1993 and again in 2000, reported that 16% of adults had suffered from some form of "neurotic disorder" in the week before interview (Jenkins et al. 1997, ONS 2001), with the most prevalent

disorder being mixed anxiety and depression followed by Generalised Anxiety (8.8% and 4.4% of the general population).

Primary care is the most common entry point for patients with mental health problems, with an estimated 90% of mental health care being provided solely by primary care health professionals (Goldberg and Huxley 1992). They also estimate that approximately one third of GP consultations are around either emotional distress or for symptoms related to this distress. However Goldberg and Huxley also suggest that statistics relating to mental health problems in primary care may be underestimates as they only include patients whose mental health problems are recognised by the GP. They suggest that the proportion of known sufferers to "hidden morbidity" i.e. suffers not recognised by the GP, is 1:1 (Goldberg and Huxley 1980).

The World Health Organisation (WHO), which has been a long advocate of the integration of mental heath into primary care (Ustun 2000), found that 24% of patients attending primary care have a current well defined mental disorder and 31% had two or more mental health symptoms e.g. sleep disorders, appetite reduction (Ustun and Sartorius 1995). This high demand on primary care resources is also compounded by the fact that patients with anxiety and depression usually have very high rates of repeat consultations in primary care independent of physical problems, often over many years (Lloyd, Jenkins and Mann 1996, Meltzer et al. 1995).

The epidemiology studies consistently show that there is a high level of mental health problems within the general population and that this population places high demand, directly and indirectly on the primary care services. However prevalence or detection of psychological problems does not necessarily mean there is a need for treatment (Pakel

1991, Dowrick 1992), it is also important to consider the level of disability and the effectiveness of current available treatments.

The extent of mental health professionals in primary care

Evidently mental health problems constitute a significant proportion of primary care health provision, but what services or professionals are in place to manage this demand? Balint's seminal work in the sixties (e.g. Balint 1964) initiated the collaboration between psychotherapy and general practice. Balint suggested that many of the problems presented to GPs were of a psychological origin and therefore that GPs should apply Psychodynamic theory to the understanding and treatment of symptoms. Some of his ideas were controversial, attracting a range of criticism (see Gask & McGrath 1989), however his work was fundamental in creating changes in how GPs managed mental health problems.

More recent changes to NHS primary care services, since 1990, have led to an increase in the opportunity for collaboration between general practice and other mental health professionals. In 1992 a survey of 261 practices across six health authorities, demonstrated the beginning of increased links between GPs and mental health professionals (Thomas and Corney 1992). With 48% of GPs reporting links with a Community Psychiatric Nurse (CPN), 21% with a Social Worker, 17% with a Counsellor, 16% with a Psychiatrist and 15% with a Psychologist. These statistics were supported by Sibbald et al. (1993) who found that 31% of general practices had links with a mental health professional, in a large survey across England and Wales. Investigating the more recent impact of GP fundholding on mental health services Corney (1996) found considerable increases since the beginning of the decade e.g. CPN 67%, counsellor 53%, Psychiatrist 27% and Psychologist 39%. However it should be

noted that across these surveys the amount of and type of contact between the professionals varied greatly between practices.

There are several different suggested models of integrating mental health services in primary care. The two most common are the "Shifted Outpatient" model and the "Consultation-Liaison" model (Dowrick 1992). In the shifted outpatient model the patient is referred to the mental health professional, who takes primary responsibility for that patient's care and sees the patient within the primary care setting. In the consultation-liaison model the mental health professional makes regularly liaison visits to the practice acting as a source of education and support to the GP in managing patients' mental health problems. The most common model currently in use in the NHS is the shifted outpatient model and this is the model that shall be the main focus here.

Advantages to providing mental health service within primary care

There have been a number of theorised advantages to treating mental health problems in primary care. Most of the advantages have been suggested when considering counselling services in particular. The first important advantage is that the primary care setting is seen to be more accessible to the patient (Corney and Jenkins 1993). An ongoing barrier to seeking help is the stigma attached to mental health problems (Sims 1993), as primary care is familiar to patients it possibly has considerably less stigma attached to it. Research has demonstrated that the number of patients who failed to attend the first appointment with a psychiatrist and a marriage guidance service to be higher than counselling in primary care (Ilman 1983). More specifically, when comparing the attendance rates of a primary care based psychiatry service and a hospital based psychiatry service Brown et al. (1988) found a higher attendance rate at the first appointment (81%) in primary care compared to that of the hospital based service

(60%). They also found the hospital based service had a higher drop-out rate of 38% compared to 29% for the primary care based service. One possible reason for this difference is that the primary care based service is more accessible or appealing to service users.

There have been numerous surveys of the clients' subjective accounts of counselling services in primary care which have generally yielded very positive results (e.g. Anderson and Hasler 1979, Boot et al. 1994, Frieldi et al. 1997). Satisfaction has been measured by a variety of methods, but most commonly by non-standardised self report questionnaires. Overall the subjective accounts imply that the large majority of clients have been pleased with primary care counselling services and believe they have benefited from the service. However the results need to be treated with some caution, due to methodological problems along with the limitations intrinsic to subjective accounts of satisfaction. A particular problem with reports of satisfaction with health care services is the ubiquitous finding that participants report quite high levels (Linn 1975). Also care must be taken in interpreting the meaning of clients' subjective reports i.e. stating that they liked the service, does not necessarily mean that it produced any significant clinical improvement (Nguyen 1983). Also with primary care services it may be especially difficult for clients to be critical of the service provided, as the primary care team will usually have the continued responsibility for the client's medical care.

As stated earlier a major proportion of patients with psychological problems are managed solely in primary care. However concern has also been expressed about doctor's failure to detect hidden psychiatric morbidity (Goldberg and Huxley 1980), especially with patients who present with psychological distress in a somatic form (Wright 1990). An advantage to having a mental health professional working as part of

the team is that this could have a positive impact on the knowledge and behaviour of other members of the PHCT. By facilitating good communication links, mental health professionals in primary care have been shown to heighten GP awareness of the psychological aspects of patients' presentations (Marsh and Barr 1975, Radley 1997) and can lead to increases in the possibilities of training/education and the sharing of skills (Gask et al. 2000, Irving 1988). In addition to the possible benefits of an increase in detection of psychological problems, research has shown that establishing GP-patient agreement on problem formulation and agenda correlates with a reduction in symptoms (Bass et al. 1986, Silverman and Draper 1995).

An ongoing and frequent criticism by GPs of psychiatric services is the lack of adequate and appropriate communication (Williams and Wallace 1974, Pullen and Yellowlees 1985). Reports of mental health professionals (e.g. Social Workers: Corney 1982, Psychiatrists: Strathdee 1988, Counsellors: Kates et al. 2001) working within primary care settings have shown that their working systems generally facilitated better collaboration and communication and assisted the development of trust between the different professionals. Also a survey of GPs reporting positive experiences of working with a primary care counsellor, included that it was easier to refer to a "personally known and valued counsellor rather than to an anonymous person in an outside agency" (Waydenfeld and Waydenfeld 1980 pp. 676). It would appear that integrating mental health services within primary care can help facilitate closer relationships between the professionals hopefully leading to more co-ordination of treatments and continuity of care.

It has also been suggested that mental health services in primary care would help to decrease the demand on secondary care mental health services. However examination

of the literature implies that this is not clear cut. A systematic review of the randomised controlled trials performed by Bower and Sibbald in 2000, examined the evidence for a reduction in referral to secondary services. Only three of the six trials suggested that an on-site mental health professional did result in a reduction in referrals. However links with a mental health professional has also been shown to lead to an increase in the overall referrals to mental health services (Corney 1996, Radley et al. 1997, Thomas and Corney 1992). The rate of referral to secondary services has a number of possible negative and positive implications. A low level could be seen as positive as it may imply that practices are effectively managing the mental health needs of its population independently, therefore reducing the demands on other NHS services. However a high rate could also have positive inferences; it could imply a high level of GP awareness of mental health problems which results in an increase in recognition of problems that may have otherwise been undetected and left untreated.

Disadvantages to providing mental health service within primary care

A frequent argument against providing mental health services within primary care is the increased cost to the NHS, largely due to the extra staff involved. This cost is especially difficult to justify if the outcome studies cannot unequivocally demonstrate the effectiveness of the service. There have been a number of studies investigating the cost effectiveness of mental health services compared to routine GP care, which have produced varying results. For example, CPNs and Psychologists working in primary care were not found to be cost effective (Gournay and Brooking 1994, Scott and Freeman 1992), counselling demonstrated no difference in cost or clinical outcome when compared to GP care (Harvey et al. 1998), whilst Robson et al. (1984) concluded that placing Psychologists within primary care was economically prudent. However in these studies the economic analysis usually had limitations, mainly due to the fact that it

was investigated secondary to clinical outcomes. Bower et al. (2000) performed a rigorous analysis of the cost of implementing a nondirective counselling service, a CBT service and usual GP care and found no significant differences between the direct and indirect costs between the three services after a 12 month period. However the authors noted that both the psychological treatments might be more cost effective in the short term (i.e. 4 months) as clinical gains were made at no extra financial cost, but this was suggested as a preliminary hypothesis as their power analysis was low. Clearly further comprehensive analysis of cost is necessary before any definite conclusions can be made.

Also related to increased cost, is the theory that a new service in the NHS, as well as satisfying existing needs, can actually increase demands (Marks 1979). This theory was seen in practice when GPs were surveyed about a new primary care psychology service (McAllister and Philip 1975) with GPs reporting that 50% of the clients seen by the psychologist would previously have only been offered routine GP treatment. However it could be argued that this is one of the main purposes of integrating mental health services in primary care; to provide a more accessible service, particularly for the patient groups traditionally poorly served by usual mental health services, e.g. homeless, ethic minorities, elderly (Kates et al. 2001). Although it may initially appear to increase the workload it is likely that in the long term integrated mental health services will decrease the burden of frequent and recurrent GP consultations by patients whose mental health problems have not been identified, diagnosed or managed.

A related issue is patient attendance rates, as higher levels of dropout are associated with decreased productivity and an increased cost of providing the service (Larsen, Nguyen, Green and Attkinson 1983), but meaningful empirical research into possible

mediating factors is lacking. Dropout rates seem to vary according to the setting of treatment, with meta-analysis studies finding rates of 8% in Randomised Controlled Trials (RCTs), 17% in specialist centres and up to 60% in primary care. There could be a number of possible variables contributing to these differences (e.g. patient selection, level of severity, therapist competency) but it implies that attendance rates can be effected by the context of the treatment, the implication being that the more specialised the treatment setting the lower the dropout rate. This could imply that primary care would have a higher dropout rate than more specialised centres, e.g. psychology departments, psychiatric hospitals.

As seen earlier the majority of mental health problems are managed solely in primary care, however another challenge within primary care is the high level of undetected mental health problems. Large surveys of the general population have shown that 60-74% of people with psychological problems have not consulted their GP about the complaint (Bebbington et al. 2000a, ONS 2001). It has also been extensively reported that GPs often fail to identify patients' psychological symptoms (e.g. Freeling et al. 1985, Wright 1990). Lack of detection of mental health problems can lead to the development of chronic problems and significant impairment of functioning (Goldberg et al. 1998, Klinkman and Okkes 1998). There are a number of possible reasons for this low recognition of psychological problems in general practice. It has been suggested that primary care staff may not necessarily have sufficient mental health orientation or awareness (Ustun 1998), including lack of basic knowledge in recognising and/or assessing mental health problems. Indeed only 50% of GPs have a psychiatric placement within their vocational training (Gask and Croft 2000), which also implies that GPs may not be adequately prepared for handling patients who present with mental health problems. It should also be acknowledged that patient factors can impact on the

detection of psychological problems. There are a number of reasons that may contribute to patients' reluctance to seek help e.g. patients beliefs around the effectiveness of treatment (Meltzer 2000), fear of stigma or feelings of embarrassment (Sims 1993). The potential lack of mental health awareness within the PHCT could be seen as a challenge to the effective integration of mental health services. However this challenge also highlights the potential importance of and advantages to integrating mental health services, to help provide an educative or consultative role increasing the psychological awareness and knowledge of the primary care team.

Another possible disadvantage, as indicated by subjective GP reports, is that mental health professionals attached to the PHCT can only provide a generic service rather than a specialist service which may be required for some problems e.g. eating disorders, learning disabilities (Paxton et al. 2000, Radley et al. 1997). Also it has been suggested that NHS investing in primary care mental health professionals could reduce funds available to develop the other specialist services (Wessely 1996). This suggests that the more traditional model of secondary mental health services might provide a more comprehensive mental health service, with more varied professionals or services, possibly with specialist training.

In addition when viewing it from the mental health workers perspective there are a number of potential difficulties due to the relative isolation of working in primary care rather than as part of a mental health team, compared to a Psychology Department or Community Mental Health Team (Davy 1999). Mental health professionals in primary care are part of a multidisciplinary team, which has much to offer, but working as part of the primary care team can also come with challenges. Mental health professionals are a relatively new addition to the primary care team and usually they will have quite

different background, training or working models than other team members. The other members of primary care team predominantly work from a biomedical perspective, and some mental health professionals may experience difficulties in working collaboratively with this perspective.

Another suggested disadvantage to providing a primary care mental health service is that the patient referred may not present with significant levels of psychological distress. The suggestion is that GPs will continue to refer similar types of and numbers of patients to secondary services, whilst referring the "worried well" to the practice based service, which questions the legitimacy of the service (Radley et al. 1997). In response to this criticism, research comparing referrals made by psychiatric services in primary care and in secondary have shown no difference in clinical symptomology between the two groups (Tryer 1984, Brown et al. 1988). Primary care psychiatrists usually received referrals with psychosis and chronic neurotic disorders, similar to secondary care psychiatrists, with secondary care psychiatry more likely to see the less common neurotic disorders e.g. eating disorders, sexual dysfunction, that may require specialist treatment (Browning et al.1987). Also in comparing primary care counselling patients and neurotic patients referred to psychiatric outpatients and clinical psychology services no differences where demonstrated in severity of clinical symptoms between the services (Hemmings 1997).

Although, as mentioned earlier there has been a steady increase in the number of mental health professionals working within primary care, there is vast variation among these professionals and the services they provide. This causes potential complications around the organisation of the services and their delivery, along with gaining meaningful measurements of their effectiveness (Ustun 1998). This, along with the fact that

currently several primary care teams do not have links with mental health staff, means that many patients have reduced access to mental health care. This raises important issues around NSF guidelines on equity of services. Also it is highly likely that the practices which do not have integrated mental health services consist of GPs who have a reduced interest in or possibly lower awareness of mental health issues, which also has possible negative implications for the potentially large number of patients registered with these practices. In addition Thomas and Corney (1992) found that practices tended to either have links with many mental health professionals or with none. They suggest that this could be due to the fact that having a connection with one mental health professional encourages or leads to the development of links with others. This further questions whether the integrated model is indeed an efficient use of resources, as some patients will have no access while other can access a wide range of mental health services.

1.2 Evaluation of Mental Health Services within Primary Care

Although the main focus of the review is Psychology services within primary care, as seen earlier there is a wide range of mental health professional working within primary care, therefore the literature for related mental health professionals in primary care shall also be reviewed. When examining the research it is also important to note that mental health workers, counsellors in particular, can vary enormously in their training and orientation, which may affect outcomes and the conclusions that can be drawn from those outcomes (Corney '93).

Counselling Services

"Counselling" is one of the most widely available forms of psychological therapy within Primary Care. However it is often poorly defined, with a wide range of therapeutic styles e.g. Rogerian, Psychodynamic and CBT (Churchill et al. 1999). Also the general public seems to strongly favour the use of counselling. In a survey on public opinions on depression, 86% of respondents believed that counselling was an effective treatment for depression and 90% believed that patients suffering with depression should be offered counselling (Paykel et al. 1998). However, in spite of its popularity the published research into the effectiveness of counselling within the context of primary care is equivocal at best.

There have been a number of trials investigating the effectiveness of counselling in primary care, Table 1.1 contains a summary. All of the trials used a generic counselling service (i.e. treating a range of presenting problems) and a wide range of theoretical orientations were implemented throughout the different trials, with brief non-directive or Rogerian being the most frequent. An early large clinical trial was carried out by Ashurst and Ward (1983) with 726 patients randomly assigned to counselling or routine GP treatment, outcome measures included the General Health Questionnaire (GHQ) and medication use. Although the authors note that some individuals appeared to greatly benefit from counselling, there were no statistical differences between the two groups at 12 weeks. However there were a number of problems with this study, firstly as highlighted by the authors, client motivation was questionable, as not all of the patients recruited specifically requested counselling. Secondly, there are concerns about subject attrition and incomplete data collection, as analysis was based on only 34% of those originally randomised. Thirdly, although the two counsellors described themselves as favouring a person centred approach, they implemented a number of different

Table 1: Trials evaluating counselling services in primary care compared to routine GP care

Study	Setting	Sample Size	Intervention(s)	Outcome Measures	Follow up	Main Findings
Ashurst & Ward 1983	2 Practices England	n 726	2 counsellors Person centred Duration not specified	GHQ end scores only Subjective accounts Utilisation of medical services	12 months	No significant differences between groups, except less prescribing in treatment condition
Brodaty & Andrews 1983	1 Practice Australia	n 56	Eight 30min.sessions of brief problem orientated psychotherapy 8 30min.sessions with GP	Medication use Subjective symptom severity. Social functioning	Scores at completion only	No significant differences between the 3 conditions
Boot, et al. 1994	7 Practices England	n 192	5 counsellors 6 sessions Unspecified orientation	GHQ, medication use, Client satisfaction	6 weeks	Treatment condition significantly improved on GHQ, greater satisfaction and less medication use
King, et al. 1994	2 Practices England	n 24	5 counsellors 6-8 sessions. Brief non directive psychotherapy	BDI, GHQ	12 weeks 6 months	No significant differences between the 2 conditions
Hemmings 1997	3 Practices East Sussex	n 188	3 Counsellors 14 sessions Varied orientations	Utilisation of medical services. Inventory of interpersonal prob-lems. Symptom index	4 months 8 months	No significant differences at completion or at follow ups
Friedli, et al. 1997	14 Practices London	n 136	4 counsellors 1-12 sessions. Rogerian psychotherapy	BDI, BSI, Social adjustment scale, Revised clinical interview schedule	3 months 9 months	No differences in clinical outcome Higher client satisfaction in treatment condition
Harvey, Nelson & Lloyd 1998	9 Practices Wales	n 162	9 counsellors 6 sessions Person centred	HAD, Delighted-terrible faces scale, Dartmouth COOP charts	4 months	No significant differences between groups in clinical outcome or cost

GHQ = General Health Questionnaire, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory, HAD = Hospital Anxiety and Depression Scale.

counselling techniques, including; behavioural, dream work, Transactional Analysis and Gestalt. Hence there is no way of knowing which particular counselling intervention was effective and indeed if the different interventions were compatible with each other.

A smaller (n=56) Australian study investigating the effectiveness of a primary care counselling service, randomly allocated Primary Care patients to one of three groups (Brodaty and Andrews 1983). There were two treatment groups; one group of eight weekly half-hour sessions with a brief problem orientated dynamic psychotherapist and a second group that received eight half-hour appointments with the family doctor. The third group received no additional treatment. They found no difference between the three groups in outcome scores measuring symptom severity, social dysfunction, physical disability and medication.

More promising short-term results were found by Boot et al. (1994). They randomly referred 192 patients from 14 practices, to a Rogerian counselling intervention or to routine GP care. The results demonstrated that the treatment condition made significantly more improvement according to scores on the GHQ, client satisfaction and levels of medication use. This study demonstrates positive results for counselling, which is supported by its strong methodology; being a randomised control trial, using good outcome measures, across a large number of practices. However the outcome was only measured at six weeks (i.e. the end of treatment) and there was an imbalance in numbers randomised to each group, although baseline demographics and morbidity characteristics were similar.

A comprehensive evaluation of non-directive Rogerian counselling in primary care was performed by Friedli et al. (1997). They randomly allocated 136 participants from 14

general practices to either a treatment condition or to routine GP care. They used validated measures, which included the Beck Depression Inventory (BDI) and the Brief Symptom Inventory (BSI), in addition audiotapes of sessions were independently evaluated to ensure adherence to therapeutic model. Although all outcome measures significantly improved over time (follow-ups at 3 and 9 months), there were no significant differences between the two conditions, except that the treatment condition reported significantly higher satisfaction levels. As the treatment intervention in this study was tightly controlled, it only reflects the outcome of Rogerian counselling. It has been noted that in real practice such counselling approaches are often integrated with other techniques (Tylee 1997) therefore questioning the generalisability of the results.

Hemmings (1997) also failed to find any difference in treatment outcome between 188 patients from 3 practices, who were randomly assigned to either counselling or routine GP care. Patients were measured at 4 month and 8 month follow ups, measures included monitoring the use of medical service, prescribing and a symptom index. However it is worth noting that half of the control group were referred to external psychological treatment as part of routine GP care, which confounds interpretation of the results. Also the three counsellors had very different training and/or experience e.g. Cognitive Analytic Therapy, Psychosynthesis and marriage counselling, which questions the internal validity of the study. Finally Harvey at al (1998) continued the trend, finding no significant differences between 162 participants randomly allocated to counselling and to routine GP care. They used a range of outcome measures, including the Hospital Anxiety and Depression scale (HAD) and followed up outcome at 4 months. In addition they noted that there was no significant difference between the costs of implementing the two conditions.

There are limitations with all of the above studies in that the control condition of "routine GP care" was not clearly defined. This may have varied quite significantly in amount of contact, content or quality of contact, prescription of psychotropic medication and as noted in the Hemmings et al. (1997) study referral to external mental health services. Also the different therapeutic styles make to difficult to distinguish what were the active features or interventions of the counselling received. Overall the studies in to the effectiveness of counsellors working in primary care are not very encouraging, with most finding no statistically significant differences between counselling interventions and routine GP care. The one study that did find improvements (Boot et al. 1994), used validated measures and a good sample size from more than one primary care setting, but the improvements were only demonstrated in the short term.

Ward et al. (2000) in a large patient preference trial (n=464) compared the clinical and cost effectiveness of non-directive counselling, CBT and usual GP care in the treatment of depression. Acknowledging the difficulties of performing randomised trials in primary care, a proportion (58%) of the participants who were unwilling to accept randomisation was given a choice of treatment. They found that after 4 months both the CBT and non-directive counselling made significant clinical improvement on depression scores compared to the usual GP care, however after 12 months there were no significant differences in levels of depression between the treatment groups and the usual GP care. Also they did not find any differences in clinical symptoms between the two treatment groups. But they conclude that the psychological therapies can be useful as they produced more rapid symptom relief than usual GP care. Ward and colleagues note that their short term results are not consistent with the previous studies of the effectiveness of non-directive counselling compared to usual GP care. In considering

the possible explanations for their more positive outcomes, a possible factor could be that recruitment was restricted to participants with medium to high levels of depression, while in other trials (e.g. Frieldi et al. 1997, Harvey et al. 1998) diagnosis were not made. The patient preference design of the trial has some implications, as it is possible that there may be preference factors which could have influenced patient attitude to treatment, patient compliance and/or outcome (McPherson et al. 1997). A preliminary hypothesis was also made that both the psychological treatments may be more cost effective in the short term (after 4 months), as clinical gains were made at no extra cost (Bower et al. 2000).

Other primary care mental health professional

There are a number of other professionals within primary care that implement mental health interventions e.g. Social Workers, Community Psychiatric Nurses (CPNs), Health Visitors. There have been a few studies looking at the effectiveness of these professionals, arising in equivocal results with any positive outcomes only demonstrating short-term effects. The results shall be briefly reviewed. The difference between using counselling skills and the activity of counselling has received much attention and when considering the work of other PHCT staff this distinction should be taken into account (e.g. BAC 1979, Rowland et al. 1989).

An early study investigated a social worker intervention compared to routine GP care (Cooper et al. 1975). The intervention was referred to as "social work counselling" however the method and duration of treatment is not clear, in addition some patients were also seen by a psychiatrist. The results did demonstrate that the treatment condition made some gains over the control, however the results are very limited as the control patients were taken from a different surgery using different criteria than the

patients selected for treatment. Social work counselling within primary care was also evaluated by Corney (1987) in comparison it to routine GP care, with a sample of 80 depressed women. Overall there were very little differences in outcome between the two groups. In further analysis the patients were stratified according to degree of severity and chronicity of the depression, which gave some indications that the more severely depressed women in the experimental condition made more improvement than the equivalent in the control condition.

Catalan et al. (1984) compared counselling by a GP to treatment with anxiolytic medication. Ninety-one participants selected by their GP as suffering from "minor affective disorder" were randomly assigned to one of the two treatment conditions. GPs were trained by the investigators to provide brief counselling which entailed; explanation of symptoms, reassurance, advice on coping and encouragement. They found that there were no differences between the two groups, with all patients showing an improvement at 7 month follow up. Therefore the authors conclude that counselling need not be intensive or involve specialist skills in order to be of benefit to patients. However it has been noted that GPs generally find it difficult to take on the role of a counsellor; they more usually take a directive and practical role, prescribing treatment (Rowland et al. 1989). It is also suggested that patients will expect their GPs to act in such a way which could imply that patients might not be receptive to counselling interventions from their GP.

Marks (1985) demonstrated positive results when investigating the effectiveness of nurse behaviour therapists in primary care. Ninety-two participants with phobias or obsessive-compulsive disorder, were randomly allocated to behavioural treatment or routine GP care. At 1 year follow-up patients in the treatment condition had

demonstrated significantly more improvement that the control group. However it should be noted that of the 220 patients screened to participate in the trial only 120 were considered unsuitable for behavioural treatment. The criteria for the screening are not provided therefore making it difficult to generalise from these results.

A controlled trial investigating health visitor intervention for the treatment postnatal depression was conducted by Holden et al. (1989). Fifty women identified as postnatally depressed were randomly allocated to two groups. The treatment group received 8 visits by health visitors trained to provide non-directive Rogerian counselling and the control condition received usual health visitor care. Three months after the beginning of treatment 69% of the treatment group no longer met the criteria for depression compared to 38% of the control condition, as measured by a self-report scale and psychiatric interview. The Holden trial, similar to Marks (1985), demonstrated success when targeting a specific client group with acute problems, unlike the trials using primary counsellors or social workers in which the presenting problems more generic. Another important factor in the Holden study is that although it employed primary care staff, and is frequently cited in the literature around primary care mental health provision, the counselling was performed during home visits. This makes it very difficult to apply the conclusions to other primary care professionals or services.

Finally Gournay and Brooking (1994) compared treatment by CPNs with routine GP care, using 177 participants from 6 primary care practices. The specific care provided by the CPNs is not clear, although "counselling" was said to be an important part of their role. Presenting problems were varied, with relationship difficulties, depression and anxiety being the most common, but details regarding the severity and chronicity of the participants' problems is unclear. All of the participants improved over the 24

weeks of the trial, but there were no significant differences in outcome between the two conditions, using a variety of measures including; Standardised Psychiatric Interview, BDI and GHQ.

Overall the results of studies into the effectiveness of other primary care team members providing "counselling" services are mixed. A number of studies demonstrate no significant differences between the counselling condition and routine GP care. Of the studies that did demonstrate significant differences in outcomes, Holden et al. (1989) shows the most positive results. However this success is only demonstrated with a specifically targeted population i.e. Postnatal Depression. The other two studies which showed significant differences in outcomes (Marks 1985, Cooper et al. 1975) both had methodological problems with their sampling, which restricts the inferences that can be drawn from these two trials. Also the mixed results of the above studies were demonstrated when using a variety of different professionals, e.g. health visitors, social workers, nurse therapists, which reduces the generalisability of the results.

Psychology Services

The majority of the trials using psychology services in primary care were designed to investigate the effectiveness of CBT for the treatment of depression. CBT treatment of depression has been demonstrated to be effective in producing clinically and statistically significant changes in several "Gold Standard" studies e.g. Rush et al. 1977, Hollon et al. 1992. Also given that around 10% of consecutive consultations in primary care have been found to be related to depressive illness (Blacker and Clare 1987) and as the longer depression is left untreated the more likely it is to develop into a long term treatment-refractory depressive disorder (Scott and Freeman 1992, Shea et al. 1992), it is reasonable to expect a quantity of research in to the CBT treatment of depression in

primary care. Yet as Earll and Kincey (1982) note, primary care referrals normally consist of a wide range of presenting problems, not only depression. Therefore the psychological treatment of the range of presenting problems needs to be evaluated, however, there is currently little conclusive evidence in this area. Table 1.2 contains a summary of the Random Controlled Trials (RCTs) investigating the effectiveness of psychologists within primary care.

Overall the controlled trials in primary care have shown that CBT can be as effective as other interventions in treating depression (Blackburn et al. 1981, Scott and Freeman 1992) and in at least two studies superior to normal GP care (Ross and Scott 1985, Scott et al. 1997). One of the earliest investigations of Psychologist treatment in primary care was conducted in Edinburgh by Blackburn et al. (1981). This study compared cognitive therapy, antidepressant medication and a combination of the two in treating 64 patients with major depressive disorder in both psychiatric outpatient setting and primary care settings. Participants in each setting were randomly allocated to one of the three treatment conditions and a number of standardised outcome measures were used. In the outpatient group the results demonstrated that cognitive therapy was minimally more effective than medication, with the combination of cognitive therapy with medication producing the best outcomes. In the primary care setting, they found that the patients who received cognitive therapy, either alone or in combination with medication, showed superior outcome than the patients who received medication treatment alone. Interestingly they also found that the participants in the primary care groups responded more quickly than the secondary care group, implying that situational factors may play a role in outcome. However the conclusions that can be drawn from this study are complicated by the fact the patients were not randomly allocated to treatment setting, however the authors note that the two populations showed no location differences on a

Table 2: Randomised controlled trials evaluating psychology services in primary care compared to routine GP care

Reference	Setting	Sample & Problem	Comparison Group(s)	Outcome Measures	Follow-up	Principle Results
Blackburn, et al. 1981	1 Practice Edinburgh	64 Depression	Antidepressants Hospital out patients	HRSD, BDI	Weekly to 20 weeks	CBT superior at completion. Primary care produced more rapid results than secondary care.
Earll & Kincey 1982	1 Practice England	50 Generic	Routine GP care	DSSI, Life satisfaction scale, Locus of Control, Use of medical services	7 months	CBT condition used significantly less medication. No differences between groups at 7 month follow up
Robson, France & Bland 1984	1 Practice England	429 Generic	Routine GP care	Devised own scale Utilisation of medical services	14, 22 weeks 12 months	CBT superior at completion but no significant differences at 12 month follow up. CBT significantly lower financial cost.
Teasdale, et al. 1984	13 Practices Oxfordshire	44 Depression	Routine GP care	BDI, HRSD, MADS	3 months	CBT superior at completion but no significant differences at 3 month follow up.
Ross & Scott 1985	Single Practice Liverpool	51 Depression	Routine GP care	BDI, MADS	3 months 12 months	CBT superior at completion and at 12 month follow up
Scott & Freeman 1992	14 Practices Edinburgh	91 Depression	Antidepressants Routine GP care Social worker care	HRSD	4 weeks 16 weeks	Antidepressants superior at 4 wk. No significant differences between the 3 groups at 16 weeks.

Reference	Setting	Sample & Problem	Comparison Group(s)	Outcome Measures	Follow-up	Principle Results
Sharp, et al. 1997	1 Practice England	149 Panic disorder	Antidepressants Placebo	GHQ, CGIS, SD	Completion scores only, 84 days	All treatment conditions superior to placebo. CBT superior to antidepressants
Miranda Munoz 1997	San Francisco	150 Depression	Routine GP care Educational video	BDI, HSC, Utilisation of medical services	12 months	CBT superior to control on depression and somatic scores at completion + 12 month follow up.
Scott, et al. 1997	11 Practices England	48 Depression	Routine GP care	BDI, HRSD, DSM-III-R	3, 6 & 12 months	CBT superior at completion. Gains maintained at 12 month follow up.
Ward, et al. 2000	13 Practices London & Manchester	464 Depression	Nondirective counselling Routine GP care	BDI, BSI	4 & 12 months	4 month both psychological therapies equivalent, but superior to GP care. At 12 month no differences between the 3 groups.

HRSD = Hamiliton Rating Scale for depression, BDI = Beck Depression Inventory, MADS = Montgomery-Asberg Depression scale, GHQ = General Health Questionnaire, CGIS = Clinical Global Improvement Scale, SD = Sheehan Disability Scale, HSC = Hopkins Symptom Checklist, BSI = Brief Symptom Inventory

number of variables e.g. age, gender, BDI scores and HRSD scores. Also there have been suggestions that the administration of drug treatment in primary care was inadequate (Goldberg 1982). Although the outcomes are not conclusive, it has been noted that the Blackburn et al. study has been extremely important in suggesting the usefulness of treating depressive disorder in primary care and of initiating research in NHS settings (Teasdale et al. 1984).

Cognitive therapy for the primary care treatment of Major Depressive Disorder was also evaluated by Teasdale et al. (1984) using a small sample of 44. Patients were randomly allocated to 20 sessions of cognitive therapy or to routine GP care. At completion patients who received cognitive therapy were significantly less depressed than the comparison group. However at 3-month follow up, the comparison condition no longer differed to the cognitive therapy condition. Teasdale et al. state that this was mainly due to the continuing improvement of the comparison group and the sustained improvement in the cognitive therapy group. They conclude that cognitive therapy can have a substantial effect on the rate of recovery of patients with major depression.

Further support for CBT treatment for depression in primary care was found by Ross and Scott (1985). Fifty-one depressed patients from a single setting were randomly allocated to either 12 sessions of individual CBT, 12 sessions of group CBT or routine GP care. Using BDI scores and blind psychiatric assessments, participants from both of the CBT conditions improved significantly more than the routine GP care group, post treatment and at 12 month follow up. There were no significant differences between the individual and group CBT.

Scott and Freeman (1992) compared the clinical efficacy, patient satisfaction and cost of three treatments for depression with routine GP care. One hundred and twenty one participants from 14 practices were randomly allocated to the treatment groups, which were antidepressant medication prescribed by a psychiatrist, CBT provided by a psychologist and a combination of counselling and casework by a social worker. The results demonstrated that all three of the treatment groups improved over 16 weeks, but clinical differences between the treatment groups and the routine GP care were small. However the provision of the treatment groups cost at least twice as much as the routine GP care. In relation to client satisfaction the social work counselling was rated more favourably than the other treatments. The authors conclude that the additional cost associated with the specialist treatments of mild to moderate depression in primary care were not proportional with their clinical superiority over routine GP care. But Amitriptyline was the antidepressant prescribed for the majority of patients in the routine GP care group, since the time of the study the use of SSRIs in treating depression has greatly increase (Frank et al. 2001). SSRIs are considerable more costly than Tricyclics, which has implications for the conclusions drawn about the cost comparisons. It should also be noted that at assessment the participants from the social work counselling group scored lower on the Hamilton Rating Scale, which impacts on the interpretation of the results, as the two groups did not have similar levels of psychological distress at baseline.

Brief cognitive therapy for the treatment of depression was also evaluated, using a randomised controlled trial by Scott et al. (1997). They used 48 patients from 11 different primary care settings, independently assessed for Major Depressive Disorder, who were randomly allocated to either the brief cognitive therapy condition or a control condition of routine GP care. Cognitive therapy consisted of 6 weekly sessions of 30

minutes duration supplemented with written material, the therapy sessions were audio-taped and the quality of therapy assessed. Results demonstrated that the treatment group significantly improved on BDI and HRSD scores at the end of treatment and at 1 year follow up. Because of the tight control over the treatment intervention the authors note that therapist skill was probably a crucial factor. They also suggest that brief cognitive therapy may not be sufficient for patients with more complex problem.

Overall the research into psychologists providing CBT treatment for depression within primary care has produced quite positive results when compared to routine GP care, with most trials finding that it provides significantly more symptom relief more rapidly. But as noted earlier patients in primary care presented with a wide range of problems, with anxiety being consistently the most commonly referred to psychologists within primary care (White 2000). However, the research into psychologists providing treatment for more generic psychological problems in primary care is not as extensively researched and is not as conclusive in its results. Firstly, Earll and Kincey (1982) randomly compared behavioural treatment with routine GP care, for 50 consecutive potential referrals to psychological treatment, within one primary care setting. The patients presented with a mixture of problems, but most common were anxiety, tension and interpersonal difficulties. At the end of treatment the only difference between the two groups was that the treatment group had received significantly less psychotropic medication, however this difference was not maintained at follow up (approximately 7 months). There were no differences between the two groups in subjective ratings of psychological distress, locus of control and life satisfaction, however the patients who received behavioural treatment reported higher levels of satisfaction with the service.

Robson, France and Bland (1984) conducted a controlled randomised clinical and economic evaluation of a behaviourally orientated clinical psychology service within primary care. Using a large sample (n=429), with a variety of presenting problems, they found that patients treated by a clinical psychologist achieved significantly greater improvement, more quickly than the patients in the control group (i.e. routine GP care). The most common presenting problems were anxiety, psychological adjustment, depression and habit disorders. However with time (1 year) the patients in the control group had improved to almost the same extent as the treatment group, but they had more frequent visits to the general practitioner and more medication use. They summarise that a psychologist in primary care provides more economically viability and more rapid relief of mental health problems than routine GP care. However there are limitations as validated outcome measures were not used, instead the authors devised their own scale measuring severity as perceived by the participant, their GP and a member of their household (see France and Robson 1982).

More recently a study investigating the effectiveness of psychological treatment of panic and agoraphobia in primary care was carried out by Sharp et al. (1997). Using 149 participants, they compared CBT, SSRI medication and a medication placebo, each used alone and in combination within a randomised double blind framework. Outcome measures, which included global ratings of improvement and GHQ, were only taken at assessment and at completion. The results demonstrated that all active treatment groups made significantly greater improvement than the placebo, with the CBT groups showing significant superiority over the medication alone. Unfortunately there is no follow-up data available on the outcomes of the groups.

Finally using a matched cohort experimental design, primary care CBT treatment of anxiety was compared to usual care, with 137 participants presenting with Generalised Anxiety Disorder (GAD) or anxiety secondary to Major Depressive Disorder (MDD) (Price et al. 2000). At 3 months both groups demonstrated an improvement in anxiety symptoms, however after 6 months the treatment group had a significantly greater reduction in clinical symptoms. Also the treatment group showed significantly higher ratings of patient satisfaction with the services provided. There were some limitations to this study, firstly the participants were not randomised, and although the two groups were matched there were some significant differences (i.e. levels of education, age), which may have affected the patients' response to treatment. Secondly the questionnaire used to measure patient satisfaction was not validated. Finally there were shortcomings with the non-treatment group. Rather than a control, the non-treatment group received "usual care", similar to other studies this was not standardised in any way but in this particular study sometimes included treatment from another mental health department.

Overall the findings of studies investigating the treatment of mental health problems other than depression by psychologist within primary care are not unequivocal. The studies specifically treating anxiety disorders (Sharp et al. 97, Price et al. 2000) show promising results, but these results need to be replicated using validated outcome measures. But the research into psychology services treating mixed presenting problems is less positive, demonstrated very little difference between the treatment conditions and routine GP care. Further investigation into this area is particularly relevant, as seen earlier patients presenting in primary care are a very heterogeneous group, with treatment being provided by a range of mental health professional with a variety working models.

1.3 Conclusion

With an increase in the recognition of the large number of mental health presentations in primary care the government has targeted primary care to effectively assess and manage mild/moderate mental health problems. The NHS treatment guidelines (DoH 2001a) indicate that CBT should be the treatment of choice for a number of these mental health problems (e.g. Depression, Anxiety) but it also recommends the use of other psychotherapies or counselling e.g. focused psychoanalytical and interpersonal. However the published research into the effectiveness of counselling within primary care is equivocal at best. The research into the effectiveness of Psychology services within primary care has demonstrated that CBT is an effective treatment for depression in primary care. However, its use for more generic psychological problems e.g. anxiety, stress, interpersonal problems, is less conclusive.

The advantages and disadvantages of having mental health workers directly attached to primary care have been explored, with sound arguments on both sides. The suggestions are that primary care services can provide a number of direct and indirect benefits to the patient, the staff and the service. But most of the conclusions have largely been anecdotal and without empirical investigation. There has been one study (Blackburn et al. 1981), which directly compared CBT treatment of depression in an outpatients setting to a primary care setting. Although there were some methodological problems with this study, the implication is that primary care provided a more rapid reduction in symptoms than a similar treatment delivered in secondary care setting.

Why compare primary to secondary care?

It has been noted by Roth and Fonagy (1996) that the majority of RCTs investigating psychotherapy outcome involves patients treated in universities or other specialist settings which were unlikely to be representative of the clinical population. When examining the literature specific to CBT, there is good evidence for the effectiveness of CBT when implemented in specialist settings (Dobson 1989), but the trials in primary care have produced equivocal results (e.g. Scott and Freeman 1992, Ward et al. 2000). This implies that treatment received in primary care may produce outcomes different to those found in other research trials. It is not clear what factors are contributing to the differences in these results, e.g. methodological differences, contextual difference. Further to these differences, the Blackburn et al. study found that patients in primary care required fewer sessions over a shorter period of time, when compared to similar patients treated in a hospital setting.

A related systematic review by Raine et al (2002) of mental health interventions for somatic disorders, investigated if research evidence from secondary care could be extrapolated to primary care. Specifically looking at back pain, chronic fatigue and irritable bowel syndrome, with interventions including cognitive behavioural therapy, medication and brief dynamic psychotherapy, they found significant differences between the outcomes of treatments implemented in primary and secondary care. Overall their results showed that interventions implemented in secondary care were more effective than primary, and therefore the authors caution against assuming that interventions that are effective in secondary care will be as effective when implemented in primary care. They offer a number of explanations for these differences, e.g. differences in levels of baseline symptom severity, differences in treatments received or

methodological variances. However they fail to address the possible qualitative factors, which may cause differences between treatments in primary and secondary care.

Chapter 2: Method

2.1 Rationale for methodology

Randomised controlled trials are seen as the "gold standard" of research and provide the best evidence for effectiveness of treatments (Roth and Fonagy 1996). However over recent years there has been much discussion of possible criticisms or limitations of the RCT methodology (e.g. Ward et al. 1999, Sackett and Wennberg 1997).

One of the more frequent criticisms of RCTs is that they do not represent real practice (Aveline et al. 1995). By their highly standardised and uniform nature RCTs often produce quite different treatment conditions than are offered in routine practice. In psychotherapy research it is also argued that RCTs are premature (Shapiro 1995), claiming that too much is still unknown about the operational characteristics of effective psychotherapy for meaningful RCTs to be carried out. Also randomisation can introduce a variety of participant problems; e.g. recruitment difficulties, often largely due to a widespread but unsupported patient belief that a new treatment is likely to be more superior to an existing treatment (Chambers 1997). Also allocation to a preferred or non-preferred treatment choice can lead to effects on patient attrition and compliance (Cooke and Campbell 1979).

Further to the general issues surrounding RCTs, the use of RCTs within primary care have received more specific debate (e.g. Hemmings 2000, King 1997). There are factors intrinsic to the primary care setting that add further complications to the effective implementation of RCTs. Gaining the cooperation of GPs in recruitment can cause a variety of challenges (Fairhurst and Dowrick 1996, Hancock et al. 1997). There

is usually little or no incentive for the primary care staff to become involved in the trial. Further, the hectic nature of the daily routine within primary care also makes the application of a RCT difficult. In relation to mental health services specifically, GPs and patients are increasingly viewing counselling as an essential service, which makes randomisation less acceptable (King 1995).

An alternative approach to measuring effectiveness of treatment is the pragmatic trial (e.g. King 1997). Pragmatic trials will often follow RCTs in evaluating treatments offered in clinical practice, aiming to investigate if the same results occur in real clinical conditions. Compared to the homogeneous RCT, the pragmatic trial will reflect the natural variations that occur in real practice. The major advantage to research in the natural setting is that it provides results that are more easily generalisble to the wider population (Robson 2002). This type of methodology was considered appropriate for a number of reasons. Firstly the treatment being investigated in this study was CBT usually in the treatment of anxiety or depression based problems, which a number of previous RCTs (e.g. Hollon et al. 1992, Clark et al. 1994) have established good levels of clinically and statistically significant effectiveness, which implies it is more suitable to this methodology. Secondly, the sample to be studied had a naturally occurring division, which lent itself to the quasi-experimental design.

Questionnaire

The main study was followed up by a postal questionnaire. This created a change in focus from outcome to gaining an understanding as to why there were differences between the two groups (Pawson and Tilley 1992). There were a number of reasons for choosing a self completed postal survey. It is considered a good survey method for targeting a larger sample. Also when considering the target sample (i.e. recent mental

health service users), the questionnaire was considered to be less intrusive. In considering other possible methods of data collection e.g. telephone or individual interviews, these were likely to require more involvement from the participants, which would reduce the likelihood for participation. Also postal questionnaires maintain the anonymity of participants, which reduced ethical considerations and also could help the response rate and encourage more honest and meaningful replies from participants.

Statistical Analysis

The aim of the statistical analysis in this trial was to examine differences between two groups, in rate of change over time. When comparing two groups over a period of time the common statistical approach taken is a t-test or analysis of variance. The important feature of these analyses is that the means of the two groups at each time point are compared for statistical significance. There are limitations to this approach, which are relevant if the number of time periods being compared is greater than two, as is the case here.

Firstly, making multiple comparisons at the different time points increases the likelihood of a significant result and therefore reduces the statistical power. Therefore it would be more useful to use evidence of a difference between the groups over the whole observation (Bland 1994). Secondly the analysis does not take into account that the measurements at different time points are from the same subject. And thirdly, dividing the results into "significant" and "non-significant" at each time point introduces an artificial dichotomy into the serial data. Most psychological or biological variables change over time in a gradual or continuous manner, therefore the concept that the difference between the groups can change from being "not significant" to "significant" at one specific time point can seem clinically unhelpful.

Drawing from medical statistics on time dependant analysis, a summary measures approach to analysis was chosen. This analysis is considered to be a simple method of producing clinically useful and statistically valid analysis, in examining data which describes each patient receiving a single treatment which may produce change in an outcome variable over time. The data in this study was considered to be growth data, in that the important feature of the data is the rate at which the outcome variable increases or decreases overtime. Therefore a recommended summary measure is the slope of a line fitted to the data, most easily measured by the regression coefficient (Matthews et al. 1990). Once calculated for each subject, this then can be treated as raw data for analysis.

2.2 Research Questions

The objective of the study was to investigate the relationship between the setting of a psychology service and the outcome of the service users, using a quasi-experimental design. It addressed the question of whether there are differences between a psychology service provided in a primary care setting and a psychology service provided within a psychiatric hospital outpatient setting, in terms of outcome and consumer satisfaction. Outcome measures and consumer satisfaction from the two treatment groups receiving treatment from one of the two conditions were compared.

Hypotheses

The main research question is whether the setting of the psychology service affects the client outcome and client satisfaction.

Hypothesis 1: Firstly, as implied by the Blackburn et al. (1981) study, it is hypothesised that the participants receiving treatment in the primary care service will demonstrate a more rapid symptom recovery than those receiving treatment in the secondary care service. The rate of change, as measured by BDI, BAI, BSI completed over the first 6 treatment sessions, will be greater in the Primary Care group than the Secondary Care group.

Hypothesis 2: The total number of treatment sessions attended by participants will be lower in the Primary Care group than the Secondary Care group.

Hypothesis 3: It is hypothesised that the clients from the Primary Care condition will report higher levels of satisfaction with the service received than the Secondary Care condition.

Hypothesis 4: There will be a higher number of participants who dropout of treatment in the Primary Care group than in the Secondary Care.

Hypothesis 5: In connection with possible indirect effects, agreement of the nature of the presenting problem as described by the referrer (i.e. GP) and described by the psychologist was also examined. The hypothesis being that there will be more GP-psychologist agreement in the referrals from the Primary Care group than from the Secondary Care group.

2.3 Design of the Study

The research question was addressed using a between-subject quasi experimental design. Two treatment conditions were compared, a CBT orientated psychology service provided in Primary Care settings and CBT psychology service in a psychiatric hospital outpatients department. Rate of change in symptom severity between the two conditions was compared using three standardised psychological measures. The measures were completed at assessment, prior to each session for the first six sessions attended and at discharge. Consumer satisfaction was also measured after six sessions and compared between the two conditions. The independent variable was the setting of the psychology service, either primary care or secondary care. The dependant variables were measures of psychological distress and consumer satisfaction

The Treatment Settings

The Community Clinical Psychology Service is a primary care psychology service, which forms part of a large NHS mental health trust in south London. It is a uni-disciplinary service receiving direct referrals from GPs only. Target referrals are adults with mild-moderate mental health problems that are suitable for short term psychological treatment. It comprises of 5 Clinical and 1 Counselling Psychologist providing 28 clinical sessions (3.5 hours per session).

The service can be divided into 2 sections. Firstly is the "On-site" service, which involves 3 Psychologists providing sessions within 6 GP surgeries. Second is the "Centralised Service", where 3 psychologists are based at a psychiatric hospital and receive referrals directly from the local GPs. All of the Psychologists work within a CBT framework providing short-term therapy for a variety of psychological problems. The two different settings i.e. on-site and centralised will be the independent variables, in the study they shall be referred to as "Primary Care" and "Secondary Care" respectively.

To try to ensure that there was equivalence of clinical competence across the therapists, only therapists who had a minimum of three years post qualification as a Chartered Psychologist were included. All of six the psychologist involved in the research had received training in CBT and aimed to provide a specialist CBT service. In addition the therapists received regular CBT peer and individual supervision.

Measures

Three well established outcome measures were used to assess change in client psychological symptoms along with a consumer satisfaction questionnaire, which are contained in appendix C. As the design is quasi experimental the use of well validated, sensitive outcome measures is essential (Ward et al. 1999). The Beck Depression Inventory, Beck Anxiety Inventory and Brief Symptom Checklist were used to measure psychological distress at assessment, and prior to the first six consecutive treatment sessions. The test materials were also administered at the end of treatment (if treatment was ongoing for more than 6 sessions). The Consumer Satisfaction Questionnaire was also administered during the sixth session (or the final session if treatment completed earlier than 6 sessions).

- Beck Depression Inventory (BDI)

Symptoms of depression were measured using the BDI (Beck and Steer 1987). The BDI is a 21 item, self report scale which assesses the current level of depression. Score ranges are: 14-20 mild depression, 21-26 moderate depression, above 27 severe depression.

- Beck Anxiety Inventory (BAI)

Anxiety levels were measured using the BAI (Beck et el. 1988). This is a 21 item, self report scale which assesses the level of somatic and psychic symptoms of anxiety. Higher scores represent more severe anxiety.

- Brief Symptom Inventory (BSI)

The BSI is a 53 item self report scale which was developed using clinical/rational and empirical/ analytic procedures (Derogatis 1992). It contains nine symptom dimensions

i.e. Somatisation, Obsessive-Complusive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism.

- The Consumer Satisfaction Questionnaire (CSQ-8)

The (CSQ-8) is an 8 item service satisfaction questionnaire in which higher scores indicate greater satisfaction developed by Nguyen et al. 1983. The scale has demonstrated good psychometric properties that are stable across many independent studies. It has been standardised on over 3500 patients attending health centres in the United States, 81% of who were outpatients. The creators suggest that the scale is especially applicable to evaluating mental health services.

- Dropout

Dropout rates were measured by the treating therapist. A dropout was defined as a patient failing to attend scheduled sessions, which resulted in their treatment being terminated prior to the number of sessions agreed with the therapist.

2.4 Research Sample

The sample was taken from the referrals to the Community Clinical Psychology Service. The service catchment area is a borough in South East London covering a population of approximately 230,000, which is characterised by high levels of social deprivation and a high level of ethnic minorities, especially Caribbean and African. It is representative of a British inner city and has elevated rates of mental health referrals.

Referrals to the psychology service present with a wide range of problems, most common are depression and anxiety disorders. Examples of referrals that would not be accepted include; alcohol/drug dependency, eating disorders or psychosis, these clients would be referred on to a more appropriate service e.g. community mental health team or other local specialist NHS services. The research sample consisted of referrals who agreed to participate in the study, and attended treatment (defined as two or more sessions) during the research period.

Due to the organisation of the service, i.e. Psychologists are only working within 6 GP surgeries throughout the borough, random allocation of the participants to the on-site or centralised service was not possible. Therefore allocation was dependant on the catchment area in which the clients resided. Matching of participants was considered and rejected for a number of reasons. Firstly, as with many NHS mental health services, this service has a reasonably high drop out rate (approx. 25%), which could lead to incomparable groups subsequent to matching. Secondly, matching would limit the number of available participants. And thirdly, pilot statistics (see section below) comparing clients seen by the two services did not show any significant differences between the two groups at assessment, on demographic data or measures of psychological distress.

2.5 Pilot statistics on the sample population

Considering the quasi-experimental design, in which participant allocation was based on catchment area rather than more formal randomisation, pilot analysis was performed on retrospective data to investigate if there were any significant difference between clients

referred to the two subdivisions of the service. All referrals received in the 6 months prior to the research project were compared on available demographic and clinical data. Table 2.1 contains details of the most common presenting problems for each service and Table 2.2 contains the means and standard deviations of the BDI, BAI and raw BSI scores for each service. The proportion of males to females in the Secondary Care service and the Primary Care service was respectively 5:4 and 5:3 and the mean ages were 44 and 42 respectively.

A Chi-square was used to compare the demographic data of the two groups (gender, marital status, presenting problem), showing no significant difference between the two groups. A MANOVA was used to compare the responses to standardised test material (BDI, BAI, BSI) taken at assessment, which also found no significant differences between the two groups on any of the variables $F(4,40) = .82$, $p = .52$. This result implies that the method of sample selection does not threaten internal validity.

Table 2.1: Percentages of pilot clients seen with the main primary presenting problems in the two service

	Secondary Care n = 36	**Primary Care** n = 30
Depression	13 (36%)	10 (33%)
Anxiety	12 (34%)	9 (30%)
Panic	3 (8%)	3 (10%)
PTSD	3 (8%)	3 (10%)
Other(e.g. bereavement, stress, anger)	5 (14)%	5 (17%)

Table 2.2: Summary of the pilot participants scores of the outcome measures for the two services

	Secondary Care		**Primary Care**			
Measure	mean	stan. dev.	mean	stan. dev.	Min.	Max.
BDI	19.81	9.71	23.13	12.68	0	63
BAI	20.09	13.71	23.25	12.69	0	63
BSI	79.11	41.66	74.29	48.27	0	212

2.6 Procedure

To ensure client anonymity throughout the study each client was allocated a patient code on receipt of referral. It is usual procedure within the service for new referrals to be offered the next available assessment session and to be notified of appointments letter. Along with the appointment letter, all clients received the three questionnaires (BDI, BAI, BSI) which they are asked to complete immediately prior to the assessment session. A "Patient Information Questionnaire" (contained in Appendix E) which was completed by the treating psychologist also gathered demographic and background clinical data. Information collected included; age, gender, martial status, employment, level of education, ethnicity, previous episodes and response to previous response to treatment.

Due to the quasi-experimental design, it was important to compare the groups on clinical factors which might effect the participants' treatment outcome. Although there have been difficulties in establishing reliable predictors of treatment outcome (Steketee and Chambers 1992), an attempt was made to record the details of the client variables which may predict outcome. These included; duration of presenting problem (Mathews et al., 1976, Huxley et al. 1979), response to previous treatment (Elkin et al. 1989).

Severity and complexity of presenting problem have also been found to predict outcome (Pearson et al. 1992), and these variables were measured by the assessment tests.

During the assessment session the psychologists provided all new clients with written information about the study and invited them to participate. If they agreed to participate, clients were required to sign a written consent form (see appendix B). The psychologist then asked the participating clients to complete the three psychological measures over the course of the six consecutive sessions (including the assessment session). The clients were asked to complete the questionnaires immediately prior to the next session and to return them to the psychologist during the session. At the sixth session (or the final session if treatment completed before session 6) the client was also required to complete the consumer satisfaction questionnaire. The satisfaction questionnaire was completed outside of the session and the client was provided with a SAE for its return. If treatment continued for more than six sessions, clients were asked to complete the outcome measures again at the end of treatment.

Measurement of agreement of the main presenting problem

The nature of the main presenting problem as described by the GP was gained from information contained in the referral letters. The referral information for each participant was examined independently by two judges. The judges were one counselling psychologist and one clinical psychologist. Using the referral information the judges were instructed to identify the main presenting problem using DSM-IV categories. In all of the participants there was consistency between the judges on the categorisation of the GP's description of the main presenting problem.

The Psychologists were asked to provide a description of the participants' primary presenting problem at assessment, using DSM-IV criteria. The presenting problems as described by the GP and the psychologist for each participant were compared and a dichotomous variable for "main presenting problem agreement" created for each.

Service Setting Evaluation Survey

The aim of the survey was to cross validate the results of the main study and to help further understand the salient contextual factors of the two settings from the perspective of the service users.

Design

A questionnaire was developed with the purpose of gathering information about participants' opinion on the contextual factors that have been highlighted by the literature to be of potential relevance to clients. The questionnaire was administered by post and content analysis performed on the responses.

Questionnaire Development

A questionnaire was developed, based on the suggestions from the earlier research/literature and from the results of the previously administered CSQ-8. The former offered guidance on the possible positive and negative contextual factors, which might effect the patient's expectations or beliefs relevant to their therapy. There were five main areas that the questionnaire aimed to address: the positive aspects of the setting, the negative aspects of the setting, issues around stigma of attending the setting, effect of GP's attitude/behaviour and the participants' attitude to the alternative setting.

Guidelines from Foddy (1994) and Oppenheim (1992) were used to develop the questionnaire. The first section of the questionnaire explained the purpose of the questionnaire and instructions for completion. The main body of the questionnaire contained 13 items, 6 of which were Likert type scaling questions and the remaining were open questions. It is acknowledged that in completing questionnaire surveys respondents can find open questions difficult to answer, which in turn may effect the response rate. However when considering the explorative purpose of the questionnaire, an open question format was considered appropriate to help identify the issues important to the respondents. The aim was to produce clear, unambiguous balanced questions.

The questionnaire was completely anonymous and treated confidentially. The participants' personal details were stored separately and were only accessible to the principle researcher.

Piloting

The questionnaire was piloted using a sample of 6 people (3 psychologists and 3 independent people). The pilot participants were informed that it was a pilot questionnaire and they were invited to provide feedback on the questionnaire itself e.g. clarity of questions, any suggestions for improvement, other relevant issues.

The responses of the pilot participants were used to develop a revised questionnaire. The major change made to the questionnaire was to create two questionnaires specific to each setting. The two questionnaires were identical apart from the wording related to the setting. To help with question clarity and ease of completion, the questionnaire items were modified to refer specifically to either primary care or secondary care e.g.

"Q.8 Was there anything about the hospital that made it difficult for you to attend the psychology service?" and "Q.8 Was there anything about the surgery that made it difficult for you to attend the psychology service?". Appendix D contains copies of the two questionnaires.

Sample

To increase external validity the sample contained all clients who had attended at least one treatment session, within the last 12 months at either the primary or the secondary care psychology service and have ended treatment (ended treatment includes; completion, dropouts, referred on etc.). The sample size was 100, 31 from Secondary Care and 69 from Primary Care.

Procedure

The revised questionnaire was posted to the participants, along with the covering letter and stamped addressed envelope. Four weeks was allowed for the participants to return their completed questionnaire.

The covering letter which accompanied the questionnaire was developed using guidelines recommended by Honville (1985). It included; the study's rationale, requirements of involvement, details around confidentiality and anonymity, details of how to contact the researcher should they have any further questions and appreciation of their help. To assure clients' confidentiality the cover letter was signed by each clients treating psychologist. The cover letter can be found in Appendix D.

To help increase the response rate the participants also received a pen and a stamped addressed envelope to return the questionnaire.

2.7 Ethical Issues

Although the quasi experimental design of the study reduced the potential ethical problems, there were still some issues which need to be addressed.

- Permission was obtained from each potential participant prior to any involvement in the study. At the assessment session, the psychologist provided clients with verbal and written information about the study inviting them to participate. The written information stated the objectives of the study and the requirements of involvement. Confidentiality was also addressed, explaining that any data used in the study would be completely anonymous. It clearly specified that participation in the study was voluntary and if they decide not to participant this would in no way effect the treatment that they would subsequently receive. Also it detailed that participants were free to withdraw from the study at any time. The clients who agreed to participate were required to sign a consent form to confirm that they fully understand the issues. Appendix B contains a copy of the Patient Information Sheet and Consent Form.

- Participant confidentiality/anonymity was thoroughly maintained throughout the study. When referrals were accepted to the service, prior to any involvement in the study, each referral was allocated a client code number. Any information about the clients used in the study (e.g. demographics, results of outcome measures, attendance rates etc.) was only identified by the client code. Participants' personal details i.e. name, address, were stored separately at all times and were not known to the researchers.

- The research was approved the ethics committee of South London and the Maudsley NHS Trust (Ethics Number 008/02). See Appendix A for copy of Ethics Approval Application.

2.8 Statistical Analysis

Preliminary Analysis

SSPS software was used to perform the analysis. Descriptive statistics are provided for the clinical and demographic information at baseline, along with descriptive statistics on the participants' scores on the outcome measures throughout the period of interest. Due to the Quasi-experimental design, both groups were compared at baseline on demographic and clinical data, using a Mulitvariate Analysis of Variance. Any unintended differences between the two conditions could then be statistically controlled for e.g. an analysis of covariance or subgroup analysis, to reduce the total amount of variance or to eliminate the confounding influence of the relevant uncontrolled variable.

Rate of change

Rate of response to treatment across the 2 settings was calculated using a summary approach to analysis of repeated measures (Matthew et al. 1990, Bland 1994). This involved producing a summary measure over time for each patient, as determined by the regression coefficient. Once calculated for each participant this was then subjected to a series of t-tests to compare the two groups on the three outcome measures.

Although there were no significant differences between the two settings (Primary Care vs. Secondary Care) in terms of attrition rates at the sixth treatment session, some patients did nevertheless complete early (23% vs. 27%) whilst others dropped out (27% vs. 19%). To account for this, only those patients that had completed the clinical outcome measurements on at least 3 occasions over the period of interest (including baseline) were included. Therefore final analysis was conducted on 49 of the initial 52 patients recruited.

Differential response to treatment

To gain clinically relevant information regarding the participants' outcome after the first six treatment sessions, a differential response to treatment over the six sessions was calculated. The percentage of change in scores on the three outcome measures was calculated for each participant who attended 3 or more sessions, i.e. baseline score – score at session 6 / baseline score x 100. If a participant attended less than 6 treatment sessions, the final collected score was used. A MANOVA was then used to compare the percentage change on the outcome measures between the two groups.

Consumer satisfaction

Descriptive statistics of the participants' scores on the SCQ-8 are provided and an independent t-test performed to compare the responses of the two groups.

Service Setting Evaluation Questionnaire

A content analysis was performed on the responses to the questionnaire. The researcher identified the main categories for each of the areas addressed by the questionnaire and an independent judge sorted the participant responses into the categories.

Chapter 3: Results

3.1 Preliminary Analysis

Demographic data

The total number of participants was 52. Table 3.1 contains a summary of the demographic details of the participants from the two groups. Almost 70% of the total sample was female. The age range of the sample was 19-63 years, with a mean of 37 and a standard deviation of 10.7.

Table 3.1: Summary statistics of the demographic details of participants by treatment group and total sample.

	Primary Care N= 25	**Secondary Care** N = 27	**Total** N= 52
Gender			
Men	4 (16%)	13 (48%)	17 (33%)
Women	21 (84%)	14 (52%)	35 (67%)
Age in years mean (s.d.)	36 (11.82)	39 (9.50)	37 (10.70)
Marital status			
Married/cohabiting	10 (40%)	12 (44%)	22 (42%)
Single	15 (60%)	15 (56%)	30 (58%)
Professional category			
Professional	7 (28%)	11 (41%)	18 (35%)
White collar	4 (16%)	4 (15%)	8 (15%)
Blue collar	2 (8%)	5 (18.5%)	7 (14%)
Unemployed	5 (20%)	5 (18.5%)	10 (19%)
Other (e.g.student, homemaker)	7 (28%)	2 (7%)	9 (17%)
Ethnicity			
White	20 (80%)	22 (82%)	42 (81%)
Black (combined)	4 (16%)	3 (11%)	7 (13%)
Other	1 (4%)	2 (7%)	3 (6%)
Living Arrangements			
Live alone	7 (28%)	11 (41%)	18 (35%)
Live with spouse	6 (24%)	7 (26%)	13 (25%)
Live with partner	4 (16%)	6 (22%)	10 (19%)
Other	8 (32%)	3 (11%)	11 (21%)

Chi-square tests were performed to investigate if there were differences between the Primary Care and the Secondary Care groups on the categorical demographic data. The small numbers in some of the categories violated the minimum expected cell frequency for the Chi-square test and therefore martial status, occupation, ethnicity and living arrangements were collapsed in order to perform the Chi-square tests.

Significant differences were only found between the two groups on gender: 84% of the Primary Care group were female compared to 52% in the Secondary Care group, $p = .019$. No significant differences were found for the other demographic variables, i.e. age, marital status, professional category, ethnicity, and living arrangements (all p values > .3).

Clinical data

Table 3.2 contains summary details of the respondents' clinical presentation at assessment, as described by the psychologist and Table 3.3 includes summary details of the history of the participants' psychological problems. Anxiety and depression based disorders were the two most common presenting problems, accounting for 88% of the total participants. Fifty-five percent of the total sample had previous contact with mental health services, of these none reported "full response to previous treatment", with 93% of this group report "little" or "partial" response to previous treatment. For 37% of the respondents the duration of current episode was less than 12 months, but for 61% of respondents the duration of the current episode was greater than 2 years.

Chi-square tests were also performed on the categorical clinical data. Again some categories i.e. nature of presenting problem, duration of this episode and number of previous treatments were collapsed. No significant differences were found between the

two groups on any of the variables, with all $p > .3$ except for nature of presenting problem $p=.07$.

Table 3.2: Nature of the main presenting problem of respondents, as described by the therapist.

Main presenting problem	**Primary Care** n = 25	**Secondary Care** n = 27	**Total** n = 52
Depression	6 (24%)	14 (52%)	20 (38.5%)
Anxiety	13 (52%)	7 (26%)	20 (38.5%)
Stress	2 (8%)	2 (7%)	4 (8%)
Anger management	2 (8%)	0	2 (4%)
Mixed anxiety/dep	2 (8%)	4 (15%)	6 (11%)

Table 3.3: Summary of the background information of the respondents' presenting problems

	Primary Care n = 25	**Secondary Care** n = 26	**Total** n = 51
Duration of this episode			
≤ 6 months	5 (20%)	4 (15%)	9 (17.5%)
≤ 12 months	3 (12%)	7 (27%)	10 (19.5%)
≤ 18 months	1 (4%)	0	1 (2%)
≤ 24 months	2 (8%)	0	2 (4%)
≥ 24 months	14 (56%)	15 (58%)	29 (57%)
History of problem			
Chronic	9 (36%)	9 (35%)	18 (35%)
Recurrent	10 (40%)	13 (50%)	23 (45%)
First episode	6 (24%)	4 (15%)	10 (20%)
No. of previous treatments			
None	14 (56%)	9 (35%)	23 (45%)
One	7 (28%)	12 (46%)	19 (37%)
Two	3 (12%)	2 (8%)	5 (10%)
Three or more	1 (4%)	3 (11%)	4 (8%)
Response to previous treatment			
Partial	8 (32%)	6 (23%)	14 (7.5%)
Little	3 (12%)	9 (35%)	12 (24.5%)
No effect	0	2 (8%)	2 (4%)
Not applicable	11 (56%)	9 (34%)	23 (45%)

Waiting times

There was wide variation in the length of time participants were required to wait before receiving treatment; the minimum waiting time was 2 weeks and the maximum waiting time was 26 weeks, with a mean = 12.5 weeks and standard deviation = 6.2. In comparing the two groups Primary Care mean waiting time was 10.5 weeks, standard deviation = 7.1 (min. = 2, max. = 26), the Secondary Care mean waiting time was 14.2 weeks, standard deviation = 4.9 (min. = 4, max. = 20).

Assessment Measures

Table 3.4 contains the summaries of the respondents' scores on the psychological measures at assessment. A one-way between-groups multivariate analysis of variance was performed to investigate differences between the two groups in scores on the three assessment questionnaires (BSI, BAI & BDI) and waiting times. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliners, with no serious violations noted. The MANOVA demonstrated no significant differences between the two groups on any of the outcome measures or length of waiting time ($F(4,34) = 2.24$, $p = .09$).

Table 3.4: Summary of participant scores on assessment measures

	Primary Care n = 22		**Secondary Care** n = 26		**Total** n = 48	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
BSI (GSI) Max = 4	1.62	0.86	1.64	0.72	1.63	0.78
BAI Max = 63	24.12	13.62	20.92	12.44	22.49	12.99
BDI Max = 63	23.00	11.84	26.24	10.64	24.64	11.26

Figure 3.1: BDI Scores at assessment for the two groups

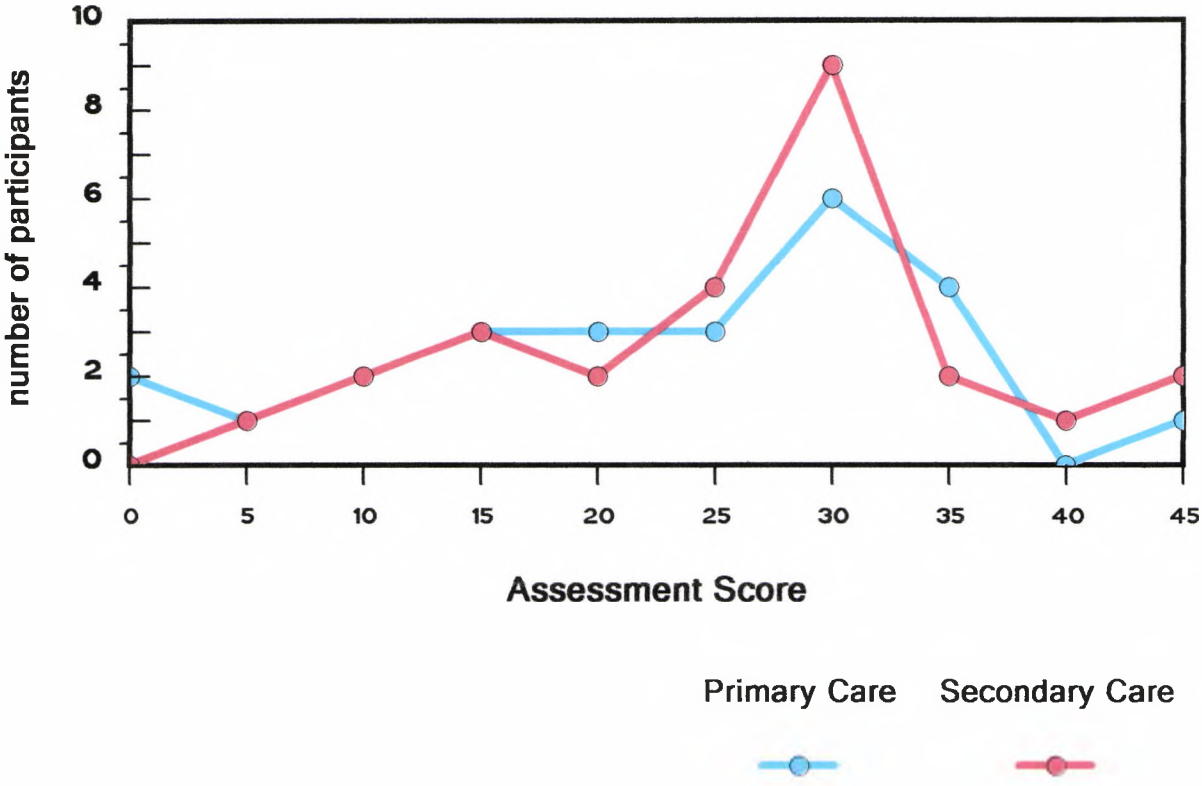


Figure 3.2: BAI Scores at assessment for the two groups

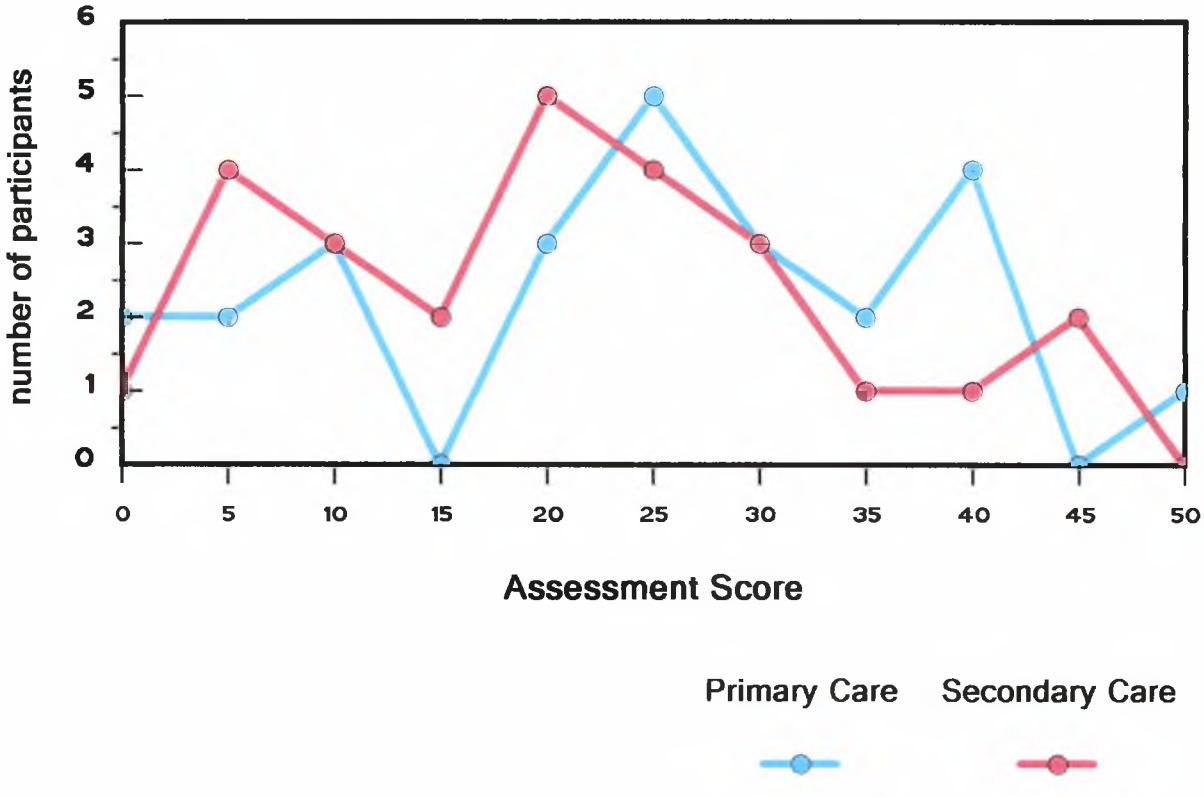
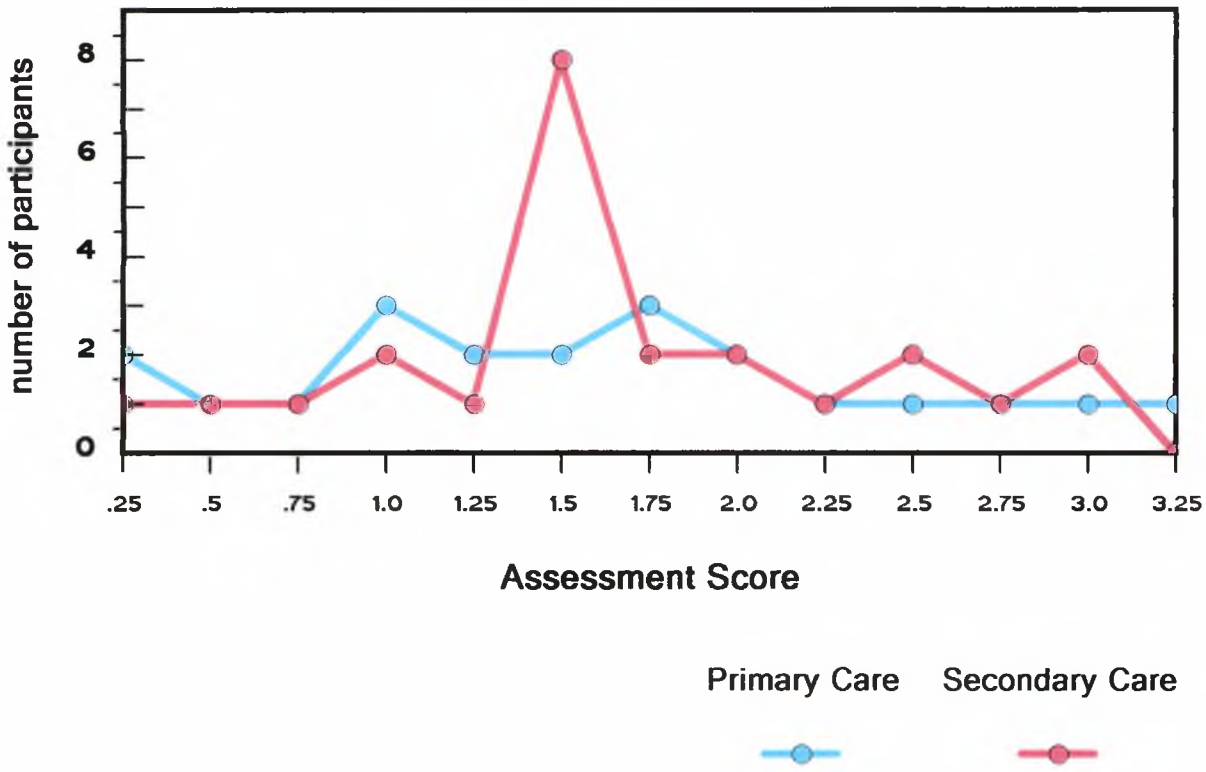


Figure 3.3: BSI Scores at assessment for the two groups



The preliminary results show that there were no statistically significant differences between the two groups at baseline on demographic or clinical data, with the exception of a higher number of female participants in the Primary Care group. On the levels of psychological distress the majority of patients scored within the moderate-severe range of symptoms of depression and anxiety, often reporting recurrent psychological problems.

3.2 Response to Treatment

Rate of Change

A summary of participants' scores on each of the three outcome measures across the first six sessions can be seen in Figures 3.4, 3.5 and 3.6. The graphs contain the mean scores of the total participants in each group over the course of the first six sessions. As can be seen in Table 3.4 and 3.6, the means of the responses to the BAI and BSI in the Primary Care group increased in week 6. This could be explained by the fact that a larger proportion (55%) of the Primary Care participants had finished treatment before week 6, compared to Secondary Care (41%), which would effect the summary means of the outcome measures. The approach detailed in section 2.1 was used to test the hypothesis that the rate of improvement in symptom severity would be quicker in the Primary Care compared to the Secondary Care group. Independent t-tests, on the regression coefficients revealed that there were significant differences between the two groups on all three outcome measures: the BSI (Primary Care $\underline{M}$ =-0.198, $\underline{SD}$ = -0.166, Secondary Care $\underline{M}$ = -0.045, $\underline{SD}$ = 0.115, $t(44) = -3.71$, $p = 0.001$), the BAI (Primary Care $\underline{M}$ = -3.01, $\underline{SD}$ = 2.45, Secondary Care $\underline{M}$ = -0.61, $\underline{SD}$ = 1.80, $t(47) = -3.95$, $p < 0.001$) and the BDI (Primary Care $\underline{M}$ = 3.36, $\underline{SD}$ = 3.66, Secondary Care $\underline{M}$ = 0.91, $\underline{SD}$ = 1.86, $t(30) = -2.86$, $p = 0.008$).

The preliminary analysis revealed no statistically significant differences between the groups on baseline clinical data. However there was variation between the two groups in "nature of presenting problem", which could be clinically relevant (24% of Primary Care group were identified as presenting with depression, compared with 52% in the Secondary Care group; anxiety disorders accounted for 52% of the Primary Care group compared with 38.5% in the Secondary Care group). In view of this difference, further analysis was performed to test the possibility that this variable may have had an impact on the rate of change. A Pearson product-moment correlation between the regression coefficients of the three outcome measures and the nature of presenting problem (collapsed into depression or anxiety based disorders) demonstrated that no such relationship existed (BSI; $r = .028$, BAI: $r = .012$, BDI: $r = .087$).

This result suggests that the rate of reduction in psychological symptoms, as measured by the BSI, BAI and BDI, was significantly more rapid in Primary Care compared to Secondary Care.

Percentage of change

A summary of the percentage of change for the total sample and the two groups can be seen in Table 3.5. The total sample showed improvement on the outcome measures over the period of interest, with the mean percentage of improvement being; BSI = 35%, BAI = 30%, BDI = 42%. A MANOVA was performed to investigate if there were differences between the two groups in the percentage of change on the three outcome measures. There was a statistically significant difference between Primary Care and Secondary Care on the combined dependant variables: $F(3,34) = 3.02$, $p = .043$;

Figure 3.4: Mean BAI scores throughout treatment

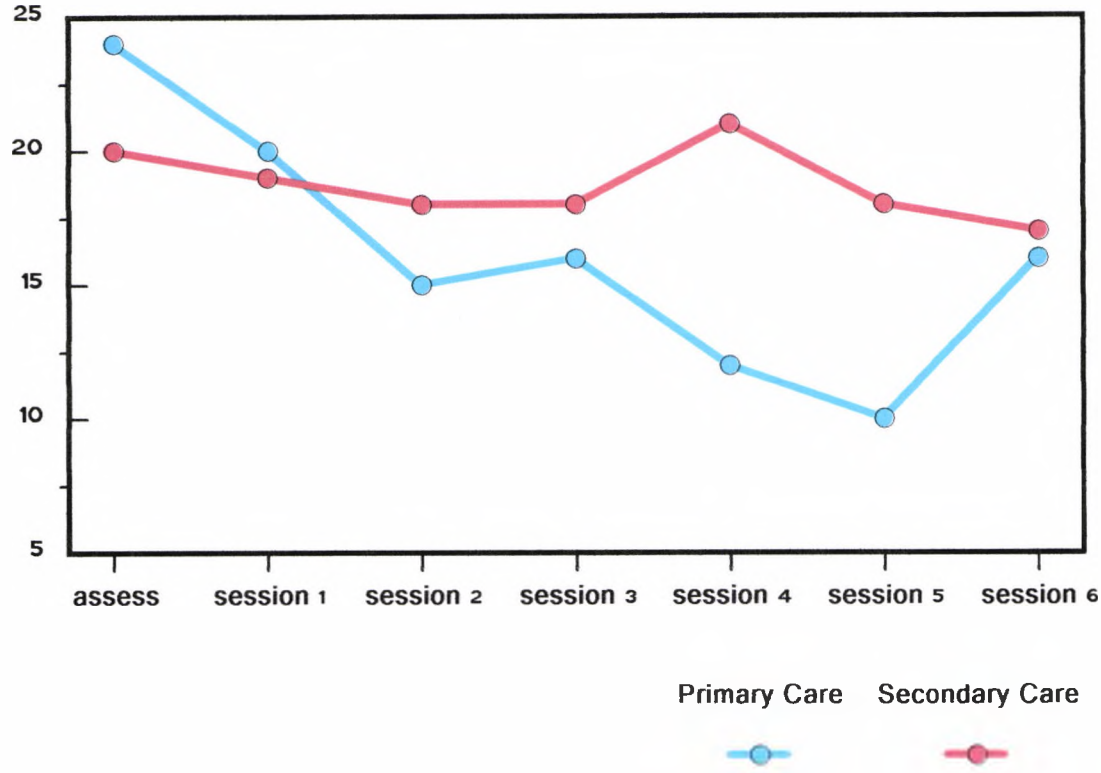


Figure 3.5: Mean BDI scores throughout treatment

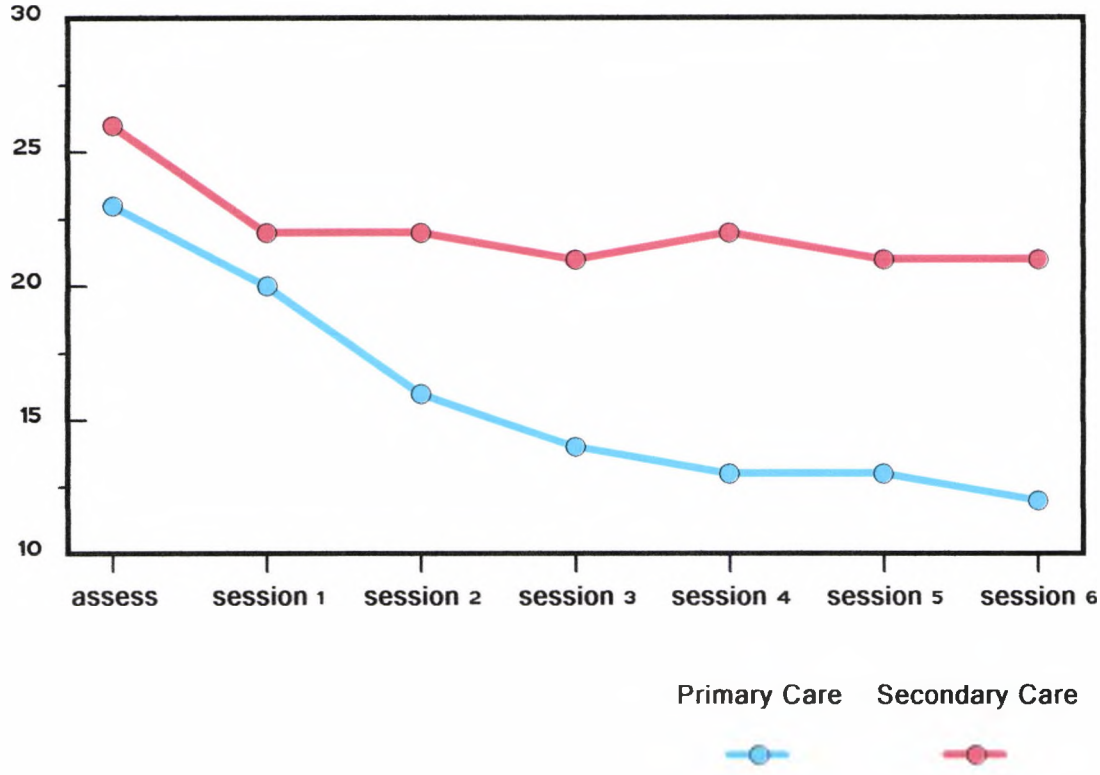
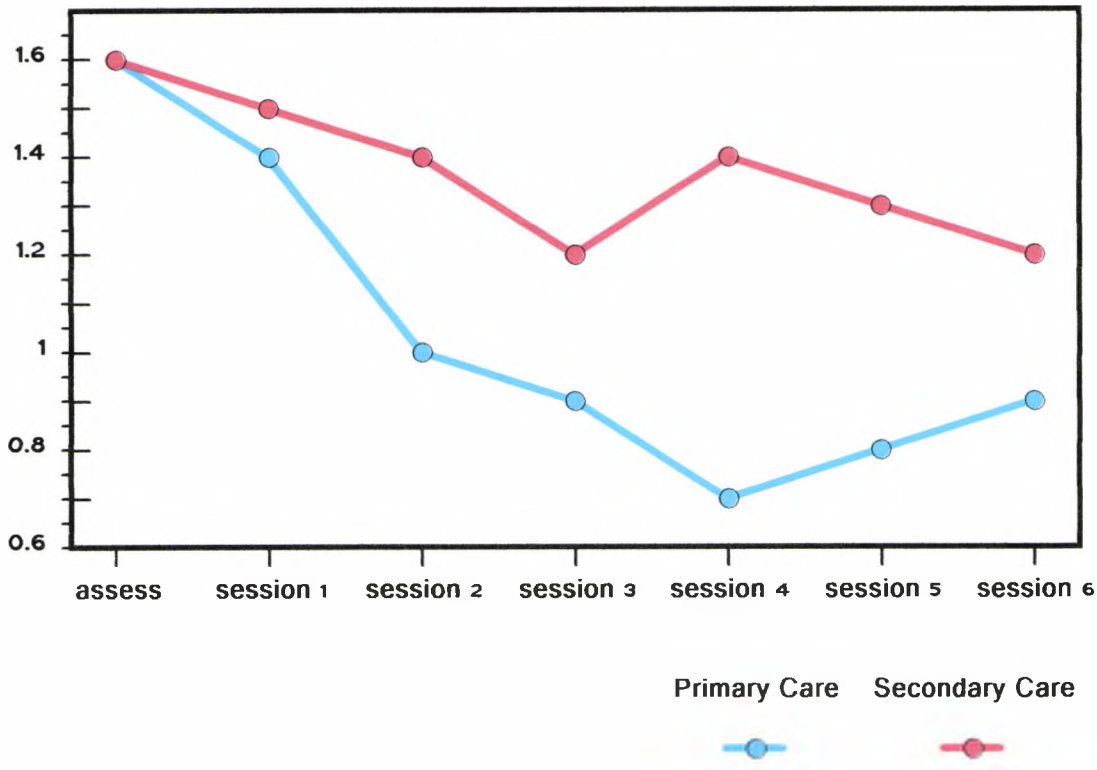


Figure 3.6: Mean BSI scores throughout treatment



Wilks Lamba = .79; partial eta squared = .21, with the Primary Care group reporting a larger percentage of improvement. When the results for the dependant variables were considered separately, all three reached statistical significance using the Bonferoni adjusted alpha level of .017. This means that the participants in the Primary Care group showed a greater percentage in improvement on all three outcome measures after the first six treatment sessions.

Table 3.5: Summary of the percentage of change in outcome measures after the first six treatment sessions*

	Primary Care n = 21		**Secondary Care** n = 26		**Total Sample** n = 47	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
BSI	52.47	27.85	20.92	39.65	35.48	37.79
BAI	52.52	32.21	12.41	42.94	30.33	43.12
BDI	58.78	28.44	29.69	41.01	42.97	38.35

*All figures are percentages.

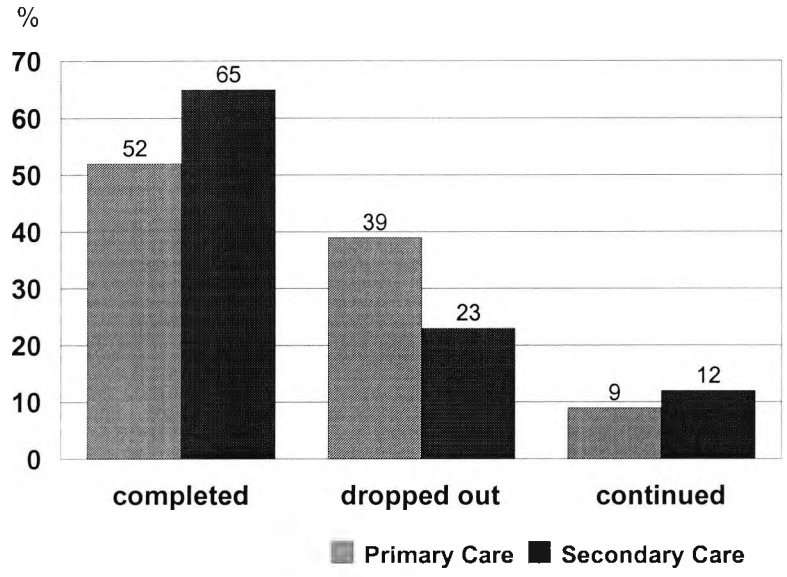
End of Treatment Data

The main focus of the research was initial rate of improvement; therefore end of treatment clinical data was not sufficiently available to conduct any meaningful statistical analysis. However the two groups were compared on end of treatment outcome and on total number of sessions. At the time of the end of the trial 59% of the total participants had completed their treatment, 31% had dropped out of treatment and 10% were still continuing with their treatment. The details of the outcome for the two groups can be seen in Figure 3.7. A Mann Whitney was used to compare the outcomes of the two groups, which did not find any significant differences. Although the percentage of patients who dropped out of treatment was higher in the Primary Care group (39%) than the Secondary Care group (23%), it was not statistically significant difference.

Table 3.6: The participants' treatment outcome

	Primary Care n = 23	**Secondary Care** n = 26	**Total** n = 46
Completed	12 (52%)	17 (65%)	29 (59%)
Dropped out	9 (39%)	6 (23%)	15 (31%)
Continuing treatment	2 (9%)	3 (12%)	5 (10%)

Figure 3.7: Summary of partcipants' treatment outcome



The total number of sessions attended by clients can be seen in Table 3.7. Overall the treatment received was relatively sort term, with the mean number of sessions attended being 9.5. An independent t-test was conducted to compare the number of sessions attended by participants in the two groups. There was a significant difference, with the Primary Care group having fewer sessions (mean = 6.1, s.d. 3.1) than the participants in the Secondary Care group (mean = 12.7, s.d. = 9.2, t(44) p = .002).

Table 3.7: Total number of sessions attended by participants in each group

	Mean	Stan. Dev.	Minimum	Maximum
Primary Care	6.1	3.1	2	13
Secondary Care	12.7	9.2	4	37
Total sample	9.5	7.6	2	37

At the end of treatment the Primary Care participants had attended significantly fewer treatment sessions than the Secondary Care participants. The Secondary Care participants had a lower drop out rate and a higher completion rate than the Primary Care group, but not significantly so.

GP-Psychologist agreement of the main presenting problem

Table 3.8 contains a summary of the psychologist and GP descriptions of the participants' main presenting problem at assessment.

Table 3.8: The main presenting problems as described by Psychologists and GPs.

	Psychologist Description n= 49	GP Description n=49
Depression	18 (37%)	20 (41%)
Anxiety- Panic	6 (12%)	5 (10%)
Specific Phobia	1 (2%)	1 (2%)
Generalised	2 (4%)	1 (2%)
Somatoform	1 (2%)	1 (2%)
Social	1 (2%)	1 (2%)
PTSD	1 (2%)	0 (0%)
not specified	7 (15%)	11 (23%)
Mixed anxiety/depression	6 (12%)	4 (8%)
Stress / Adjustment	4 (8%)	2 (4%)
Anger management	2 (4%)	1 (2%)
Other	0	2 (4%)

Agreement between the psychologist and GP was given a dichotomous rating for each participant. In 53% of the total sample there was agreement between GP and psychologist. In comparing the two groups, there was agreement between referrer and psychologist in 45% of the primary care group, compared to 59% in the Secondary Care group. A Chi-square demonstrated that there was no relationship between the setting and GP-Psychologist agreement, $X^2 = .46$, $p = .49$.

3.3 Consumer satisfaction

Overall the participants' levels of satisfaction as measured by the CSQ-8 were high, mean = 28.47 (s.d. = 3.98, maximum score = 32). The descriptive statistics of the responses to the CSQ-8 can be found in Table 3.9. An independent t-test was used to compare CSQ-8 means between Primary Care and Secondary Care respondents. There was a significant difference between the two groups $t(31) = 2.41$, $p = .02$. The effect size of the difference in the means was large (eta squared = .14) using Cohen's (1998) guidelines.

Table 3.9: Summary of participant's scores on the CSQ-8

	Mean min =0 max=32	Stan. Dev.
Total sample N = 38	28.47	3.98
Primary Care n = 17	30.00	2.03
Secondary Care n = 21	27.24	4.73

Further analysis of the participants' responses to the individual items of the CSQ-8 using Mann-Whitney tests showed significant differences between the responses of the two groups on 2 items. Item 4 "If a friend were in need of similar help, would you recommend our program to him or her?", Primary Care rated significantly more positive $U = -2.39$, $p = .017$. (Primary Care mode response was "yes definitely" given by 94% of the group; Secondary Care mode response was "yes definitely" given by 57% of the group). Item 8 "If you were to seek help again, would you come back to our program?" was also rated significantly more positively by Primary Care participants than Secondary, $U = -2.64$, $p = .008$. (Primary Care mode was "yes definitely" 94% of the population; Secondary Care mode was "yes definitely" 52% of group.

As the research procedure involved administering the CSQ-8 at session 6 (or in the final session if treatment completed earlier) some participants had not completed their treatment when they completed the CSQ-8. Therefore a Pearson product-moment correlation was used to investigate if there was a relationship between levels of satisfaction and the participants' stage of treatment (i.e. treatment completed or ongoing) at the time of administration of the CSQ-8. No correlation was found between the two variables ($r = -.18$, $n = 36$). This implies that the Primary Care participants were more satisfied than the Secondary regardless of the stage of treatment that satisfaction was measured.

Previous studies have shown that the CSQ-8 has a good internal consistency with a Cronbach alpha coefficient of .87 (Nguyen et al. 1983). In the current study the Cronbach alpha coefficient was .84, with an item analysis demonstrating good item-total correlations (range .489 to .675; mean .57).

3.4 Service Setting Evaluation Questionnaire

A content analysis was performed on the responses to the questionnaire. The researcher identified the main categories for each of the five areas addressed by the questionnaire and an independent judge sorted the participant responses into the categories.

There was an overall response rate of 41% (n = 41) to the postal questionnaire, the response rate was similar between the two groups 36% in Secondary Care group and 43% in Primary Care. There were differences in the numbers of participants in the two groups, (Secondary Care 11, Primary Care 30), therefore the results will be mainly reported as percentages. Table 3.10 contains a summary of the participants' responses to all of the scaling questions. The questionnaire addressed five main areas: Positive aspects of the setting, Negative aspects of the setting, Stigma, GP effects and Participant attitude to the alternative setting.

Positive aspects of the setting

Questions 2 "Was there anything about the setting (i.e. hospital/ surgery) that you particularly liked?" and 7 "Was there anything about the hospital/the surgery that made it easy for you to attend the psychology service?", were both open questions, which aimed to help identify what the participants found helpful or beneficial about the setting of the service. Analysing the two questions in combination, this area received the most commentary from participants. The content analysis produced five main categories of positive responses, which are described in Table 3.11. A total of 21 positive comments were made by the secondary Care group and a total of 51 by the Primary Care group. In both groups the item most frequently stated by participants was "Ease of location", with 70% of the Primary Care participants and 81% of the Secondary Care participants

Table 3.10: Summary of participants' responses to the scaling questions of the Service Setting Evaluation Questionnaire

Question 1: Overall how satisfied were you with the psychological treatment you received?

	Primary Care	Secondary Care
Very satisfied	20 (67%)	7 (64%)
Mostly satisfied	9 (30%)	4 (36%)
Mildly dissatisfied	1 (3%)	0
Dissatisfied	0	0

Question 4: Did you find it in any way embarrassing or uncomfortable to attend the Surgery/ Hospital for psychological treatment?

	Primary Care	Secondary Care
Very much so	2 (7%)	1 (9%)
Somewhat	4 (13%)	0
A little	5 (17%)	7 (64%)
Not at all	19 (63%)	3 (27%)

Question 5: Did you find the reception staff to be helpful?

	Primary Care	Secondary Care
Very much so	15 (50%)	4 (36.4%)
Somewhat	12 (40%)	3 (27.3%)
A little	3 (10%)	3 (27.3%)
Not at all	0	1 (9%)

Question 6: Was the fact that your psychologist was based at the hospital/surgery, in any way off putting?

	Primary Care	Secondary Care
Very much so	1 (3%)	0
Somewhat	2 (7%)	1 (9%)
A little	6 (20%)	4 (36%)
Not at all	21 (70%)	6 (55%)

Question 9: How much information did your GP provide you with about the psychology service when suggesting a referral?

	Primary Care	Secondary Care
None	3 (10%)	4 (36.5%)
Very little	10 (33.3%)	4 (36.5%)
Quite a bit	13 (43.3%)	3 (27%)
A lot	4 (13.3%)	0

Question 10: Did your GP's attitude in any way influence your decision to attend our service?

	Primary Care	Secondary Care
Yes	14 (47%)	4 (36%)
No	16 (53%)	7 (64%)

Question 11: Would you have been more likely to attend if the service was located at you GP surgery/ hospital?

	Primary Care	Secondary Care
Yes more likely	2 (6%)	3 (27%)
No difference	14 (47%)	6 (55%)
No, less likely	14 (47%)	2 (18%)

Question 12: If you had been offered the same service in your GP surgery/ hospital do you think that you would have responded any differently?

	Primary Care	Secondary Care
Yes	14 (47%)	4 (30%)
No	16 (53%)	6 (60%)

referring to it. Almost half of the Primary Care group commented on finding the setting familiar as a positive aspect of the service, referring to both familiarity with the physical environment and of the staff.

Positive comments about the staff were made more frequently in the Secondary Care than the Primary Care group (44% and 18% respectively). This category contained references to both the clinical and the non-clinical staff. The physical environment also received a number of positive comments from both groups, but as will be seen below also attracted a number of negative comments

Table 3.11: Numbers and percentages of participants referring to the positive aspects of the treatment setting

Category	**Primary Care**	**Secondary Care**
Ease of location	21 **(70%)**	9 **(81%)**
Physical environment	11 **(37%)**	3 **(27%)**
Positive staff attitude/behaviour	5 **(18%)**	4 **(44%)**
Familiarity	13 **(48%)**	1 **(11%)**
Timing of appointments	1 **(3%)**	3 **(27%)**

The large number of responses in this area implies that overall the participants from both groups were positive about the setting of the service. The major difference between the responses of the two groups was that Primary Care commented more on the familiarity of the setting, while a higher proportion of Secondary Care respondents referred to the staff being helpful.

Negative aspects of the setting

Questions 3 "Was there anything about the setting that you particularly disliked?" and 8 "Was there anything about the hospital/the surgery that made it difficult for you to

attend the psychology service?", were both open questions, which aimed to ascertain what the participants found difficult or unhelpful about the setting of their treatment. Overall there were few comments made by participants from both groups in response to these two questions, a total of 15 comments (9 in Primary Care and 6 from Secondary Care). The most common category mentioned was "Physical environment" accounting for 66% of the negative responses; with 4 (36%) of Secondary Care and 6 (20%) of the Primary Care participants negatively commenting on this aspect of the setting. The other negative themes which were mentioned were; inconvenience of appointment times, difficulties with the location and embarrassment, but the numbers of participants referring to these categories were very small. In response to Question 3, 19 (63%) participants in the Primary Care group and 3 (27%) in the Secondary Care group made a statement asserting that there was nothing about the setting that they disliked. This combined with the low number of responses to the questions could suggest that the patients were happy with the setting, but more prominently so in the Primary Care group.

Stigma

Questions 4 "Did you find it in anyway embarrassing or uncomfortable to attend the hospital/GP surgery for psychological treatment?" and 6 "Was the fact that your psychologist was based at the hospital/ your GP surgery, in anyway off putting?", were mainly concerned with the possible stigma or embarrassment attached to attending psychology. Both Question 4 and Question 6 were Likert type question. In response to Question 4 "Did you find it in any way embarrassing or uncomfortable to attend the surgery / hospital for psychological treatment?", 63% of the Primary Care group responded "Not at all" to compared to 27% in the Secondary Care group.

In response to Question 6 "Was the fact that your psychologist was based at the hospital / surgery, in any way off putting?" the majority of the Primary Care group (i.e. 70%) answered "Not at all", while in the Secondary Care group 55% responded with "Not at all" and the remaining 45% answering "A little" or "Somewhat". Thus it would appear that overall the participants from Primary Care setting experienced less stigma than the Secondary Care setting.

GP effects

Questions 9 and 10 addressed the possible effects of the GP's behaviour or attitude. Question 9 "How much information did your GP provide you with about the psychology service when suggesting a referral?", in the Primary Care group 57% responded with either "Quite a bit" or "A lot" compared to 27% in the Secondary Care group. While in the Secondary Care group 73% responded with either "Very little" or "None" compared to 43% in the Primary Care group.

Question 10 "Did your GPs attitude in any way influence your decision to attend our service?", there was no difference in the responses of the two groups for this question, with just over half responding with "No" in both groups. Question 10 also had a filter question asking in what way their GP's attitude influenced them. Overall the participants' from both groups responded to this in a very positive manner, with most expressing high levels of understanding and reassurance from their GP, e.g. "*Dr X was truly there for me and his positive attitude and encouragement influenced me to attend*", "*He reassured me that it would do some good*" and *"He was helpful and responded how I'd hoped. I wanted to see a counsellor and he responded effectively"*. Only one participant in each group commented that their GP was unhelpful.

This implies that overall there did not seem to be differences in how the participants from the two settings perceived their GP's behaviour or attitude towards the psychology service, but the Primary Care group seemed to have been provided with more information about the psychology service than the Secondary Care group.

Participant attitude to the alternative setting

The purpose of Questions 11 and 12 was to allow the participant to consider how they might have responded if their treatment had been located in the opposing setting. Question 11 was a scaling question and Question 12 was an open question. Question 11 asked, "Would you have been more likely to attend if the service was located at the local hospital/your GP surgery?". Approximately 50% of the participants from each group responded "No difference", but the Primary Care group 47% stated that they would have been less likely to attend a hospital based service and 27% of the Secondary Care group responded that they would be more likely to attend a Primary Care based service.

Question 12 asked the participants how they might have responded if the service had been offered in the alternative setting. 53% of the Primary Care group and 60% of the Secondary Care group stated "No difference". In the open section of this question, 4 (36%) participants from the Secondary Care group made additional comments. Three of these comments suggested that the participants believed the hospital treatment would be superior to a Primary Care based service, e.g. "*I think the staff at the hospital would be better*". The fourth participant stated that they would "be happier to" attend the Primary Care based service. Twelve (40%) of the Primary Care participants made additional comments, in 11 of these the participants reflected negatively on a possible hospital based service. The comments were quite varied but the most common theme,

identified by 5 (19%) of the Primary Care group referred to the negative atmosphere of hospitals, e.g. "*Hospitals can be very cold, factory like environments*", "*Hospitals are not nice places*". "*I will feel lost*". Four (13%) of participants' comments referred to the fact that a hospital service would imply to them that their problems were more severe, e.g. "*It might have made me feel that I was very sick*", "*I may have felt the problem was more serious – that I was more 'nutty'*".

Chapter 4: Discussion

4.1 Summary of Results

Hypothesis 1: The rate of response to treatment will be more rapid in Primary Care than in Secondary Care. The results indicated that the Primary Care group experienced a significantly quicker reduction in levels of psychological distress than the Secondary Care group, as measured by the BDI, BAI and BSI over the course of the first six treatment sessions. The Primary Care group also demonstrated a significantly greater differential response to treatment after the first six treatment sessions, compare to the Secondary Care group.

Hypothesis 2: The total number of treatment sessions attended by participants will be lower in the Primary Care group than the Secondary Care group. The results showed that the participants in the Primary Care did attend significantly fewer sessions than the Secondary Care participants.

Hypothesis 3: The Primary Care participants will report higher levels of satisfaction with the service received than the Secondary Care condition. Levels of satisfaction in the Primary Care group were significantly higher than in the Secondary Care group, as measured by the CSQ-8.

Hypothesis 4: There will be a higher dropout rate in the Primary Care group than in the Secondary Care. There were no statistically significant differences between the two groups in the proportion of participants who completed or dropped out of treatment.

Hypothesis 5: Consistency between the GP and the psychologist in their description of participants' main presenting problem would occur more frequently in the referrals from the Primary Care group than referrals from the Secondary Care group. The results found no relationship between the setting and GP-psychologist agreement of presenting problem.

4.2 Participant Characteristics

Overall the results showed that the two groups seen in Primary Care and Secondary Care were similar in clinical presentation and demographics. There was only one statistically significant difference between the two groups, which was gender with a larger proportion of females within the Primary Care group (84%) than the Secondary care group (52%). Generally mental health problems do tend to be more frequently identified in females than in males and there are a number of suggestions as to why this occurs (e.g. Ussher 1991). Also women are known to attend general practice more frequently than men (Mann et al. 1981). The secondary care service has successfully managed to attract a balanced number of referrals from both genders, unlike the primary care service, but there does not appear to be any apparent reasons for the discrepancy between the two groups. Previous examinations of psychiatric referral patterns have produced similar results, with secondary care services receiving a higher proportion of male patients (Browning et al. 1987, Brown et al. 1988). The results suggests that the male patients in the primary care settings are not accessing services, but it is unclear at what stage this is happening, e.g. presentation to GP, referral, attendance at assessment.

Eighty percent of the total sample identified themselves as white and 14% as black. According to the 2001 national census, 63% of the borough population is white with the combined black categories accounting for 26% of the population. This would suggest that ethnic minorities are under represented in both branches of the service. It has been consistently demonstrated that ethnic minorities' under utilise mental health services (e.g. Sue 1991, Odell et al. 1997). It is clear from the research data that further work is needed to help increase the accessibility of the service to accommodate the needs of the local population, especially in relation to ethnic minorities and males.

Clinical presentation

Overall the clinical presentations of the participants in the two groups were very similar at baseline, with no statistically significant differences between the two groups. Although not statistically different, there were differences between the groups in the description of "main presenting problem", which could be clinically important. The Secondary Care group had a higher number of participants identified as depressed (52%) compared to Primary Care (24%), and anxiety was lower in Secondary Care (26%) compared to Primary Care (52%). One possible explanation for this discrepancy could be a waiting list management effort employed by the secondary care service. A new local NHS specialist anxiety treatment centre opened approximately the same time as the beginning of the trial. In an attempt to help reduce the waiting time in the secondary care service, the manager was referring a large proportion of referrals with anxiety disorders to this service prior to assessment. An earlier study using participants from the same secondary care service, prior to the opening of the Centre for Anxiety Disorders and Trauma, found that 43% of the sample presented with anxiety and 53% presented with depression (Hirsch et al. 2000). In addition the pilot statistics on earlier referrals did not demonstrate any difference in the presenting problems of the two

groups. This would imply that the new centre has impacted on the nature of the referrals been seen by the secondary care service.

Also it should be noted that the categorisation of "main presenting problem" was not independently validated. The treating psychologist was required to identify the main presenting problem at assessment, using DSM-IV criteria. Although there appears to be differences between the two groups in terms of the description of the primary problem, there were no differences between the two groups on symptoms of depression and anxiety as measured by the BDI and BAI at assessment. This could imply errors in the therapists' description of the problem or could suggest high levels of co-morbidity within the participants.

There were no significant differences between the groups in scores on the three psychological measures at assessment or on history of presenting problem and previous episodes of psychological treatment. This is consistent with earlier research which contradicts the theory that primary care mental health services tend to see the "worried well" (Brown et al. 1988, Hemmings 1997). Overall the participants from both groups were experiencing high levels of psychological distress at assessment, the mean assessment score on the BDI was 25 and the BAI was 23, which are both within the moderate-severe range for symptoms of depression and anxiety. Fifty-eight percent of the sample had had previous contact with mental health service, with 93% of this group reporting only "little" or "partial" response to treatment. This implies that contrary to some suggestions, the psychologists working in primary care are working with patients with severe levels of psychological distress and often presenting with long term psychological problems. In addition some of the participants in the Primary Care group presented with problems which usually require longer term treatment than is

traditionally offered in primary care e.g. posttraumatic stress disorder, major depression disorder.

In comparing the two groups, the Primary Care group appeared to have more variance in the participants' presenting problem at assessment. This was clear from greater variation in description of the primary presenting problem and also from the range of the scores at assessment on the psychological measures. On all three psychological measures the Primary Care group had larger standard deviations than the Secondary Care group, which implies more variance in their levels of psychological symptoms. This could be seen as support for the accessibility of the service, as it is possible that some of these clients (e.g. stress related problems, anger management and milder psychological presentations) would not otherwise be offered psychological treatment. However it also questions the concept that primary care mental health services deal with the more simplistic cases. Working with a wider range of presenting problems may place an increased demand on the psychologist, especially as in primary care they are likely to be working in relative isolation.

4.3 Response to treatment

Overall both groups demonstrated improvements on the outcome measures over the first six weeks of treatment. The results demonstrated that the Primary Care group responded more quickly to treatment than the Secondary Care group. This was measured by change in scores on the three outcome measures over the course of the first six sessions, in which the Primary Care participants showed a more rapid reduction. The Primary Care group also demonstrated a significantly greater percentage of change

in their scores on the three outcome measures between assessment and session six. In addition, the total number of sessions attended by participants was smaller in the Primary Care group than the Secondary Care group.

Although the results show significant differences between the rates of recovery between the two groups, it is not entirely clear what factors contributed to the difference. The clinical data recorded at assessment suggests no significant differences between the two groups, but it is possible that subtle or unrecorded differences existed between the two groups at baseline, which might have impacted on the patients response to treatment, e.g. personality factors, motivation levels, stage of illness. As discussed earlier, it has been suggested that a psychologist based within the primary care setting could result in more appropriate referrals being made. This could be due to an increase in psychological awareness of the GP and more familiarity with the work of the individual psychologist. Also it is possible that basing the psychologist within the GP practice makes the service seem more personal to the GP, and therefore increases the GPs desire to use the service efficiently. These factors could lead to subtle differences in the nature of the referrals, which may not have been apparent from the baseline measures applied in this research. However even if the differences in response to treatment were due to referral factors, this would suggest that integrating psychology services in primary care results in a more effective use of resources.

One possible explanation for the difference in response to treatment could be the meaning of the setting for the patient. There has been much work on the psychosocial aspects of health behaviour and one widely documented and researched proposal is the Health Belief Model (e.g. Becker and Maiman 1975, Becker et al. 1977). This model attempts to explain illness behaviour and compliance by focusing on the social and

cognitive factors which contribute to the individual's behaviour and actions. It suggests that there are a number of factors which influence a person's compliance with health recommendations and treatment. It places an emphasis on the person's perception and the role of cognitions in generating their health behaviours. Drawing from this model, it is possible that when an individual is referred for psychological treatment the setting in which the treatment will be received could have certain meanings and implications for that individual. The person will have preconceived beliefs or expectations about the setting that will be a product of personal experiences, knowledge and social norms. It is suggested that when referred to a psychologist in primary care, the patient interprets this differently than when referred to secondary care and this perception could affect the client's response to treatment.

A primary care referral is likely to imply to the patient that his/her problems are more common or less severe than if referred to the hospital. The primary care setting could have a normalising effect for the patient, whilst a referral to the psychiatric hospital may imply that they are more unwell. It is possible that the client's perception of their problems could affect treatment in a number of ways, e.g. perception of symptoms, treatment expectancies. This was implied in some of the participants' responses to the Service Setting Evaluation Questionnaire, with a number of participants from the Primary Care group stating that had they been referred to the hospital, they would have associated this with more serious problems. This is a tentative hypothesis and further research would be required to investigate the beliefs associated with the two settings, prior to attending treatment. It would then also need to be established if and how these beliefs were connected with patient adherence or response to treatment. The Health Belief Model has attracted criticism and one of the problems is difficulty with empirical investigation of the model (Prokop and Bradley 1981).

An alternative explanation for the differences in rate of change could be the role of therapist factors, influenced by the different working models of the two treatment settings. Present in all NHS services, but perhaps most apparent in primary care is pressure on resources. GPs usually have very full clinics, seeing large numbers of patients, with average consultation times lasting less than 10 minutes (Scott and Freeman 1992). This culture can also create stresses for the mental health worker, one of which is the frequent expectation to provide short term psychological treatment (e.g. Davy 1999, House 1995). In principle, primary care psychology services work with mild to moderate psychological problems, with the more severe and longer term problems being referred on to secondary care. This working model should enable the primary care psychologist to keep the treatment time limited, typically 6 sessions. However as seen from the results of this study and others (e.g. Brown et al. 1988, Hemmings 1997), primary care services are frequently seeing complex cases but are perhaps still expected to work within a short term framework.

The time limitations could have various possible affects on the course of treatment. From the therapist's perspective it may result in an earlier introduction of interventions or higher levels of therapist directiveness. Or the client might be encouraged to engage in higher levels of self-help or homework outside of the sessions. It has also been suggested that if the client knows that their therapy is short term, they will make a more conscientious effort to make the most of the time (Hudson-Allez 1997). Therefore the time limited nature of primary care work may influence the therapists' and the clients' pacing of treatment, which could produce more rapid improvement.

Typically CBT is time limited, but in this research the average number of sessions attended by clients in Primary Care was significantly fewer than in Secondary Care. This could mean that by week 6 the patients in Secondary Care were at a different stage of treatment than the Primary Care. Often in CBT the first four sessions will be used to develop a case conceptualisation and socialisation (Wells 1997). If the therapist is working within a shorter term framework, as is usually the case in primary care, the work would need to be more concise and focused. This would mean that by session six in Primary Care the therapist and client should be at the ending stages of treatment, e.g. working on consolidating the CBT interventions covered and relapse prevention. While in Secondary Care at sessions 6 they may be still be in the earlier stages of treatment, e.g. working on identifying negative thoughts or early stages of exposure exercises. This possible difference in stage of treatment would certainly affect the clients' scores on the outcome measures used. But this also raises questions as to the efficacy of working in a sorter timescale than recommended by the theoretical model.

Dropout Rates

The dropout rate in Primary Care was 39% compared to 23% in the Secondary Care group. Although this difference between the groups is not statistically significant, the size of the difference may have clinical implications. There are a number of long term and short term consequences of dropping out of treatment for patients. These include; a decreased likelihood of the patients' immediate condition improving (Sue 1977), an increased likelihood that their problems will become chronic or affect other areas of their life (Baekeland and Lundwall 1975) and patients are less likely to be re-referred for treatment subsequent to an earlier dropout (Organista et al. 1994). Dropouts also have consequences for the service, placing extra demands on the service, possibly increasing waiting times and the cost of service provision (Larsen et al. 1983).

Meta-analysis have found dropout rates of 47% for attendance at outpatient mental health referrals (Wierzbicki and Pekarik 1981), which implies that the rates in this trial were below average. It is very difficult to interpret the reasons for patient dropout, they could suggest evidence of effective treatment or could indicate poor service delivery. Major differences have been found in drop-out rates in different settings. RCT tend to have rates of about 8%, specialist clinics a rate of 17% and psychotherapy offered in mental health centres between 30-60% (Hunt and Andrews 1992). The results from this study would also suggest that a service set in secondary care is likely to have lower rates of patient dropout than a similar service offered in primary care. This difference in attendance has implications for both the service users and the service providers.

GP-Psychologist agreement

Contrary to the hypothesis the rate of psychologist-GP agreement was higher in the Secondary Care group than in the Primary Care group (59% and 45% respectively), although this difference between the groups was not statistically significant. This implies that the psychologists working within primary care did not have an effect on the diagnostic skills of the GPs with whom they were working.

There are methodological limitations, which need to be considered in view of this result. Firstly the patients' description of the problem was not examined. It was assumed to be likely that the psychologists' description of the main presenting problem would be similar to that of the patient, as a main aspect of CBT is to gain a joint conceptualisation of the problem. However recent research by Gabby et al. (2003) examining the effects of patient–practitioner agreement of problem formation only found an agreement rate of 23% between the patients and psychotherapists. The therapists participating were CBT

orientated clinical psychologist and non-directive counsellors, they noted that the psychologists had a significantly higher rate of practitioner-patient agreement than the counsellors, however they failed to give the rates of agreement for the two professions separately. Another methodological limitation is that, as discussed earlier, the psychologist description of the presenting problem was not independently rated.

It should also be noted that the results were taken from three psychologists working across six GP practices. The amount of and type of psychologist-GP contact in each of the practices is likely to be quite varied and this was not considered in the analysis of the data.

Overall the result implies that having a psychologist working within the practice did not lead to an increase in the referring GPs' psychological awareness. The literature around primary care mental heath services frequently refers to a number of assumed indirect effects and benefits of the service, however this research and the earlier work by Bower and Sibbald (2000) questions the validity of these assumptions and highlights the need for more comprehensive research in this area.

Consumer Satisfaction

Overall the participants from both groups responded with high levels of satisfaction with the psychology service they received. As seen earlier this is a frequent outcome when evaluating health care services (Linn 1975, Williams and Calnan 1991). In comparing the levels of satisfaction between the Primary Care group and the Secondary Care group, the Primary Care group responded with significantly higher levels of satisfaction, as measured by the CSQ-8 (effect size of 0.14). This supports the

hypothesis that psychology services offered within primary care settings are more appealing to patients. As noted earlier high levels of satisfaction do not necessarily mean that any clinical improvements are made. But if patients feel satisfied with the services that they are receiving this is likely to help increase patient attrition and compliance with treatment (Becker and Maiman 1975). This difference in participants' level of satisfaction is also important considering the increase in focus of Government policies on creating a more consumer focused NHS (e.g. DoH 2001b).

Further analysis of the responses showed that two items on the CSQ-8 were rated significantly more highly by the Primary Care group than by the Secondary Care group. The two items that demonstrated more variance in levels of satisfaction were more specific or behavioural in nature. The first was Question 4 "If a friend were in need of similar help, would you recommend our program to him or her?". The Primary Care group rating this item more positively could be seen to suggest a lower level of stigma attached to the service for this group. The second item rated more highly by the Primary Care group was Question 8: "If you were to seek help again, would you come back to our program?". This also offers support to the suggestion that services provided in primary care are more acceptable to patients. Furthermore the fact that patients feel happy to return to the service has positive preventative implications. This may lead to the patient requesting treatment at an earlier stage, should they experience psychological problems in the future and an earlier intervention may lead to a better outcome. Yet it could be possible that this question was a little ambiguous given the context of the research. In the Primary Care group it may have been a little unclear whether the question was referring to the psychology service or the primary care team, which would have implications for how the participants might respond.

A possible alternative explanation for the difference in levels of satisfaction could be that the Primary Care responders are more likely to provide "grateful testimonials". A challenge in measuring levels of satisfaction is the tendency for participants to frequently answer positively, which could be due to a desire or perceived obligation to provide "grateful testimonials" (Nguyen et al. 1983). If this was an operational factor, it is likely to be more powerful in the Primary Care group. These participants may perceive the psychologist as a part of the PHCT, which will be responsible for providing on-going care for their physical and psychological well-being, and this may make it more difficult for the patient to be critical of the service.

4.4 Service Setting Evaluation Questionnaire

It was unclear from the CSQ-8 what specifically might have resulted in the higher levels of satisfaction in the primary care services and what factors might have contributed to the differences in response to treatment. The Service Setting Evaluation Questionnaire was an attempt to try to begin to further understand these differences. The response rate to the questionnaire was low (41%) and therefore there are limitations to the conclusions that can be drawn from it. The main purpose of the Questionnaire was to begin to identify the qualitative aspects of the two settings, which might have contributed to the difference in the participants' responses. Overall the participants from both groups were mainly positive in how they answered the questions, even when invited to offer displeasure only a small proportion of participants did so.

There were a number of differences in the responses of the two groups. Firstly, the Primary Care group frequently referred to the familiarity of the setting as a helpful

aspect of treatment setting. Secondly the primary care setting was associated with lower levels of stigma or embarrassment for the participants. Both of these factors imply that patients could find it easier or more acceptable to attend treatment provided in primary care. Thirdly, the Secondary Care seemed to associate their setting with higher levels of treatment efficacy. Finally and perhaps most relevant, is the finding that nearly half of the Primary Care group stated that they would have been less likely to attend if the same treatment had been offered in a secondary care setting.

Although there were no major differences in the participants' perception of their GP's attitude to the service, the Primary Care participants felt that they received more information about psychological treatment from their GP than the Secondary Care group. Although the earlier results implied that the primary care psychologists did not have an impact on the diagnostic skills of their fellow GPs, these findings suggest that the psychologist working in the practice increased the GPs knowledge of psychological treatments and their skills in communicating with patients. This may be an important variance as providing patients with adequate information before referral is thought to help increase treatment attendance (Shepperd et al.1999).

These results support the suggestion that primary care is more accessible to the participants, for a number of reasons. The result that patients would be less likely to attend treatment in secondary care has important implications for the structure of mental health services. Firstly from a service perspective the secondary care service may have increased levels of non-attendance. More important are the implications for patients, as not attending treatment could result in the development of longer term, more debilitating problems.

There are limitations to the representativeness of the sample. Firstly due to the low response rate and secondly as the sample only included the patients who had attended the psychology service. It is likely that the non-responders and also patients who were referred but never attended the service would have very different attitudes towards the service. If these patients had been included it is likely that they could greatly change the results and possible conclusions. Further research could aim to more effectively target non-attenders and dropouts to help provide greater understanding of their attitudes with the aim of increasing services accessibility.

4.5 Limitations

One important limitation of the research is that there was no examination of the long term outcome of clients. The main focus of the research was to examine differences in the rate of recovery in the short term, and longer follow term was beyond the scope of this project. It is acknowledged that longer term follow up of patient progress in the two settings is essential before definite conclusions can be made. However recent encouraging research has found that rapid gains occurring in the early stages of psychological treatment are correlated with improved long term outcome (Tang and DeRubies 1999, Stiles et al. 2003).

Another limitation is the representativeness of the sample, as not all participants who were invited to participate agreed to do so. The non-participants may have varied on a number of factors e.g. levels of motivation, treatment compliance, and severity of symptoms and some of these factors may also affect treatment outcome. There is no available data to compare the non-participants and participants. In future research it

may be helpful to record baseline data of non-participants (e.g. demographic, psychological symptoms at assessment) to investigate differences between the two groups.

A common strategy, which was deliberately not used in this study, is to use specific sub-groups of patients defined as having particular problems. This was contradictory to the methodological rationale of examining treatment in real practice. Also as seen in the epidemiology section primary care is the point of access for patients with a wide range of presenting problems, therefore it seemed important to evaluate the effectiveness of integrated mental health service in the treatment of the variety of presenting problems seen in routine practice.

Although the quasi-experimental design helped to increase the external validity of the study, there are still some limitations to the generalisability of the findings. The results are drawn from psychologists providing CBT treatment in six different primary care settings and one secondary care setting. As seen earlier primary care has a wide variety of attached mental health workers, and the results from this study can not be automatically generalised to the other professionals or orientations. The nature of the setting is a major challenge that exists in performing comprehensive evaluations of primary care mental health services. The variety of mental health professionals, the heterogeneity of the sample population and the working conditions of the primary care environment, are all significant factors that provide challenges in performing effective evaluations. Also when considering the generalisability of the results it should be noted that the primary care psychology service from which the data was taken, is well established with much previous efforts being made by the psychologists and practices

involved in developing an integrated service. This may not be the case with all primary care psychology services.

The lack of a no-treatment control also places some limits on the conclusions. Although the main focus was comparing CBT treatment provided in two different settings, it is uncertain how patients would have progressed without any treatment intervention. There has been much contention over rates of spontaneous remission (e.g. Roth and Fonagy 1996), but a range of 30-40% has been suggested (Lambert 1976). However it has also been found that that 70% of patients presenting to their GP with depression or anxiety are still affected 12 months later (Weich et al. 1997). Also in a larger follow up study, Lloyd et al. (1996) found that 50% of patients who initially presenting with non-psychotic psychological problems in primary care, were suffering from chronic problems at an 11 years follow up. This would imply a low rate of spontaneous remission within this sample population and again highlights the need for effective detection and management of mental health problems within primary care.

4.6 Implications for practice

Overall it seems that integrated mental health services have a lot to offer patients and primary care teams. The results suggest that psychology services integrated in primary care is a more effective method of service provision than the more traditional hospital based service. Many authors have commented on the development of effective primary care services, with different suggestions being made for service provision (e.g. Dowrick 1992, Corney 1998, Kates et al. 2001). One of the important features in the integration of services is careful consultation with the practice staff in the development of protocols

and procedures for the effective use of the services. This could include work on the effective detection of psychological disorders and suitability of referrals. It could also include examination of the psychological needs of the individual surgery, e.g. the specific needs of the practice population, increasing the psychological skills of the primary care team.

There can be a tendency for mental health workers in primary care to work independently, without much contact with the other team members (Corney 1998). One of the main advantages to primary care is the increased possibility for interprofessional collaboration. This can include providing feedback on appropriateness of referrals, increasing GP's proficiency in detecting mental health problems and increasing GPs skills in managing psychological problems. Obviously individual patient care is foremost, but there is potential for the mental health worker to have a more varied role within the team. An effectively integrated primary care service has the potential to produce a number of indirect benefits. It could lead to higher levels of detection and more effective management of mental health problems. This in turn could help reduce the patient demands on GPs' time. Although the effects on the number of referrals made to secondary care services is not clear, it is possible that integrated primary care services could lead to more appropriate use of secondary or specialist services. But as noted earlier, further research is needed before making definite conclusions about the possible indirect benefits or effects.

Although the numbers of mental health professionals in primary care is increasing, as seen earlier, currently not all practices have linked mental health workers. These differences could be due to a variety of factors, e.g. lack of interest, lack of resources. But this has important implications for equity of services. This may be especially

relevant if future resources are focused on increasing primary care service, as this could mean that the practices, which do not have mental health links, might have problems accessing appropriate psychological services.

It has been suggested that increasing mental health services in primary care could lead to a more fragmented service than can be provided by multidisciplinary teams within the community. As the results of this and earlier research have shown, the referrals in primary care are often of a similar clinical presentation to those seen in secondary care. This may have implications for patients and for the workers within primary care. It is suggested that emphasis also needs to be placed on building co-operation and liaison between primary care mental health workers and secondary services to ensure the most appropriate management of patients' care.

4.7 Conclusions

The research aimed to investigate differences in client response to psychological treatments based in primary care and secondary care. The main finding was that participants receiving CBT treatment in primary care made improvements more quickly than participants with similar psychological presentation receiving treatment in a secondary care setting. There were significant differences in the rate of reduction in levels of psychological distress, with primary care treatment providing a more rapid response than in secondary care. The treatment received in primary care was also briefer than in secondary. It is unclear at this stage exactly which factors contributed to this difference, but possibilities include; difference in therapist working model,

difference in patient beliefs around their problem and the treatment or difference in nature of referrals.

Another important result was that the participants seen in primary care were significantly more satisfied with the service they received when compared to the secondary care participants. Further exploration of the contextual differences between the two settings, revealed that primary care was associated with less stigma and greater accessibility. There are preliminary indications that clients are more likely to attend psychological treatment when it is offered in a primary care setting as opposed to a hospital setting.

Changes in NHS structures have placed an emphasis on increasing the provision of mental health services in primary care. This research offers support to this principle, in terms of clinical outcome, consumer satisfaction and efficient use of resources. Although further research is needed to examine the longer term outcomes, this research implies that primary care has a vital role in the management of mental health problems.

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Section C

Case Study

Chapter 5: CBT treatment for adolescent gambling

5.1 Abstract

The client presentation describes the application of cognitive behavioural treatment for problem gambling within a school setting. The client presented is a male adolescent seen within his school environment for help with problem gambling. The client is presented as the work is an informative example of the how contextual factors can significantly impact on the course of treatment. Firstly it reflects on the issues around adapting a theoretical model when working with young people in general. Secondly it addresses more specifically the challenges inherent to working with young people within the school setting. This client was particularly interesting as along with the common challenges of engaging young people within the school setting, the environment also contained a number of factors which were central to the development and maintenance of the presenting problem, which confounded the course of treatment. These issues are addressed along with a description of the assessment and treatment plan, followed by the application of cognitive behavioural interventions and client's progress. The implications of working with young people and within a school setting are also discussed.

5.2 Setting and Referral

The counselling took place in a voluntary sector organisation that provides a counselling service for young people aged between 13 and 18. The service was funded by Social Services and the Local Health Authority and staff consisted of counsellors and counselling psychologists along with trainee counsellors on placements. An external Chartered Counselling Psychologist provided supervision. The organisation aimed to target young people who are less likely to access other child and adolescent mental health services, this includes; clients from ethnic minorities, clients from deprived backgrounds and gay and lesbian clients. Counsellors also work on site within a number of local secondary schools, with the aim of increasing the accessibility of the service.

Along with self referrals, clients are referred from a wide range of organisations, e.g. social services, education welfare, schools and police. Clients present with a wide variety of psychological problems, common presenting problems include anxiety, mood disorders, drug use, school difficulties, family difficulties and abuse.

The client reported was seen in one of the secondary schools with which the organisation had a working partnership. It was a mixed comprehensive school in an East London borough with a large proportion of students from diverse ethnic backgrounds. Referrals were usually received from the Deputy Head Teacher, who would discuss counselling with the students prior to referral. Charlie[1] was referred because he was frequently gambling in school. He had been caught and disciplined by

teachers on a number of occasions and the teacher felt that Charlie had become addicted to gambling. She also

explained that Charlie was generally a good student, who had no significant previous problems in school. The aim is to arrange appointments within two weeks of receiving the referral and students are informed of the appointment time at morning registration.

Biographical Details

Charlie is a thirteen year old young man. He identifies himself as Black British, with his family being of Caribbean origin. He lives with his mother, an older sister and brother and two younger brothers. There is currently no father figure in the family home and Charlie reported that he has never known his biological father. He described his family as very close, and that he had a strong relationship with his mother. It was his second year in the school and he reported that academically he is usually an above average student.

5.3 Theoretical Orientation

The theoretical approach used with this client was Cognitive Behavioural Therapy, largely based on a treatment model for problem gambling (Sharpe and Tarrier 1993). This orientation was chosen for a number of reasons; firstly Charlie presented with the specific problem of gambling which the effectiveness of CBT has been demonstrated (Ladoucer et al 2001, Sylvain, Ladoucer & Boisvert 1997, Echeburua et al 1996). Secondly meta-analysis of psychological treatments for young people have consistently shown behavioural interventions to have larger effect sizes than non-behavioural

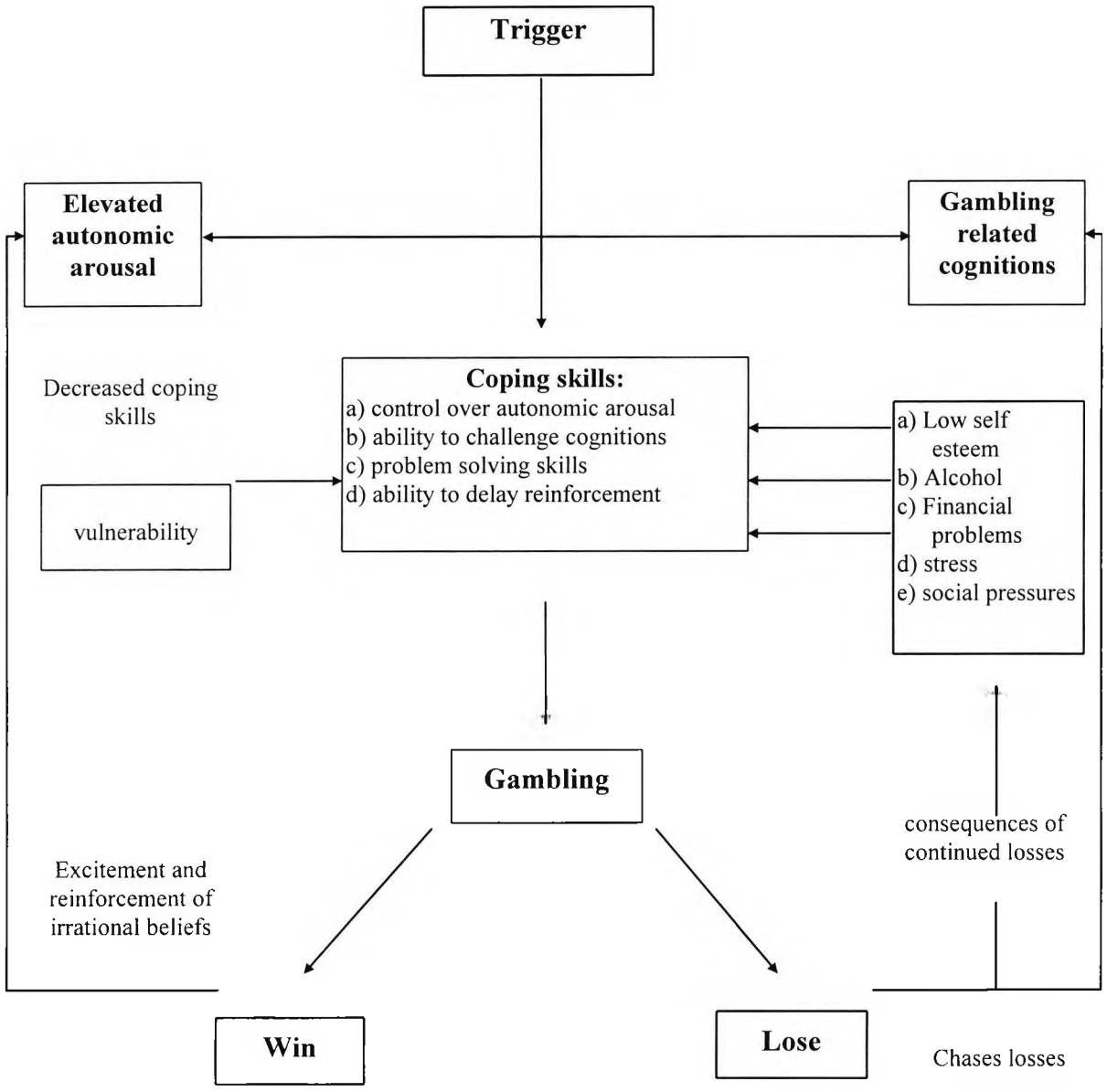
[1] To ensure client confidentiality all names and identifying information has been changed

interventions (Roth and Fonagy 1996). Thirdly CBT, compared to other therapies, more readily views the client as an equal partner working collaboratively (Gelfand and Hartmann 1984), which was considered important regarding the content of the therapy (see below).

Sharpe and Tarrier (1993) describe a cyclic cognitive behavioural model for the development and maintenance of problem gambling, see Figure 5.1. It describes gambling as being triggered by external or internal stimuli, for example walking past a betting shop or by cognitions such as "I feel lucky today". This trigger then affects the person's autonomic arousal and/or their gambling related cognitions. This means that the person will feel physically more excited or aroused and will also access gambling related cognitions e.g. "This is my lucky betting shop", "I am due a win". Depending on the strength of person's coping techniques s/he will or will not go on to gamble. If the coping techniques are weak gambling is more likely to occur which will result in either a win or a loss. If the gambler wins, the win will cause further excitement and physical arousal and will also reinforce the gambling related cognitions e.g. "I knew I was feeling lucky" or "Yes this is indeed my lucky betting shop". The increase in autonomic arousal and reinforcement of gambling related cognitions will feed back into the cycle decreasing the gambler's coping skills.

However, if the gambler loses, this may also negatively impact on his/her coping skills. After a loss, gamblers tend to "Chase Losses" (Leopard 1978), gamblers learn to expect losses so they conceptualise these losses by developing maladaptive cognitions in relation to randomness, e.g. they tend to believe that if they have lost they are then more likely to win the next time. These distorted cognitions reinforce the gambling related behaviour and have a negative impact on the person's coping skills.

Fig. 5.1. A CBT model of the development and maintenance of problem gambling Sharpe and Tarrier (1993).



Once gambling behaviour has been established there may be further consequences of continued losses e.g. alcohol difficulties, financial problems, stress and social pressures from peers to continue gambling, family pressure to stop gambling. These consequences can adversely impact on the already weakened coping skills making it more difficult for the gambler to break out of the cycle of gambling behaviour. Once

the urge to gamble is triggered the likelihood of gambling is dictated by the availability of the individual's coping skills. The main coping skills include; control over autonomic arousal, ability to challenge cognitions, problem solving skills and ability to delay reinforcement. The strength or weakness of the coping skills determines the likelihood of gambling once a trigger is encountered and also may determine whether the gambling behaviour is likely to escalate into a problem.

Treatment Techniques

Sharpe and Tarrier suggest that treatment should be individualised, encapsulating the client's individual experience of gambling as applied to the model. The main focus of treatment should be the development of coping skills. This includes firstly, educating and challenging gambling related cognitions, e.g. educating the individual about randomness, developing realistic cognitions about the probabilities of winning and addressing and challenging the client's idiosyncratic gambling related cognitions. Secondly treatment should include developing problem solving skills, e.g. control over spending, budgeting, alternative activities. Also important is social skills training (Sylvain et al 1997), including assertive techniques in saying 'no' in gambling situations.

Contextual Factors

There were two significant contextual factors which impacted on the course of therapy: Charlie as a young person and the school setting. Christensen (2000, 2002) proposes the importance of considering the context of treatment as a factor in predicting client adherence and progress, with Charlie these two contextual factors played an important role in both his engagement and progress of treatment.

Adapting CBT to working with Young People

With Charlie a CBT approach which allowed the therapist and client to work collaboratively and actively towards agreed goals was employed. However this model was adapted in consideration of Charlie's age. When working with young people some cognitive techniques may appear too technical or abstract (Ronen 1998), therefore care was taken to explain interventions and techniques in a way that was clear and sensible to Charlie, using language similar to the client's vocabulary (Ronen 1992, Knell 1993). Also the therapist frequently checked the client's comprehension of any concepts, feedback and homework assignments.

Although the therapeutic relationship is a crucial factor for any effective CBT (Burns & Auerbach 1996) when working with adolescents the therapeutic style is of vital importance (Thompson Prout 1998). Therapist genuineness with a spontaneous, conversational approach to help engage the client is suggested, with a strong emphasis on accepting and validating the client. Extra flexibility and creativity is also useful e.g. using humour, being aware of current fads (Ribner 2000). These suggestions were particularly important at the beginning stages to help Charlie engage, but care was taken to work on maintaining a strong therapeutic relationship through out treatment.

Working within the School Setting

The school setting was also an important factor impacting on the therapy, firstly in client engagement and secondly as a factor maintaining the problem behaviour. As discussed earlier emphasis was placed on building a therapeutic relationship with Charlie, however the therapist was also aware that school setting could possibly negatively impact on the development of the relationship. Firstly, as Charlie had been referred by

a teacher rather than being a self referral, at assessment it was essential to gather information about Charlie's thoughts about the problem and his referral to counselling (Kendall 2000). Charlie seemed to be quite open and receptive to receiving help, however the therapist still clearly emphasised to Charlie that attending counselling was his choice and that he had control over the treatment (Bond 1998).

All effective CBT is collaborative, but considering the school context of the therapy, it was seen as especially important to build a collaborative therapeutic relationship, avoiding the therapist seen perceived as an "expert" or "teacher". This was achieved by the therapist taking a stance or style as described by Kendall (2000) as "Coaching", which involves helping the client makes sense of their experience and providing them with opportunities to learn from previous and new experiences. Also the role of the psychologist was explicitly clarified, in particular issues concerning confidentiality and the position of the psychologist as separate to the school.

The school context also contained elements which significantly contributed to the development and maintenance of Charlie's problem gambling. These factors also negatively impacted on the progress of treatment and are discussed in more detail in a later section.

5.4 Assessment

During the assessment session Charlie presented neatly dressed in school uniform, he appeared to be a little tense but was quite open and talkative. Firstly the psychologist introduced herself and explained a little about what counselling entailed and what the

first session would involve. The assessment, took place over two sessions, using the Kirk's (1989) guidelines for CBT assessments, examining the description and development of the problem, its maintaining factors and Charlie's beliefs about the problem behaviour. Charlie openly admitted that he had a problem with gambling; for approximately 6 months he had been gambling for money within school. Charlie stated that he began gambling mainly because some of his friends suggested it. When it first began Charlie mainly gambled with a few friends, however with time he was gambling more frequent and with a wider variety of other students. Charlie admitted that for the last two months he was gambling every day in school; during every break time, between lessons and occasionally during lessons. He would gamble with pocket money, lunch money and frequently borrowed money from friends. The gambling usually involved dice or marble games. Teachers had caught Charlie a number of occasions which had resulted in him being sent home from school, also he had being excluded from school on four occasions as discipline for his gambling.

Although CBT with adults is usually largely problem focused, when working with young people it can be useful to change the emphasis at times and focus on more positive or light-hearted topics (Kendall 2000). Therefore some time was spent discussing Charlie's interests and pastimes. Also the Psychologist tried to guide the dialogue to talk about what Charlie was good at (e.g. basket ball, hanging out, playing gambling games) to try focus on his strengths and resources (Durrant 1995).

During the assessment it became apparent that most of the adults involved in Charlie's life saw gambling as a problem and they had made their disapproval explicit to Charlie. Often different parties involved, e.g. schools, parents, client, can have different beliefs about problem behaviour (Upton 1998), so the psychologist made an effort to remain

neutral, not condoning gambling but allowing Charlie time and space to explore his own thoughts and feelings about it. Charlie admitted that the gambling was having a number of adverse effects. It was causing problems with his teachers, his mother and he realised that it had begun to affect his schoolwork. Charlie's gambling had also become a major part of his social life outside of school. He realised that he could not continue to gamble within school, mainly due to the fact that it was getting him into trouble. But Charlie was not yet prepared to stop gambling outside of school. Using Sharpe and Tarrier's model of problem gambling information relevant to Charlie's experience of gambling was gathered to help formulate an understanding of his individualised experience of gambling, on which to base treatment interventions (see Figure 5.2). Also during the assessment session confidentiality and child protection policies were discussed with Charlie.

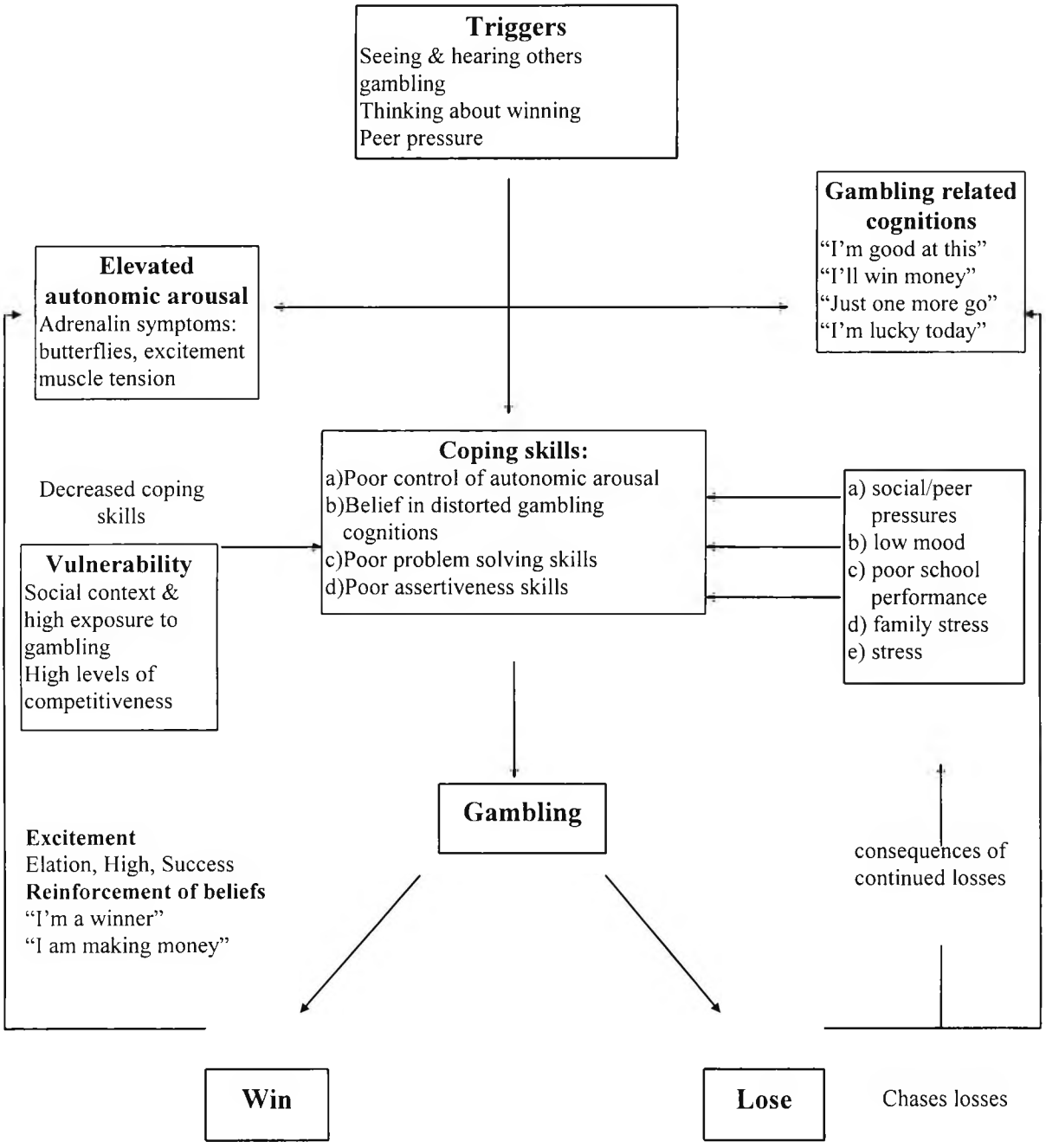
Competency

Before working with young people under the age of sixteen it is essential to assess if they are competent to consent to treatment without parental consent. The organisation takes a child centred approach and will aim to work solely with the child unless s/he wishes to include his/her parents or if the young person presents with a mental health problem which may require the intervention of other professionals. However, it is encouraged that the child informs their parents that they are attending counselling if this seems to be at all appropriate. In order for the young person to consent to counselling s/he must be assessed as competent to do so using the Gillick ruling (see Hamilton and Hopegood 1996).

During the assessment session Charlie appeared to be social and intellectually well developed. He had a good understanding of and insight into his problem behaviour and

was aware of the possible consequences of his behaviour. He demonstrated an understanding of counselling and what it would involve and appeared to be willing to engage. He was assessed as competent and written informed consent was received. Charlie decided to inform his mother about the counselling. As she already knew that he was gambling at school, Charlie felt that telling his mother about counselling would help show her that he was actively trying to address the problem.

Fig. 5.2. Formulation of Charlie's problem gambling using Sharpe and Tarrier's (1993) model.



Contract and Goals

Beck (1993) suggests that goals must be established mutually to enhance the therapeutic alliance and collaboration. When working with young people it is especially important to give them a sense of active participation and control to help facilitate a sense of collaboration for the young person. Charlie's main goal was to stop gambling during school. He did not define gambling itself to be a problem but rather the negative consequences of gambling in school. The psychologist was aware of the possible addictive nature of gambling so time was spent exploring his belief that he would be able to successfully stop gambling during school hours whilst continuing to gamble outside of school. At assessment Charlie believed that this was a realistic expectation. Thompson Prout (1998) stress that to engage young people it is essential to initially negotiate goals that fit with the young person's expectations and needs, even if they are not in total agreement with the therapists and/or the referrers aims. This is consistent with the CBT emphasis on mutually establishing goals and was also considered important as Charlie was not a self-referral. Therefore it was agreed that the initial goal was to help Charlie stop gambling in school. This goal was further broken down into smaller, more concrete steps that could be more easily achieved, to help increase the likelihood of client progress (Beck et al 1993, 1995). It was agreed that Charlie would begin by working on stopping gambling during lessons, then to work on stopping gambling between lessons and thirdly to try stop gambling during break times. This hierarchy worked towards Charlie gradually not gambling at all within school.

Beginning stages of any CBT treatment should include appropriate psychoeducation and socialisation into the model (Beck 1995). A preliminary treatment plan based on Sharpe

and Tarrier's (1993) model was described to Charlie, explaining that counselling would involve looking at and changing Charlie's thoughts and behaviours associated with gambling. It was explained that it would involve homework and trying out exercises outside of our sessions. Charlie acknowledged that he would like to work on reducing his gambling and seemed receptive to receiving counselling. We agreed to initially meet for six sessions, with the possibility of further sessions if necessary.

5.5 Content and Process of the Sessions

Motivational Work

At the start of treatment Charlie's main social activity was gambling. It was an activity that Charlie greatly enjoyed, providing him with a lot of excitement, social contact and the belief that he obtained monetary gains. Sharp (1998) comment on the importance of client motivation and cooperation. Therefore the beginning stage of therapy focused on motivational work, drawing from the literature on CBT treatment of addictive disorders (e.g. Beck et al 1993, Prochaska and DiClemente 1983). Charlie acknowledged that he would find it difficult to stop gambling and therefore we explored how it might be beneficial to spend time clarifying his reasons for stopping with the aim of increasing his motivation.

Miller (1983) developed the technique of motivational interviewing, similar to Beck's Advantages and Disadvantages Analysis (see Beck et al 1993), which aims to increase the person's awareness of the problem and its consequences with the aim of reinforcing the decision to change. This technique involves the use of guided discovery to gently help the client think about the advantages and disadvantages of the problem behaviour.

This process aimed to increase Charlie's awareness of the disadvantages of gambling, whilst also help him understand the factors which are maintaining the problem behaviour. Charlie's main advantages included; the positive affect associated with winning e.g. "feeling high" "being a winner", the excitement of playing, the money that he won and how he enjoyed the competitiveness of gambling. His disadvantages included; the negative affect associated with losing e.g. upset and angry, how he was getting into a lot of trouble at school, it was negatively effecting his school work, it caused trouble with his mother and he had often borrowed money from his school friends which he was aware could lead to stress and possible verbal or physical fights if he continued.

When exploring the advantages and disadvantages the focus was on the more immediate or short term gains and losses as this can help make therapy seem more useful or relevant for young people (Thompson Proutt 1998). This exercise made it apparent to Charlie that there were more disadvantages than advantages in continuing to gamble, however the advantages were clearly still very important to Charlie. This exercise highlighted to Charlie how powerful his desire to gamble was and he realised the main reason he continued to gamble was because of the strong urge he felt to participate in the excitement. Charlie began to admit that he felt out of control with his gambling and he believed that he might not be able to stop. This was a very important and honest, yet scary thing for Charlie to admit but it helped to increase his motivation, as he was angry that gambling had taken such a hold on him. At the end of the session the list of Charlie's disadvantages and advantages was written up for him to refer to when his motivation was low.

One of the identified advantages to Charlie's gambling was his belief that he made monetary gains. A behavioural experiment was designed to test the validity of this belief, which involved Charlie keeping a "Winning- Losing Diary" monitoring how much money he gained or lost at the end of each day. After one week this successfully demonstrated to Charlie that he lost significantly more frequently than he won. This homework exercise resulted in two important learning points for Charlie. Firstly it demonstrated that the belief was incorrect, as he had lost a lot more money than he had won. The dairy was therefore used as a basis to begin challenging Charlie's maladaptive cognitions and to educate him about randomness and the probabilities of winning, which has been found to be a key aspect of treatment (Ladoucer, et al 2001, Sharpe and Tarrier 1993). Secondly focusing on his losses helped to demonstrate to Charlie his negative feelings associated with losing, Charlie described that he felt "dumb" and "stupid" when he lost. Although Charlie still greatly enjoyed participating in gambling he realised that he lost and therefore felt "bad" more often than he won. It was agreed that Charlie would continue monitor his daily monetary gains and losses through out therapy to help refute his distorted cognitions about winning.

Another motivational intervention employed was "Outcome Psychodrama" (Moorey 1989). This involved Charlie considering his future and describing a detailed account of what may happen as a result of choosing to either continue or stop gambling. This intervention was chosen as Charlie had previously discussed the importance of his schoolwork and how this had been significantly adversely effected by his gambling. Charlie was usually an above average student and he appeared to be quite ambitious. This exercise was considered to be successful, as Charlie was able to envisage a two contrasting futures realising the possible longer term consequences of gambling.

Behavioural Interventions

Charlie reported that he found it very difficult to resist when he saw other students in groups gambling. Hearing the cheers and excitement of others would both raise his autonomic arousal levels and trigger his gambling related cognitions. As suggested by Sharpe and Tarrier (1993) treatment largely focused on building the client's coping skills to resist gambling. During sessions three and four we began to explore how Charlie could control his arousal along with challenging his cognitions. Firstly we explored the possibility of avoiding the other students gambling. This was exceptionally difficult as gambling was a serious problem through out the school. During break times there were students gambling in most parts of the school and Charlie reported that he would never be far from the groups and the triggers associated with gambling. An agreed starting point was for Charlie to not sit with his friends who gamble during lessons, which he felt would increase his confidence in his ability to stop gambling in lessons. However Charlie realised that time outside of lessons would be more difficult. Charlie did have a few friends who did not gamble, but he admitted that he found them more boring that the gambling friends. Although a little reluctant Charlie agreed that he would try to spend more time between lessons with them and away from other gamblers.

Social pressure has been demonstrated to be an important factor effecting the reduction of addictive behaviours (Cummings et al 1980) and it appeared that the school was providing a high level of peer pressure. The possibility that Charlie inform his friends about his decision to stop gambling was considered. Charlie acknowledged that it could be useful if they knew, but felt that his friends would not believe he was seriously trying to stop and would make fun of him rather than help him. A behavioural experiment was devised to try to test this negative assumption, which involved Charlie telling one

friend about his decision, to test the validity of his prediction. Charlie chose to tell one of his non-gambling friends, who although supportive unfortunately also stated that he thought Charlie would not be able to stop. This partial confirmed Charlie's negative belief, although the friend was supportive and agreed that it would be beneficial for Charlie to stop, it made Charlie reluctant to tell any other friends. This again emphasised the level of social pressure within the school context.

Also connected to the school context was the fact that Charlie had frequent exposure to other students gambling. Charlie described feeling a "rush" of anticipation and a feeling of "high" when expose to the other students gambling. Charlie also reported signs of physiological arousal: his heart would beat faster, he would feel tension in his body and excitement in his stomach. Physiological arousal is a much documented aspect of problem gambling (Blaszczynski et al 1987, Griffiths 1995) and Sharpe and Tarrier (1993) emphasise that gaining control over this physical arousal is a crucial coping skill. Therefore the importance of Charlie learning how to recognise and reduce the initial physical signs of anticipation and excitement was explained. Rapid relaxation techniques (Clarke 1989, Barlow & Cerny 1988) were introduced during the session and Charlie was encouraged to practise the exercises when not aroused to help familiarise himself with the techniques, which could then be applied in situations when his physical excitement was initiated. Also relaxation techniques could help by producing a time lag after the initial urge to gamble, during which the urge could subside naturally and/or Charlie would have the opportunity to employ his coping skills (Beck et al. 1993). During the session possible simple distraction techniques (Fennell 1989) were also discussed as a short-term method of helping Charlie cope with urges.

Charlie recognised that it would be more difficult for him to stop gambling if he did not have anything else with which to fill his time. This is accentuated by Sharpe's (1998) suggestion that of identifying the positive functions of gambling and finding more adaptive ways of achieving these. Using activity scheduling (Beck et al 1993), we planned activities which Charlie could participate in instead of gambling, suggests were based on Charlie's previous interests and activities. Charlie suggested that he could take up more sports, this was an area that he was very interested in previously and there were a lot of sport opportunities within school. This also had the potential benefit of provide Charlie with some competition and physical arousal. Charlie also acknowledged that it would be helpful to spend more time with non-gambling friends and to concentrate more on his schoolwork as exams were approaching. The activities served two purposes, firstly to provide Charlie with an immediate alternative to gambling when he felt an urge and secondly to help him develop longer term interests apart from gambling.

Cognitive Interventions

Charlie was developing good behavioural strategies to help cope with stopping but further work on the cognitive aspects of his gambling needed to be addressed. Research has shown the importance of people's erroneous beliefs when gambling (Ladouceur, et al 2001, Ladoucer, et al 1998, Sylvain et al 1997). Therefore a crucial part of Charlie's therapy was to recognise his gambling related cognitions and learn how to control and challenge these thoughts. Charlie recognised that he would often think about gambling almost to the exclusion of everything else, and these thoughts were usually associated with a high levels of excitement and anticipation. Firstly it was suggested that when Charlie began to think about gambling he could use the earlier motivational work to remind himself of his reasons for stopping and the disadvantages of gambling. To help

him focus, at school Charlie carried flashcards (Beck et al 1993) listing his most significant disadvantages.

Charlie also needed to identify his particular distorted cognitions related to gambling e.g. "I will be a winner", ""I am good at this". Charlie had been gathering evidence to challenge some of these thoughts through his "Winning-Losing Diary" which provided a very good foundation on which to begin educating Charlie about randomness and developing more realistic beliefs about the probability of winning.

Client Progress

By session four Charlie had stopped gambling in classes for nearly two weeks, which was a major achievement. It is important when positively reinforcing change to help the client acknowledge his/her strengths (George, Iverson and Ratner 1990), by ensuring that Charlie was clear as to how he had achieved this goal would hopefully help him to maintain the success and apply the skills to other areas. In class Charlie had avoided sitting with his gambling friends, he reminded himself of the disadvantages and concentrated on the content of his lessons to distract himself. Charlie was encouraged to think about how to apply the successful strategies to gambling between classes. Charlie was very pleased with his progress, he felt like a winner. This success and the associated positive affect improved Charlie's motivation and greatly increased his confidence in his ability to stop gambling outside of lessons.

Between sessions four and five Charlie had been caught gambling and was again excluded from school. When reporting this Charlie felt very ashamed that he had been caught and excluded. His form teacher informed him that he was now on his last chance and there was now a high possibility that he could be permanently excluded from school

if he was caught again. This was an opportunity for Charlie to look again at the longer-term consequences of gambling. The fear of being permanently excluded from school highlighted the possible consequences of gambling on his future education and his future career prospects. Looking at the negative consequences on this occasion was significantly more powerful than previously, as Charlie had high levels of associated negative affect. Charlie was upset and disappointed with himself but also felt angry that he had lost control of his gambling. The disappointment encouraged Charlie to decide to try stop gambling completely. To help him feel more in control and positive about his ability to change we focused again on how he had succeed stopping gambling in classes, identifying his strengths and his previously successful strategies.

In an attempt to use the context of the therapy more positively, the suggestion of picking a supportive teacher as a confidant as suggested by Sharp and Cowie (1998) was considered. Charlie felt that he had a good relationship with his form teacher, he generally found her to be understanding and supportive. It was suggested that Charlie could use her as "emergency" support if he was finding it difficult to control his gambling at school. As well as offering support to Charlie the psychologist hoped that this intervention could also function as a distraction technique, e.g. locating the teacher and spending time with her could behavioural distract Charlie from his gambling urges.

Between sessions five and six Charlie had been caught gambling once more and had again been excluded from school. Charlie had successfully gone four days without any gambling, on the beginning of the fifth day on the way to school he met one of his gambling friends, and as he was not yet in school thought it would be ok to gamble a little. However when he arrived at school he continued to gamble until a teacher discovered him. Charlie was very angry with himself, firstly for giving in to the urge to

gamble having successfully stopped for four days and secondly for starting to gamble in the first instance, without realising that it would lead to such negative consequences and difficulties in stopping.

There were two important interventions during this session, firstly the reinforcement of the successful four days stopping and secondly learning from the lapse. Charlie seemed to think that because he had given in and started to gamble again that he had failed and it was important to challenge this perception. Firstly the lapse was reframed as a learning experience, the situation was examined to look at how it happened and how Charlie could approach similar situations more prepared. There was another very important learning point for Charlie from this incident, as it had demonstrated to him the difficulty in stopping gambling once he had started. He realised that once he had given in to his urge and allowed himself to gamble, the physical and emotional arousal and thoughts connected to gambling were very powerful, making it very difficult for him to stop. It highlighted the importance of controlling his urges in the early stages, the more he gave into them the more difficult it was to change or to stop them. This also caused Charlie to decide to stop gambling completely, not just in the school environment.

Again Charlie was feeling very low about his lapse so it was also important to focus on Charlie's successes before his lapse, to identify and reinforce his strengths and successes.

Ending

By the seventh and final session Charlie had successfully managed to significantly reduce his gambling but not to stop it completely. He had not gambled within school

for over one week, but unfortunately was still gambling after school hours with friends from his neighbourhood. During this session the main focus was positive reinforcement of the success that Charlie had achieved and identifying the techniques that had helped him the most. Charlie had been avoiding his gambling friends and was developing other interests at school. He found distracting himself and reminding himself of the disadvantages very helpful in maintaining his change. Also his gambling related cognitions had changed. He now had more realistic expectations of randomness and realised that rather than winning he was more likely to lose and suffer the negative consequences.

Unfortunately as it was the end of the school term, further sessions could not be offered. However, Charlie was reasonable confident that he would be able to continue and build on his resources. Also Charlie had now realised that his gambling could not be limited to certain situations. Originally we agreed that we would work on reducing his gambling within school, but now Charlie was aware that if he continued to gamble outside of school he would continue to "feed his addiction". This demonstrated a major cognitive shift for Charlie, which was positively reflected back to him to help increase his confidence and motivation to continue change. He was prepared to try to cut down on his gambling outside of school during the summer holidays by applying the techniques that worked in school. It has been noted that young people receiving psychological treatments have continue to make considerable improvements after the end of treatment (e.g. Levitt 1957, Smith et al. 1980). Charlie was also given the option to re-attend counselling in the following school year if he wished.

Supervision

In our later sessions as Charlie was not progressing as much as he and the psychologist would have liked, Charlie's problems were presented in supervision. The sessions had provided Charlie with good strategies for helping him to stop gambling, although his gambling had significantly reduced, he was still occasionally finding it too difficult to resist the temptation in school and participated in gambling. During sessions the importance of avoiding triggers, such as other students gambling was discussed, however due to the extent of the problem within the school it was almost impossible for Charlie to avoid the other gamblers. The role of the social context of gambling was discussed and supervision highlighted the difficulties and limitations of working with a client who had consistent and virtually unavoidable exposure to gambling stimuli. This provided more realistic expectations of working with Charlie considering the school environment. Also the supervisor noted that as Charlie and the therapy were part of the school system, a system intervention could be useful. It was suggested that feedback could be provided to the referrer using Charlie's case to highlight the complexity of gambling problems with the possibility looking at alternative solutions within the school.

Consultation with the Referrer

Permission was received from Charlie to briefly discuss his progress with his referrer, the Deputy Head Teacher. The gambling problem within the school was discussed using guidelines from Dowling and Osborne (1994) and Durrant (1995) on consulting within schools. Psychological theory from Sharpe and Tarrier's (1993) model and the successes and difficulties from Charlie's case and were used to examine how to approach the problem.

The teacher acknowledged that gambling was currently a prevalent problem, which the school was having difficulties in tackling. When students were caught gambling the procedure was for the student to be sent home and if they persisted in gambling they would then be excluded from school. However, as it was currently a very popular activity within the school, it was impossible to enforce this procedure with every student, therefore the teachers were mainly focusing on the students who they perceived as having a problem with gambling. This was creating two problems, firstly it created a group of students who were being singled out and punished for gambling, seemingly unfairly. Secondly there were students who were not being punished in any way, and so continued to gamble within school perpetuating the problem. The following possible solutions were considered:

- To initially try to equally discipline all students who gambled, however it was acknowledged that persistent gamblers may require stricter rules.
- For discipline to include writing an essay on the consequences of gambling, with the aim of helping the students to realise possible negative consequences of their behaviour.
- Organise an assembly dedicated to gambling and its consequences, perhaps with an ex-gambler as an invited speaker.
- The possibility of organising a therapy or support group for persistent gamblers, there has been some success sown in this area (Griffiths & MacDonald, 1999, Echeburua et al 1996)

5.6 Conclusion and Evaluation

The application of Sharpe and Tarrier's (1993) model of problem gambling was successful in helping Charlie reduced his gambling within school. Unfortunately

because of time constraints the therapy was unable to continue to aid Charlie in applying his skills outside of school. However therapy had provided Charlie with a greater understanding of his problem behaviour and skills and techniques to help him to continue to make progress independently. Also the knowledge that he had successfully stopped gambling at school, had increased Charlie's motivation and self-confidence.

Not only had Charlie's behaviour changed but also his attitude towards his gambling. Charlie now realised the importance of stopping his gambling completely, he no longer perceived it as just a school based problem. Charlie was aware of the possible long term consequences of gambling and had acknowledged that he felt out of control of his behaviour. He realised the importance of stopping gambling completely and at discharge was motivated to do so. It was this change in his gambling related cognitions that would be crucial in helping Charlie maintain and further develop his success.

The context of the therapy was also a significant factor in guiding therapy. The school setting contained important factors which contributed to the maintenance of the problem behaviour. The CBT model had to be adapted to work effectively with these factors, along with being adapted to work with the features of Charlie's age and level of development. It would have been more beneficial to have initiated earlier collaboration with the school, approaching the problem within the entire system. This could have helped both Charlie individually in coping with his problem gambling but also could have been helpful by setting up a framework to aid the other students involved in gambling.

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Section D

Literature Review

Chapter 6: An investigation into the CBT treatment for school refusing behaviour

And then the whining schoolboy, with his satchel,
And shining morning face, creeping like a snail
Unwillingly to school.

-William Shakespeare (1598-1600)

6.1 Abstract

The aim of this review is to critically examine the literature surrounding the role of cognitive and behavioural principles in the treatment of school refusal, which highlights the lack of understanding around the effectiveness of current treatments. School refusal is a very complex problem which can have important long term consequences and is a growing area of concern within the educational and mental health services. The clinical presentation of the problem behaviour, its epidemiology and aetiology is introduced followed by an examination of classification and assessment issues. An overview of the CBT treatments is then provided, followed by a review of the research in to the effectiveness of the treatments. The findings provide some support for the CBT treatments, however there are important limitations to the conclusions, largely due to the heterogeneous nature of the presenting problem and the variety of CBT interventions investigated. The conclusions and implications for practice and research are discussed.

6.2 Introduction

Definition and clinical presentation

Although school is often associated with negative emotions, some children[1] experience excessive anxiety or emotional distress, which can result in an inability to attend school. School refusal, which is sometimes referred to as school phobia in the literature and the media, is a complex and heterogeneous problem behaviour. It is characterised by difficulties in attending school and emotional distress at the prospect of going to school, with the absence of antisocial behaviours (Berg, Nichols and Pritchard 1969). It is different from truancy, in that truancy the school avoidance is usually concealed from the parents and is associated with other problems such as antisocial behaviour, but not anxiety (Lee and Miltenberger 1996).

The child presenting with school refusal usually demonstrates anxiety or panic when s/he is expected to attend school. Physical symptoms can include muscular tension, breathing irregularities, changes in pallor and frequently the child will report illness, such as headaches and stomach aches, for which there is no organic cause (Berstein, Massie, Thuras and Perwien 1997). When children are forced to attend school often they will leave during the day and visits to the school nurse are frequent. The child's behaviour can include protests, whining and temper tantrums. School refusers will tend to stay in the secure environment of his/her home, in contrast to truancy where the child's absence from school is usually concealed from the significant adults.

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1 For ease of reading, the terms child or children shall be used to refer to all school age children and adolescents, when relevant ages shall be provided.

Epidemiology

There have been limited comprehensive studies on the epidemiology of school refusal, but they have produced very mixed reports on its prevalence, primarily due to the use of differing defining criteria (Last and Frances 1988). In the United States its prevalence has been estimated to be 5% (Kearney and Beasley 1994) while Olendick and Mayer (1984).found it to be 0.4% using more stringent criteria. More recent reviews have suggested a rate of 1% in all school aged children and 5% in clinic-referred children (King et al 2000).

The studies have shown that school refusal tends to be equal between genders (Kennedy 1965, McShane 2001), and occurs through out the school years but is most likely to appear between the ages of 5 to 6 years and 10 to 11 years (Olendick and Mayer 1984). In the United States, where this research was conducted, these ages coincide with entry into school and the transition from elementary to middle school. An Australian study also found a similar age patterns, with high prevalence rates occurring during the first and second year in high school (McShane 2001). This implies that changing school may be a significant contributory factor in the onset of school refusal. Last et al. (1987) found that younger children more frequently presented with school refusal comorbid with separation anxiety whilst school refusing adolescents more frequently presented with comorbid simple or social phobia. It appears to be spread evenly across intelligence levels and socio-economic groups (Berg 1992, Last and Strauss 1990).

Aetiology

It is acknowledged that other orientations (e.g. systemic and psychodynamic) are frequently employed in the treatment of school refusal, however the vast majority of the published research into school refusal and in particular its treatment has been from a broad social learning perspective, predominantly cognitive behavioural. Therefore, it is mainly this perspective that shall be represented in this review. From this theoretical stance school refusal is viewed as a complex set of learned responses that have specific affective, cognitive and behavioural elements (King et al. 1995).

Family and twin studies suggest that there is a possible biological predisposition (King et al. 1995), but also stressful life events at home or at school often coincide with the onset of the problem behaviour (Hersov 1960, Blagg, 1987). In a study of 50 cases of school refusal Hersov (1960) reported that the most common precipitating factor was a change to a new school, followed by an illness, operation or accident that led to the child spending a significant period of time at home. The death or departure of a parent, usually the mother was the third most frequent precipitating life event. Similar factors were found to be associated with onset by McShane (2001), but the most common factor was conflict at home which was present in 43% of cases. McShane also found that in 53% of cases there was a history of maternal psychiatric illness.

Following the initial cause, the anxiety reduction due to avoidance of school or the positive reinforcement of staying at home become important factors in the child continuing to refuse to attend school (Kearney and Silverman 1990). The child's perception and cognitions also seem to play an important role in development of the problem. Preliminary research suggests that school refusing children have low expectations of their coping skills and a

tendency to negatively interpret neutral or ambiguous stimuli (McNamara 1988). The family context can also play an important role in the development and maintenance of the problem behaviour. Stressful family events often coincide with the onset of the problem but family factors may also contribute because of possible positive reinforcement of the behaviour or because of the parent's lack of child behaviour management skills (King et al. 1995, Mansdorf and Lukens 1987).

Effects

Aside from the implications of the obvious legal requirements to attend school, school refusal is associated with wide ranging possible immediate and long-term negative consequences. Initially school refusal causes significant distress to the child and his/her family, and can interfere with the child's educational and social development. If left untreated chronic cases of school refusal can require hospitalisation (Blagg and Yule 1984).

School is a fundamental setting for children to establish and develop social skills, relationships and various elements of their personality, so failure in this setting may have long-term consequences for the child's future functioning (Place et al 2000). Follow up studies, over a 12- 29 year span, have shown that previous school refusers apply for psychiatric help in early adulthood significantly more frequently than individuals from the general population (Flakierska-Praquin et al. 1988, 1997). Also at follow-up the previous school refusers were more likely to reside with their parents and had fewer children than the general population group. This may indicate that grown up school refusers have more limited social skills or difficulties forming relationships. Long term effects were also found by Berg and Jackson (1985) who demonstrated an increased risk of school refusers in

developing anxiety disorders in adulthood as well as social adjustment and employment problems. In contrast, Weiss and Burke (1967) found that although 50% school refusers at a 5-10 year follow up had social relationship problems, they were well adjusted at school or work.

It is clear that school refusal has negative consequences for the child and his/her family in the short term, whilst also possibly impeding the child's social and educational development. The follow up studies also suggests that these detrimental effects may continue to into adulthood, with possible implications for occupational, social and psychological functioning. This highlights the importance of possible prevention, early detection and effective treatment of the problem.

Assessment and diagnosis

When working with children clinicians must be familiar with human development in order to be able to distinguish between problem behaviour and normal development issues (Thompson Prout 1998). This has been highlighted by the classic developmental study by MacFarlane, Allen and Honzik (1954) who found that parents considered a number of behaviours to be problems yet these behaviours were actually normative for different age levels. Clinicians therefore must take child development into consideration during the assessment, treatment formulation and through out the treatment process.

The main form of assessment is a clinical behavioural interview (Ollendick and King 1998), which aims to obtain detailed information regarding the overall functioning of the child, the target behaviours and influencing variables, in order to begin formulating the

problem and its treatment. It is generally agreed to be useful to obtain reports from parents and/or teachers to help obtain as much information about the manifestation of the problem behaviour as possible (e.g. Burke and Sliverman 1987, Kearney and Silverman 1990, Lee and Miltenberger 1996). Also if at all feasible, direct observations of the target behaviours are the hallmark of a sound behavioural assessment. There are also a number of self report measures designed to aid assessment with children e.g. Fear Survey Schedule for Children, School Refusal Assessment Scale, Children's Manifest Anxiety Scale (see Ollendick and King 1998 for further details).

School refusal has not been represented as a separate diagnostic category in any edition of the DSM, but rather as a symptom that can be associated with a wide range of anxiety disorders (e.g separation anxiety disorder, generalised anxiety disorder, panic disorder, simple phobia and social phobia) in addition to affective and adjustment disorders.

In an attempt to understand the diagnostic composition of school refusers Bernstein (1991) evaluated 96 children using DSM-III criteria. She found that four groups emerged. The first group where those with separation anxiety and/or overanxious disorder (*anxiety disorder only*), the second group were children who presented with depressive disorder (*depressive disorder only*), the third group included children who received both an anxiety and depression diagnosis (*anxiety and depressive disorders*), and the final group included children who did not present with either diagnosis (*no anxiety or depressive disorder*). Bernstein found that one third of the participants received a comorbid diagnosis of an anxiety or a depressive disorder with the school refusal.

There have been two other studies important in highlighting the heterogeneity of school refusal. Firstly, the diagnostic composition of 63 children with school refusal was examined using DSM-III-R criteria by Last and Strauss (1990). They found that in total 75% of the children were diagnosed with a comorbid anxiety or affective disorder. Separation anxiety was the most frequent comorbid presentation (38.1%), followed by social phobia (30.2%) and simple phobia (22.2%). More recently, the characteristic of school resfusers were examined, using a large sample of 192 by McShane et al (2001). They found high levels of comorbidity in sample, with diagnosis of anxiety and depression being most common, 54% and 52% respectively. Disruptive behaviour disorders were also present in 38% of the population, which is not consistent with the earlier suggestions by Lee and Miltenberger (1996). Over half of the sample had more than one than one concurrent diagnosis, stressing the complexity of the problem.

Diagnostic categories can be useful in facilitating efficient and universal communication between professionals and in developing sound clinical assessment and treatment techniques (Pritchard et al. 1998). Also the use of diagnostic categories in examining school refusal has emphaised the heterogeneity of the problem, with frequent concurrent diagnosis of anxiety and/or affective disorders. Therefore this information should be applied to clinical work, in guiding a thorough comprehensive assessment on which to base individual treatments. Also if school refusal is found to be comorbid it may be important to distinguish which is the primary problem in order to provide the most appropriate treatment.

6.3 The treatment of school refusal

Firstly research investigating how practitioners are referring and treating school refusal shall be presented, followed by an introduction of the treatments being provided and a review of the documented research into their efficacy. Along with being a heterogeneous problem there is also wide variety in the possible treatments forums available. School refusers are usually initially identified by the family or the school, and the management of the problem can sometimes be contained within the school or educational services (Elliot 1999). However, frequently school refusers are referred to child mental health services by school authorities, GPs or by parents (King et al 1998a). Because of the legal and educational commitments often social services and educational services will remain involved with the family and the importance of close liaison between all the parties concerned had been emphasised (Murphy and Wolkind 1996).

Kearney and Beasley (1994) noted that the information regarding the presenting characteristics and relevant treatment of school refusal is not widely available to the various professionals who work with this population, e.g. school counsellors, teachers. They suggest that this is due to a communication gap between practitioners and researchers of child and adolescent psychology. To help gain a better understanding of the clinical practices being employed in the referral and treatment of school refusal, Kearney and Beasley (1994) surveyed 300 psychologists in the United States who specialised in youth and family practice. Although the results should be treated with some caution due to the low response rate (21%), there were some interesting findings (see Table 6.1). With respect to etiology, they found that children most commonly refuse to attend school

because of a desire to remain at home with parents (26%) and to avoid aversive social situations (25%) e.g. social interactions, tests, oral presentations, curriculum difficulties.

Table 6.1

Summary of Major Survey Answers about Youngsters Treated for School Refusal Behaviour

1. Severity of school refusal behaviour based on reports from:			
	Child	Parent	Therapist
Mild	23.6	28.5	18.1
Moderate	32.3	28.5	44.5
Severe	27.6	26.4	27.7
Very severe	16.5	16.7	9.7
2. Primary Reason for school refusal behaviour:			
Desire to stay with one or both parents at home			26.1
Aversive social situations			25.0
Difficulty with homework or curriculum			12.2
Aversive evaluative situations including tests			10.0
Fear of specific stimulus in or related to school setting			10.0
Positive tangible rewards			7.8
Other			8.9
3. Role of the parents in treatment:			
Child and parents seen together			51.2
Child and parents seen separately			37.2
Child seen only/parents not seen			8.5
Parents seen only/child not seen			3.1
4. Treatment approach primarily used and percent successful:			
Parent training/ contingency management			40.3 (75)
Cognitive restructuring			14.4 (82)
Contingency contracting			12.2 (60)
Forced school attendance			11.6 (100)
Imaginal or in vivo systematic desensitisation			8.3 (75)
Modelling and role play			6.6 (55)
Play therapy			6.1 (70)
Pharmacotherapy			0.6 (100)

Note. All numbers represent percentages.

From Kearney, C.A. and Beasley, J.F. (1994) "The clinical treatment of school refusal behaviour: A survey of referral and practice characteristics" *Psychology within the Schools, 31*, p128

In focusing on the treatment of school refusal, an interesting finding was that in 91.5% of cases the clinicians interact with both the parent and the child. Parent training/contingency management was the most common single method of treatment, used in 40.3 % of cases, with a 75% reported success rate. The majority of the interventions were based on cognitive behavioural principles e.g. contingency management, cognitive restructuring, systematic desensitisation.

They also found that although forced school attendance and pharmacotherapy had excellent reported success rates (100%) they were used infrequently, in only 11.6% and 0.6% of the cases respectively. One explanation for the low numbers treated with medication is that the study surveyed psychologists, while pharmacotherapy is usually implemented by psychiatrists. Overall Kearney and Beasley's findings demonstrate that therapists most commonly treat school refusal with behavioural and cognitive interventions incorporating parents with reasonable reported success rates. Although the findings add to our understanding of how school refusal presents and which treatments are being provided, because of the survey methodology there are limitations to the information provided. It is unclear how the respondents measured response rates and does not add to our knowledge of the efficacy of the treatments being employed. Nor does it inform us on what evidence clinicians base their choice of treatments.

Pharmacological treatments and research support

There have been controversies surrounding the use of pharmacological treatments with children. Some conclude that medication can only offer minimal benefits in the treatment of school refusal (e.g. Murphy and Wolkind 1996), while others (e.g. King et al 1995)

consider it to play an important adjunctive role. As seen above, although their use was not frequently reported by the practitioners in Kearney and Beasley (1994) survey, when used pharmacotherapy was rated as 100% successful. Also as pharmacotherapy is frequently prescribed and researched in conjunction with CBT, the research into its effectiveness shall be briefly reviewed here.

Tricyclic antidepressants The use of tricyclic antidepressants in adults is well established and they have also been commonly used since the 1960's to treat children with anxiety disorders (Frommer 1967). There have been five double blind, placebo controlled studies examining the efficacy of tricyclic antidepressants for school refusal associated with anxiety, which have produced conflicting results. Gittelman-Klein and Klein (1971, 1980) found that imipramine combined with CBT was more effective than a placebo combined with CBT, in reducing levels of anxiety and increasing school attendance.

Three other trials failed to replicate these results (Klein et al. in 1992, Berney, Kolvin and Bhate 1981 and Bernstein et al. 1990). The inconclusive findings might be explained by different clinical presentations, different medication dosages and lack of concurrent psychological therapies.

A more recent double-blind RCT compared imipramine and a placebo, both in combination with CBT, in the treatment of school refusal in adolescents with comorbid depression and anxiety (Bernstein et al 2000). Over eight weeks of treatment the imipramine combined with CBT was significantly more effective than CBT with placebo in reducing levels of depression and increasing school attendance. From this the authors recommend a multimodal approach, combining pharmacotherapy and psychological therapies, in the

treatment of school refusal. However the sample only contained adolescents (all over 12 years old) comorbid with both depression and anxiety. Therefore results can not be generalised to younger children or children with different clinical presentations. Also in a naturalistic follow up after a period of one year, there were no significant differences between the original two comparison groups, but the positive gains were not maintained (Bernstein et al 2001). They found that 64% of children fulfilled the criteria for anxiety disorders and 33% for depression. Also, in the interim period, 67% of the follow up sample had received psychotropic medication and 77% received further outpatient psychotherapy. Unfortunately rates of school attendance were not available. The authors suggest that this follow up information demonstrates the seriousness of problem of school refusal and suggest further longitudinal studies are needed to understand the course of school refusal and its successful treatment. It is worth noting that the original study used children with high levels of comorbidity, this high level of symptom severity could impact on the effectiveness of CBT treatment (Jarrett et al 1991, Black et al 1994). However it still questions the long term effectiveness of both pharmacotherapy and CBT treatments.

Benzodiazepines There have been two early studies which suggest that benzodiazepines are successful in the treatment of school refusal (D'Amato 1962, Kraft 1965). Benzodiazepines can produce a number of side effects and due to their addictive nature are not recommended for long term use. More recent prescribing guidelines suggest a reduction in their use (e.g. Rees, Lipsedge and Ball 1997). However, given the success rates, it has been argued that benzodiazepines may have a role in the treatment of severe school refusal over brief periods if used in conjunction with psychological treatments (Tonge 1998).

Serotonin reuptake inhibitors More recently, with the development of SSRIs, there has been one study investigating their use with three school refusing children (Lepola et al. 1996). They found that low doses of citalopram were effective in increasing school attendance and eliminating panic attacks. However Lepola et al. acknowledge that further controlled studies are needed to demonstrate safety, efficacy and appropriate length of citalopram treatment. But it has been suggested that due to the better-tolerated side effects and evidence of efficacy in adults, the application of SSRIs in treating children is promising (Allen, Leonard and Suedo 1995).

Apart from Gittelman-Klein and Klein (1971), there is no conclusive research to demonstrate the effectiveness of pharmacotherapy in treating school refusal. Although the aim of the above research was not to directly address the effectiveness of CBT, two of the trials have implications for the practice of CBT. Gittelman-Klein and Klein (1971, 1980), implies that the use of CBT in conjunction with antidepressant medication might be significantly more effective than CBT used alone. Also the Bernstein results questions the long term benefits of CBT treatment.

Psychological treatments

Behavioural Techniques The rational for these treatment methods has largely been based on the successful treatment of adult anxiety disorders. Exposure has also been widely used in the treatment of children with a variety of anxiety disorders, including school refusal (e.g. Kendell 1994, Kennedy 1965). In controlled studies, exposure to feared objects or situations has been extensively demonstrated as a successful treatment (Roth and Fonagy 1996, Barlow and Beck 1984). In school refusal exposure usually involves a graduated

return to school with the child overcoming the anxiety at each stage. Behavioural techniques can also include relaxation training (e.g. Ost 1987) to help the child cope with the physiological arousal of anxiety and/or the somatic complaints.

Another common strategy based on operant principles is contingency management. This involves the parent or relevant caretaker eliminating any positive consequences of not attending school (e.g. watching television), arranging appropriate punishment for not attending school and positive reinforcement for successfully attending school (Lee and Miltenberger 1996).

Cognitive Techniques Negative self statements or expectations can be an important factor in the development and maintenance of anxiety problems (Clark 1986, Beck, Emery and Greenberg 1985). Helping children to be aware of and to control their anxiety provoking thoughts can help them cope with potentially distressing situations (Kendall et al. 1992, Mansdorf and Lukens 1987). Cognitive strategies can include; thought diaries, cognitive restructuring and positive self statements.

Parent Training This was the most commonly used treatment intervention as reported by Kearney and Beasley (1994). Parent training tends to be behavioural in orientation providing parents with an understanding of operant principles underlying the child's behaviour (e.g. Blagg 1987, Forehand and McMahon 1981). It can include teaching the parents to recognise and praise positive behaviour and to ignore tantrums or somatic behaviours, which can be further developed into contingency management. Also parents can be trained in how to communicate effectively with their children, e.g. learning get the

child's attention and to give clear instructions. Similar principles can also be used during consultations with teachers in relation to the treatment of school refusal (King et al. 1995).

6.4 Research supporting the psychological treatments

Case Studies

There have been a number of uncontrolled early case studies to demonstrate the effectiveness of behavioural treatments for school refusal. For example, Lazarus, Davison and Polefka (1965) used systematic desensitisation to treat a 9 year old boy who presented with separation anxiety and school refusal. At a 10 month follow-up he was still attending regularly school. Ayllon, Smith and Rogers (1970) used a prompting-shaping procedure, with a mild aversive element in treating an 8 year old girl. At a nine month follow-up she regularly attended school and demonstrated improvements in academic and social skills. More recently Hargett and Webster (1996) used an individualised behavioural treatment program to treat a 7 year old male who was refusing to attend school. Treatment also involved parental and teacher input. After three weeks of graduated exposure and positive reinforcement the child was attending school full time and continued to regularly attended at seven month follow up.

Treatment evolved in 1987 when Mansdorf and Lukens introduced combining cognitive therapy with behavioural procedures in the treatment of a 10 year old male and a 12 year old female. They introduced cognitive restructuring and the teaching of coping self statements in the beginning stages of therapy, which were then combined with graduated exposure. Treatment also included parents by teaching them behaviour management

techniques and challenging their own distorted beliefs concerning their child's ability to attend school. Successful school attendance was achieved and after 4 weeks and maintained at a three month follow-up for both children.

A 10 session cognitive behavioural treatment was implemented by Rollings et al. (1998) over a six month period with a 13 year old female experiencing school refusal with depression. Unlike the majority of case studies the parents or the teachers were not directly involved in the treatment. They found that regular school attendance and reduced emotional distress were maintained at a three month follow up. The unusually lengthy delivery of the treatment (6 months) was due to a number of factors, including client resistance to return to school and decisions to change school. However in school refusal the importance of a prompt return to school has often been stressed (e.g. King et al 1998a, Kennedy 1965). Rollings et al. suggested that had the parents been involved in the treatment process, the adolescent may of returned to school more quickly. The Mansdorf and Lukens' (1987) cognitive behavioural treatment approach was successfully applied to an older (13 year old) male by Anderson et al. (1998). Seven treatment sessions were implemented over three weeks with the adolescent, which were combined with sessions with his parents and one consultation with the school. At 5 month follow up the adolescent was attending school successfully and had reduced anxiety symptoms. Anderson et al. suggest that an important factor in the success of this case may have been the firm approach taken by his parents.

Although the reported case studies implementing behavioural, and more recently cognitive, techniques to treat school refusal have demonstrated positive results, they do not adequately demonstrate treatment efficacy. Also the treatments often entailed a variety of

interventions: behavioural approaches, cognitive work and/or parental or teacher input, but are unable to provide evidence as to which interventions contributed to changes in the clinical presentations. Also all of the case studies reported the treatment of younger school refusers, with the eldest being 13 years. The prognosis is considered to be poorer when treating school refusal in older children or adolescents (Last et al 1998) and has been suggested that the behaviour may be indicative of greater pathology (Chapel 1967).

Non-randomised Trials

Kennedy (1965) developed a simple and pragmatic treatment program for school refusing children using behavioural principles. Kennedy stressed the importance of an early return to school and his treatment aimed to facilitate a rapid return to school. The treatment involved applying learning theory by blocking the escape of the child, preventing secondary gains and increasing the positive reinforcement of attending school. It has been suggested that the critical feature in his study was forced school attendance or flooding (King et al. 1995). Over an eight year period, Kennedy's rapid treatment program was used successfully in the treatment of 50 school refusing children, between the ages of 4 and 16. At annual follow-ups, success rates were maintained in all the children. However as Kennedy did not use any nontreatment controls to evaluate his treatment program there are limitations to the conclusions that can be drawn from it. Also his sample mainly consisted of children with a short duration of the problem, which has been associated with more rapid recovery (Atkinson et al 1985). Also the use of flooding as the main component of treatment may effect treatment compliance and raises possible ethical considerations (Gelfand 1978, Wolfe 1978).

A large comparative, study using 66 children, provided positive support for the effectiveness of behavioural treatment of school refusal (Blagg and Yule 1984). The behavioural treatment was administered to 30 children and outcomes compared to a group of 16 hospitalised school refusers and group of 20 school refusers who received home instructions and psychotherapy. There were four major components to the CBT treatment: 1) desensitisation to the feared stimulus 2) blocking the avoidance response through forced school attendance 3) positive reinforcement for school attendance, at home and at school 4) contingency management to reduce fear reactions, protests and psychosomatic complaints. Blagg and Yule stressed the importance of an early return to school and the need to be flexible in the application of the treatment procedures to the individual child.

The participants were not randomly allocated to the treatment groups, however comparisons between groups showed that there were no significant differences in gender, social class distribution or intelligence. All of the children were between the ages of 11 and 16 years and presented with similar symptoms of anxieties and similar parental attitudes. Outcome was only measured by school attendance. One year after treatment 93.3% of the behavioural treatment group were considered to be successful compared with 37.5% of the hospitalised group and 10% of the psychotherapy group. Success rates were compared again two years after treatment, which demonstrated that 83% of the behavioural treatment group had an attendance rate of over 80%, compared to 31% of the hospitalised group and none of the psychotherapy group. Blagg and Yule noted that in the behavioural treatment group it was five girls who failed to successfully return to school. These girls were all over that age of 13, had siblings who had attendance difficulties and parents who were noted to be uncooperative during the treatment. As well as having significantly higher success rates,

it was also commented that the behavioural treatment was more economically efficient in relation to time and costs.

Although influential, the study can be criticised on a number of points, firstly there was no control condition so the extent of spontaneous remission can not be monitored. However given the extent of the differences in the outcomes between the three groups it is unlikely that spontaneous remission was the operative variable in the behavioural treatment group. Another criticism is the study did not randomly allocate the participants to the treatment conditions, which questions the internal validity if the study. Also treatment evaluation measures were limited, as success was only measured by school attendance, changes in anxiety levels, affect or general functioning were not monitored.

In an effort to address deficiencies in the research into the treatment of school refusal Kearney and Silverman (1990) developed and tested the effectiveness of a functional analysis approach to treatment. Drawing from their clinical work and the research literature, they developed a model of school refusing behaviour which focused on identifying the factors involved in the maintenance of the problem behaviour. They devised four categories to help explain children's refusal to attend school; Category 1, (*specific fearfulness/ general overanxiousness*) includes children with a fear of specific aspect of school e.g. teacher or the class room, or a more generalised school related fear. Category 2, (*escape from aversive social situations*) describes children with difficult peer relationships or high social anxiety. Category 3, (*attention-getting/separation anxious behaviour*) describes children who demonstrate behaviour which primarily aims to keep them at home or with a specific parent or caretaker. Category 4 (*tangible reinforcement*) includes children who wish to stay at home for other more tangible reasons such as

watching television, playing with friends. Categories 1 and 2 describe children who avoid school due to negative reinforcement while categories 3 and 4 describe children who refuse to attend school due to the positive rewards of being at home.

Seven children, between the ages of 9 and 16, presenting with school refusal were assessed by Kearney and Silverman (1990) and were assigned to one of the four categories. The treatment was then based upon the functional category or the motivating factors for school refusal. The first category consisted of one child who was treated with relaxation training and systematic desensitisation. There were four children in the second category who were treated with cognitive interventions and/or modelling to improve social skills performance. The third category contained one child, his treatment consisted of shaping and differential reinforcement of other behaviours. And finally the fourth category contained one child, who was treated via contingency management. Treatment was conducted over three to nine weeks, at the end of which, full time school attendance was achieved by 6 of the 7 children. This success was maintained at six month follow up. The child who did not successfully return to school, was a 16 year old female who began work instead. All of the children reported improvements in daily levels of anxiety, depression and global distress. Kearney and Silverman conclude that school refusers can be divided into four main types and argue that an a priori assessment approach is useful in predicting which treatment strategy will work best for a specific type of presentation of school refusal. In addition Kearney and Silverman also developed the School Refusal Assessment Scale (SRAS), a tool to aid assessment of school refusing behaviour, which has gained preliminary support for its reliability and validity (Kearney and Silverman 1990, 1993). The SRAS focuses on identifying the specific maintaining variables and aims to provide foundations on which to develop treatments.

Kearney and Silverman's study highlights the usefulness of a functional analysis approach to assessment which could be helpful in the development and implementation of individualised treatment packages. However their conclusions are limited as they are based on evidence from only seven case studies, which lacked control conditions. Also it is not clear whether any of the treatments used could have been equally or perhaps more effective if implemented with children from a different category. But overall the model is highly treatment relevant, allowing treatment to be assigned on an individual bases, it has produced promising outcomes but further empirical research is needed.

Random controlled trials

Following on from Blagg and Yule (1984) there were three recent random controlled trials of the effectiveness of CBT in the treatment of school refusal. Firstly, King et al. (1998b) evaluated the efficacy of a four-week CBT treatment program, by randomly allocating 34 children to a CBT treatment group and a waiting list control group. The children's ages ranged between 5-15 and 85% were experiencing a concurrent anxiety disorder. The treatment condition involved child CBT plus parent/teacher training in child behaviour management skills. The CBT was based on Kendall's 1990 treatment for childhood anxiety, but was briefer and involved increase parental training. It consisted of teaching coping skills to deal with anxiety, recognising and assessing self-talk, relaxation training, and imaginal and in vivo exposure. Compared to the waiting list control condition, the children who received CBT significantly improved in school attendance. The children in the CBT condition also improved in self-reports of fear, anxiety, depression and coping, as well as caregiver and clinician reports, which were all maintained at 3 month follow up.

King et al. considered the parental training to be a crucial factor in the success of their treatment, but as the parental training was not treated as an independent variable, their study did not empirically test this hypothesis. Also the King et al. study is limited because of the absence of a placebo control condition. The changes in the children could have been due to the non-specific components of the treatment condition, e.g. therapist attention or positive expectations of treatment.

In the second study, Last et al. (1998) investigated the effectiveness of CBT for school refusal using a placebo condition. In their study 56 children were randomly allocated to either a 12 week CBT treatment group or a placebo control condition. Last et al's CBT treatment, which was based on Barlow, O'Brien and Last's (1984) treatment for adult agoraphobics, contained similar interventions as King et al's (1998b) treatment. The main features were cognitive self-statement training and graduated in vivo exposure. Also the CBT treatment involved input with at least one of each child's parents.

Last et al's placebo group received educational support therapy, which was a modification of Heimberg et al. (1990). This group received a combination of educational presentations and supportive therapy. The children were encouraged to talk about their fears and to learn to distinguish between fear, anxiety and phobia. They were also encouraged to keep a diary of their fears and maladaptive thinking. Unlike the CBT condition, the therapists in the placebo condition did not provide encouragement or instructions for the children to confront their fears or to adapt their maladaptive thinking.

Contrary to their expectations, Last et al did not find any differences between the CBT and the placebo condition; both produced statistically and clinically significant improvements

after 12 weeks, on measures of school attendance and self report levels of anxiety and depression. Last et al. propose that the successful feature of the educational support (placebo) condition may have been that it provided the children with a foundation on which to then approach school gradually, this could also be claimed of the CBT condition. They also noted that the CBT condition had a high drop out rate (16%) compared to no dropouts in the placebo condition. They suggest that this could have been caused by the exposure aspect of treatment inducing an increase in the children's anxiety. In contrast the King at al CBT condition, which also included exposure, had no treatment dropouts. This discrepancy in drop out rates could have been due to a number of factors, but one possibility is that the King et al. treatment involved more imaginal exposure. However, because of their high drop out rate Last et al. suggest that educational support may be the more effective treatment for anxiety based school refusal.

In the Last et al. study it could be suggested that the educational support was not an adequate placebo. The main difference between the placebo condition and the CBT condition was that the placebo did not include exposure or training in how to modify maladaptive thinking. But it contained many features similar to CBT interventions, specifically training in identifying and recording maladaptive thinking. In the treatment of adult anxiety problems, there has been some success in the use of cognitive therapy without exposure (Emmelkamp et al 1985). Therefore it is suggested that the educational support is too similar to the cognitive aspects of CBT to act as an adequate placebo. Similarly to King et al. (1998b), this study is further limited as the treatment contained parental training which was not controlled as a separate variable.

Heyne, et al (2002) took note of the suggestion that parental input might enhance the effectiveness of CBT treatment of anxiety disorders (Barrett et al 1996) and performed a controlled trial aimed at evaluating the effectiveness of child therapy, parent/teacher training and a combination of the two. Sixty one school refusing children were randomly assigned to one of the three treatment conditions. A manualised treatment which was based on cognitive behavioural principles, took place over a four week period. Using measures of attendance records, self-report levels of distress and third party reports of emotional distress and functioning, both statistically and clinically significant improvements were made in each group. The child therapy group made slower progress, although contrary to the authors' hypothesis, at follow up equal progress had been made by all three groups. From the results the authors assume that exposure was the crucial factor common to all three groups. But this study questions earlier tendencies to combine child therapy with parental input. Parental involvement may facilitate more a rapid return to school, however it appears that individual treatment, either with the child or the parents, produces similar results whilst placing less demands on resources.

Overall the RCTs imply that CBT interventions can produce improvements in school refusing behaviour. However there are important limitations to be considered. Firstly, it remains unclear which specific elements of CBT are creating the changes in the clinical populations. Some treatments have demonstrated positive results using a purely behavioural approach (e.g. Blagg and Yule 1984) and others suggest combining cognitive and behavioural treatments (e.g. King et al 1998b). Whilst the Last et al (1999) study suggests that cognitive interventions may be effective, it also highlights the possible important role of the non-specific aspects of therapy. Overall the studies can not draw any adequate conclusions as to which are the operative variables of the treatments.

The other important factor which the RCTs fail to address is the heterogeneous nature of school refusal. As seen earlier school refusing children vary considerably across demographic variables and clinical presentations. The research so far does not explicitly try to control these factors, usually providing the same treatments to participants from a wide age range and differing clinical presentations (e.g. comorbid with depression or anxiety disorders). It has been noted that age and duration of the problem can effect outcome (Last et al 1998, Chapel 1967). Also different clinical presentations, mainly depression and anxiety, have different recommended CBT interventions (Roth and Fonagy 1996). This might suggest that school refusing children with differing comorbidity would benefit from different types of CBT treatments.

A final consideration in evaluating the RCTS is the lack of long term follow-up. Drawing from the research on the use of pharmacotherapy in conjunction with CBT, the long term effectiveness of both treatments is questionable. Therefore before any meaningful conclusions can be reached, maintenance of positive outcomes would need to be demonstrated over time.

6.5 Conclusion

The literature into school refusal demonstrates that it is a complex and heterogeneous problem, which can have serious educational psychological and social consequences for the child involved. This emphasises the importance of accessible and effective evidence based treatments. However empirically sound research into treatment efficacy has been limited. There are a number of case studies demonstrating positive outcomes for behavioural and cognitive interventions, but there are limitations to the conclusions that can be drawn from these. Three recent controlled trials using CBT have demonstrated conflicting results. King et al. (1998b) found CBT had positive outcomes in comparison to a waiting list control, while Last et al. (1998) concluded that the placebo treatment condition was more effective than CBT. The third study by Heyne et al (2002), implies CBT is effective, but questions the previous recommendations of combined child and parent treatments.

Given the diversity in clinical presentation and high comorbity one hopeful approach is the functional analysis approach suggested by Kearney and Silverman (1990). This recommends the use of individual cognitive and behavioural interventions based on a functional analysis of the problem behaviour. But again its research is restricted to case studies, which although show positive results have limitations and therefore further controlled trials are needed to demonstrate its efficacy.

An important consideration is that throughout the research, a variety of behavioural, cognitive and parental interventions have been used in a variety of combinations. But the different therapeutic interventions have not been looked at as separate variables. Therefore it is impossible to judge which aspects of the treatments are the operative variables. To add

to this difficulty the heterogeneous nature of school refusal also adds to the possible confounding variables when evaluating effectiveness of treatment. What can be concluded from the literature is that it appears cognitive behavioural interventions, possibly involving parents, can be effective in reducing school refusal behaviour in the short term, especially if this treatment is based on a sound functional analysis of the problem behaviour. But perhaps a more important conclusion is that there is a great need for further detailed research into this important area before clinicians can perform sound evidence based practice.

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Appendices

Appendix A

Ethics Approval Application

THIS FORM SHOULD BE COMPLETED IN TYPESCRIPT AND RETURNED TO THE COMMITTEE ADMINISTRATOR, PERSONNEL DEPARTMENT, MAUDSLEY HOSPITAL. PLEASE REFER TO THE NOTES FOR GUIDANCE AS YOU COMPLETE THE FORM. PLEASE NOTE THAT IT IS THE APPLICANT'S RESPONSIBILITY TO ENSURE THAT SUBMITTED FORMS ARE OF SUFFICIENT QUALITY TO BE LEGIBLY REPRODUCED AND THAT SIGNATURES OF APPLICANT, PRINCIPAL INVESTIGATOR AND INVESTIGATOR(S) ARE APPENDED AT THE END

Applicants are reminded that ethical justification must be given for the inclusion of special groups of subjects eg mentally incapacitated in research projects

INSTITUTE OF PSYCHIATRY
THE BETHLEM AND MAUDSLEY NHS TRUST

REF NO. 008/02

APPLICATION TO THE ETHICAL COMMITTEE RESEARCH FOR APPROVAL OF A RESEARCH PROJECT

Section 1 Details of Applicants* (NOTE 3A)

(a) Applicant **Ms Lorna Fortune** Status **Counselling Psychologist**

Department **Community Clinical Psychology Service**

Address for Correspondence **Clinical Treatment Centre, Maudsley Hospital**

Telephone Number **020 7919 2194**

(b) Principal Investigator **Dr Miriam Burke** Status **Consultant Clinical Psychologist / Honourary Lecturer**

Department **Community Clinical Psychology Service**

Address **Clinical Treatment Centre, Maudsley Hospital**

Telephone No. **020 7919 2194**

(the principal investigator should be of Consultant or Senior Lecturer Status and hold a contract with the Bethlem and Maudsley Trust or Institute of Psychiatry. The Principal Investigator is responsible for the study to the Trust/IOP. Please refer to the Notes for Guidance)

(c) Investigator(s) **Dr David Gracey** Status **Psychologist in Clinical Training**

*Please note that a 1 page curriculum vitae is required for each applicant or investigator not under contract to, or a student of, the Trust or Institute of Psychiatry. Principal Investigators must hold a contract with either the Trust or Institute

(d) **Research Strategy Group** _____

(e) **Sponsoring Organisation** _____

Please give details of any organisation sponsoring the research proposal eg pharmaceutical or device manufacturer or charitable organisation

Section 2 TITLE OF PROJECT

"The effect of service settings on treatment outcome : a comparison between cognitive behavioural therapeutic (CBT) approaches in primary and secondary care"

PROPOSED START DATE **Our intention is that the project will commence once it has met ethical approval.**

Section 3 Purpose of Project (NOTE 3B)

(This section should state, **as far as possible in lay language,** the hypothesis to be addressed and the clinical relevance and benefit of the study)

This study will evaluate the hypothesis that a primary care service will provide more rapid recovery than that of an outpatients service. Such differences will be assessed in terms of both changes in symptom severity and consumer satisfaction. The main aim is to identify ways in which the point of service contact for patients might contribute not only to a speedier reduction in their psychological distress but also mean an improvement in terms of patient satisfaction with the type of service provided.

Section 4 Conduct of Project (NOTE 3C)

(a) Location **GP Practices served by the Trust and the Community Clincial Psychology Service at the Maudsley Hospital**

(b) Nature of Subjects **Adults presenting with a wide range of psychological problems, most common of which are depression, anxiety and panic.**

Number **40**

Exclusion criteria **Examples of referrals that would not be accepted include alcohol/drug dependancy, eating disorders or psychosis**

Will any of the subjects involved in this study be detained patients under the Mental Health Act? If so, please justify in Section 6. **No**

(c) Will patients/volunteers be recruited from within the Trust? **Yes**

Please give details of any patients/volunteers who will be recruited from outside the Trust

(d) Is it proposed to use staff members of the Institute or the Joint Hospital as subjects in this study? **No**

(e) Does the researcher foresee any interference with their duties? **No**

(f) Expected duration of Project **10 months**

(g) Proposed frequency and duration of procedures:

i) for research subjects **5 minutes to complete a set of questionnaires before each therapy session, for a period of 6 sessions.**

ii) for controls **Not applicable**

(h) Proposed payment (if any) to subjects **None**

(i) Funding (if any) sought for project (NOTE 3C cont.)

Please state i) Source _____

ii) Amount _____

ii) to whom payable (please complete whichever is applicable):

_____ (as a personal emolument)

_____ (Institute/Hospital funds)

(j) Grant Reference Number (if known) _____

(k) Will data relating to subjects/controls resulting from the research be stored on computer

YES

If so, please state that the requirements of the Data Protection Act will be complied with

YES

(l) Please state that you will observe the Code of Practice on the Use of Audio-Visual Material (if applicable)

Not applicable

(m) Description of design, methodology and techniques
(as far as possible in lay language)

This study is a between-subjects quasi experimental design. 2 treatment conditions will be compared - a CBT Psychology Service located in Primary Care and a CBT Psychology Service in a hospital outpatients department. Patients who express an interest in participating will be provided with an information sheet and consent form by their therapist. Changes in symptom severity between the 2 conditions shall be evaluated by standardised measures completed weekly over the first 6 sessions of therapy. Differences in consumer satisfaction will be compared using a Client Evaluation of Services questionnaire given at the end of treatment. The independent variable will be the setting of the Psychology Service (primary vs secondary care). The dependant variable will be measurable responses (symptom severity and consumer satisfaction).

<u>Section 5 Scientific Background</u> (NOTE 3D)

(a) Has this investigation been carried out previously with human subjects? If so, why is it being repeated? **No**

(b) Which research instruments will be used? (avoid using acronyms)
i) Demographic Questionnaire ii) Beck Depression Inventory iii) Beck Anxiety Inventory iv) Brief Symptom Inventory v) Consumer Satisfaction Questionnaire

(c) How has the number of recruits been decided upon? (please justify the statistical viability - see Notes for Guidance Note 3D)
Power calculations suggest a minimum of n=40 to detect significant differences on the various questionnaires.

Section 6 Ethical Considerations (NOTE 3E)

(a) Please provide a brief account **IN LAY LANGUAGE** of the ethical considerations raised by this project

Given the quasi experimental design of the study and the fact that regular monitoring of symptom severity and consumer satisfaction may generally be considered 'best practice', the potential for ethical problems are reduced. However, there are still some issues that need to be addressed. Permission will be obtained from each potential participant prior to any involvement in the study. Confidentiality is also of the utmost importance. As such, participants will be made fully aware that any data gathered from this study will remain completely anonymous. Data kept on participants will be securely held and remain confidential to the applicant. Accordingly, participant identification will be restricted to a code number and access to this data will be restricted to applicant, principle investigator and other investigator.

(b) What are the benefits of the study to the NHS?

To gain an understanding about the nature and type of service contact point (primary or secondary care) that might be identifiable as contributing more to both faster symptom reduction and greater patient satisfaction.

Will the benefits be	short term	✓
	medium term	✓
	long term	✓
	potential for prevention	

Section 7 Safety and Other Controls (NOTE 3F)

(a) Does this study involve ionising radiation eg X Rays, Nuclear Medicine?

Not applicable

If so, please complete and submit the Application Form for Procedures which involve the use of ionising radiation (available from Committee Administrator)

(b) Have you obtained a certificate from the Administration of Radioactive Substances Act Committee (ARSAC?)

Not applicable

Section 8 Drug Studies (NOTE 3G)

(a) If drugs are to be used, then does the drug that is the subject of the investigation have:

i) a full Clinical Trial Certificate **Not applicable**

ii) a Clinical Trial Exemption Certificate **Not applicable**

iii) If neither (i) or (ii), apply, is the substance being used without a Product Licence for the stated indication **Not applicable**

b) Please state all other drugs involved in the study
Are these being supplied by a Drug Company? **Not applicable**

If yes, by whom _____

(e) Pharmacy Support (NOTE 3G contd.)

Has the Principal Pharmacist been informed of this research proposal
Not applicable

Section 9 Insurance and Indemnity
(NOTE 3H)

(a) Is this study being sponsored by an Industrial or drug company? **No**

If yes, have you obtained indemnity from the sponsoring industrial or drug company?

Not applicable
(Please attach a copy where applicable to your application)

(b) If the study is not sponsored and involves healthy volunteers, please indicate what insurance arrangements have been made for these participants (See Note 3Hb) of the Notes for Guidance)

Section 10 Consents (NOTE 3I)

(a) Please state how you propose to obtain informed consent, how such consent will be recorded, and why you consider the proposed method to be appropriate to this particular project. A copy of the information and the consent form (both duly headed) should be supplied.

Patients attending their first therapy session will be given a consent form and an information sheet about the study. They will not be able to participate in this study unless a signed consent form has been received.

(b) Please indicate how you are gaining permission from consultants in charge of patients (if applicable)

DECLARATION
The above information is correct to the best of our knowledge. We have read and approved all the relevant supporting documents.

Signed_____(Principal Investigator)

Signed_____(Applicant)
(if different from above)

Signed _____ _____(Investigator(s))

_____
(if different from above)

Date of Submission _____

Form to be returned to: Committee Administrator, QAE Dept, Maudsley Hospital, Denmark Hill, LONDON SE5

Appendix B

Participant Consent Form

INFORMATION FOR PATIENTS : RESEARCH STUDY INTO THE EFFECTS OF TREATMENT IN DIFFERENT SERVICE SETTINGS

Please read this carefully if you wish to participate in our study. Your participation is entirely voluntary.

You are invited to take part in a research study which aims to look at how service setting (GP practice or hospital) might affect treatment outcome and consumer satisfaction. This will require you to fill out some standard treatment assessment questionnaires, something which should take you only about 5 minutes to complete on each occasion.

Normally, such questionnaires are given from time to time during the course of treatment. For the purpose of this study, however, we would require you to fill them out a bit more regularly. This would be done prior to attending each of your treatment sessions. As these questionnaires can be used as an aid to monitor progress, your therapist will on occasion be able to provide you with feedback based on the information you have provided. At the end of treatment you will also be given a consumer satisfaction questionnaire to fill out.

Remember that you are free to withdraw from the study at any time without the need to justify your decision. Non-participation in this study will not affect your treatment in any way.

Your identity at all times will remain anonymous. Any information that is gathered will be kept securely by us. Your will not be identified on our records by name, but by participant number, and all information will be strictly confidential.

If you have any questions or require more information you can contact Lorna Fortune on : 0207 919 2194.

Consent :

√ I confirm that I have read and understood the information given for the above study.
√ I know that my participation is voluntary and that I am free to withdraw at any time.
√ I agree to take part in the study.

Name (printed) of the participant

Signature (participant) **Date:**

Signature (investigator) **Date:**

Investigators:
Lorna Fortune
Counselling Psychologist

Supervisor:
Miriam Burke
Consultant Clincial Psychologist

Appendix C

Outcome Measures

BDI®

Date: _____

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today.** If several statements within a group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1
0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11
0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

_____ Subtotal Page 1

CONTINUED ON BACK

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14
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19
0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20
0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

BAI®

NAME _____ **DATE** _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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26 27 28 29 30 31 32 33 34 35 A B C D E
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BSI®
Brief Symptom Inventory

Leonard R. Derogatis, PhD

Last Name First MI

ID Number

Age Gender Test Date

DIRECTIONS:

1. Print your name, identification number, age, gender, and test date in the area to the left.
2. Use a lead pencil only and make a dark mark when responding to the items on page 3.
3. If you want to change an answer, erase it carefully and then fill in your new choice.
4. Do not make any marks outside the circles.

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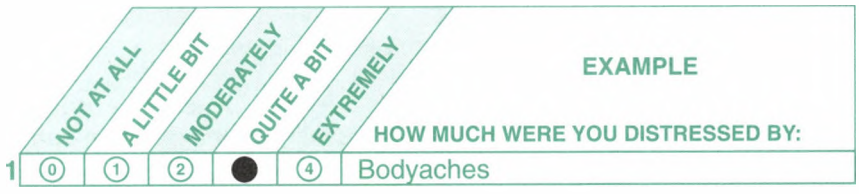
INSTRUCTIONS:

On the next page is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.



	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
10	0	1	2	3	4	Feeling that most people cannot be trusted
11	0	1	2	3	4	Poor appetite
12	0	1	2	3	4	Suddenly scared for no reason
13	0	1	2	3	4	Temper outbursts that you could not control
14	0	1	2	3	4	Feeling lonely even when you are with people
15	0	1	2	3	4	Feeling blocked in getting things done
16	0	1	2	3	4	Feeling lonely
17	0	1	2	3	4	Feeling blue
18	0	1	2	3	4	Feeling no interest in things
19	0	1	2	3	4	Feeling fearful
20	0	1	2	3	4	Your feelings being easily hurt
21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
22	0	1	2	3	4	Feeling inferior to others
23	0	1	2	3	4	Nausea or upset stomach
24	0	1	2	3	4	Feeling that you are watched or talked about by others
25	0	1	2	3	4	Trouble falling asleep
26	0	1	2	3	4	Having to check and double-check what you do
27	0	1	2	3	4	Difficulty making decisions
28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
29	0	1	2	3	4	Trouble getting your breath
30	0	1	2	3	4	Hot or cold spells
31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
32	0	1	2	3	4	Your mind going blank
33	0	1	2	3	4	Numbness or tingling in parts of your body
34	0	1	2	3	4	The idea that you should be punished for your sins
35	0	1	2	3	4	Feeling hopeless about the future
36	0	1	2	3	4	Trouble concentrating
37	0	1	2	3	4	Feeling weak in parts of your body
38	0	1	2	3	4	Feeling tense or keyed up
39	0	1	2	3	4	Thoughts of death or dying
40	0	1	2	3	4	Having urges to beat, injure, or harm someone
41	0	1	2	3	4	Having urges to break or smash things
42	0	1	2	3	4	Feeling very self-conscious with others
43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
44	0	1	2	3	4	Never feeling close to another person
45	0	1	2	3	4	Spells of terror or panic
46	0	1	2	3	4	Getting into frequent arguments
47	0	1	2	3	4	Feeling nervous when you are left alone
48	0	1	2	3	4	Others not giving you proper credit for your achievements
49	0	1	2	3	4	Feeling so restless you couldn't sit still
50	0	1	2	3	4	Feelings of worthlessness
51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
52	0	1	2	3	4	Feelings of guilt
53	0	1	2	3	4	The idea that something is wrong with your mind

Client Evaluation of Services

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of the service you have received?

   Excellent Good Fair Poor

2. Did you get the kind of service you wanted?

   No, definitely not No, not really Yes, generally Yes, definitely

3. To what extent has our program met your needs?

   Almost all of my needs have been met Most of my needs have been met Only a few of my needs have been met None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?

   No definitely not No, I don't think so Yes, I think so Yes, definitely

5. How satisfied are you with the amount of help you have received?

   Quite dissatisfied Indifferent or mildly Mostly satisfied Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

   Yes, they helped a great deal Yes, they helped somewhat No, they really didn't help No, they seemed to make things worse

7. In an overall general sense, how satisfied are you with the service you have received?

   Very satisfied Mostly satisfied Indifferent or mildly dissatisfied Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

   No, definitely not No, I don't think so Yes, I think so Yes, definitely

Appendix D

Service Setting Evaluation Questionnaire

South London and Maudsley NHS
NHS Trust

Community Clinical Psychology Service
1st Floor, Clinical Treatments Centre
Maudsley Hospital
Denmark Hill
London SE5 8AZ

2-5-03

Dear

We are writing to ask if you would be interested in completing the enclosed questionnaire to help us with our research. We are very keen to provide the kind of psychology service that clients want, and the research is designed to help us find out more about what clients would like from the service.

Our earlier research has shown that clients report different levels of satisfaction, depending on the setting of treatment. We are interested in your opinion about the location (i.e. hospital / surgery) in which you received your treatment. We have enclosed a questionnaire which we invite you to complete and return as soon as possible, using the stamped addressed envelop enclosed. This should only take about five minutes of your time

Your participation is entirely voluntary. Also your responses to the questionnaire are completely anonymous and will be treatment strictly confidently.

If you have any questions or comments please contact Lorna Fortune on 020 7919 2194.

We really value your opinions, and the information that you give will be used to improve the service.

Best wishes,

Lorna Fortune
Counselling Psychologist

Miriam Burke
Clinical Psychologist

Service Evaluation Questionnaire

The following questionnaire is designed to help us understand how you felt about the setting (e.g. Hospital or GP surgery) of your treatment. There are no correct or incorrect answers. We are interested in hearing your personal opinions, whether they are negative or positive.

All responses are anonymous and will be treated with complete confidentiality.

Please read the following questions and circle your answers or provide comments and suggestions.

1. Overall how satisfied were you with the psychological treatment you received?

Very satisfied	Mostly satisfied	Mildly dissatisfied	Quite dissatisfied

2. Was there any thing about the setting (i.e. the surgery) that you particularly liked?

3. Was there any thing about the setting (i.e. the surgery) that you particularly disliked?

4. Did you find it in any way embarrassing or uncomfortable to attend the your GP surgery for psychological treatment?

Very much so	Somewhat	A little	Not at all

5. Did you find the surgery reception staff to be helpful

Very much so	Somewhat	A little	Not at all

6. Was the fact that your psychologist was based at your GP surgery, in anyway off putting?

Very much so Somewhat A little Not at all

7. Was there anything about the surgery that made it easy for you to attend the psychology service?

8. Was there anything about the surgery that made it difficult for you to attend the psychology service?

9. How much information did your GP (or other doctor) provide you with about the psychology service when suggesting a referral?

None Very little Quite a bit A Lot

10. Did your GP's attitude in any way influence your decision to attend our service?

Yes No

If yes in what way?

11. Would you have been more likely to attend if the service was located at a local hospital?

Yes, more likely No difference No, less likely

12. If you had been offered the same service at a local hospital, do you think you would have responded differently?

Yes No

If yes in what way

13. Do you have any other comments you would like to make about the setting of the psychology service?

Thank you very much for all your help

Service Evaluation Questionnaire

The following questionnaire is designed to help us understand how you felt about the setting (e.g. Hospital or GP surgery) of your treatment. There are no correct or incorrect answers. We are interested in hearing your personal opinions, whether they are negative or positive.

All responses are anonymous and will be treated with complete confidentiality.

Please read the following questions and circle your answers or provide comments and suggestions.

1. Overall how satisfied were you with the psychological treatment you received?

Very satisfied	Mostly satisfied	Mildly dissatisfied	Quite dissatisfied

2. Was there any thing about the setting (i.e. hospital) that you particularly liked?

3. Was there any thing about the setting (i.e. hospital) that you particularly disliked?

4. Did you find it in any way embarrassing or uncomfortable to attend the Maudsely Hospital for psychological treatment?

Very much so	Somewhat	A little	Not at all

5. Did you find the hospital reception staff to be helpful

Very much so	Somewhat	A little	Not at all

6. Was the fact that your psychologist was based at hospital, in anyway off putting?

Very much so Somewhat A little Not at all

7. Was there anything about the hospital that made it easy for you to attend the psychology service?

8. Was there anything about the hospital that made it difficult for you to attend the psychology service?

9. How much information did your GP (or other doctor) provide you with about the psychology service when suggesting a referral?

None Very little Quite a bit A Lot

10. Did your GP's attitude in any way influence your decision to attend our service?

Yes No

If yes in what way?

11. Would you have been more likely to attend if the service was located at your GP surgery?

Yes, more likely No difference No, less likely

12. If you had been offered the same service in your GP surgery, do you think you would have responded differently?

Yes No

If yes in what way

13. Do you have any other comments you would like to make about the setting of the psychology service?

Thank you very much for all your help

Appendix E

Patient Information Questionnaire

Patient Information Sheet

(to be completed by therapist)

Patient Code: _____

Gender: Male / Female D.O.B: _____

Marital Status: Single / Married / Co-habiting / Divorce / Separated

Occupation: _____

Ethnicity: _____

Living Arrangements: Live alone / live with partner / live with husband or wife
live with your children / live with parents / live with friends
live with other family members

Referred by: GP / Psychiatrist / other (please specify_____)

Date First Seen: _____

Principle problem as described by client: _____

Principle problem as described by referrer: _____

Principle problem as described by therapist: _____

Duration of principle problem (in years/months): _____

Is the problem: chronic / recurrent episode / first episode

Number of previous episodes of contact with mental health services: _____

Response to previous treatment: full / partial / little effect / no effect

Assessment Scores: BSI: _____

BAI: _____

BDI: _____

Outcome: Completed / on-going / dropped out / referred on