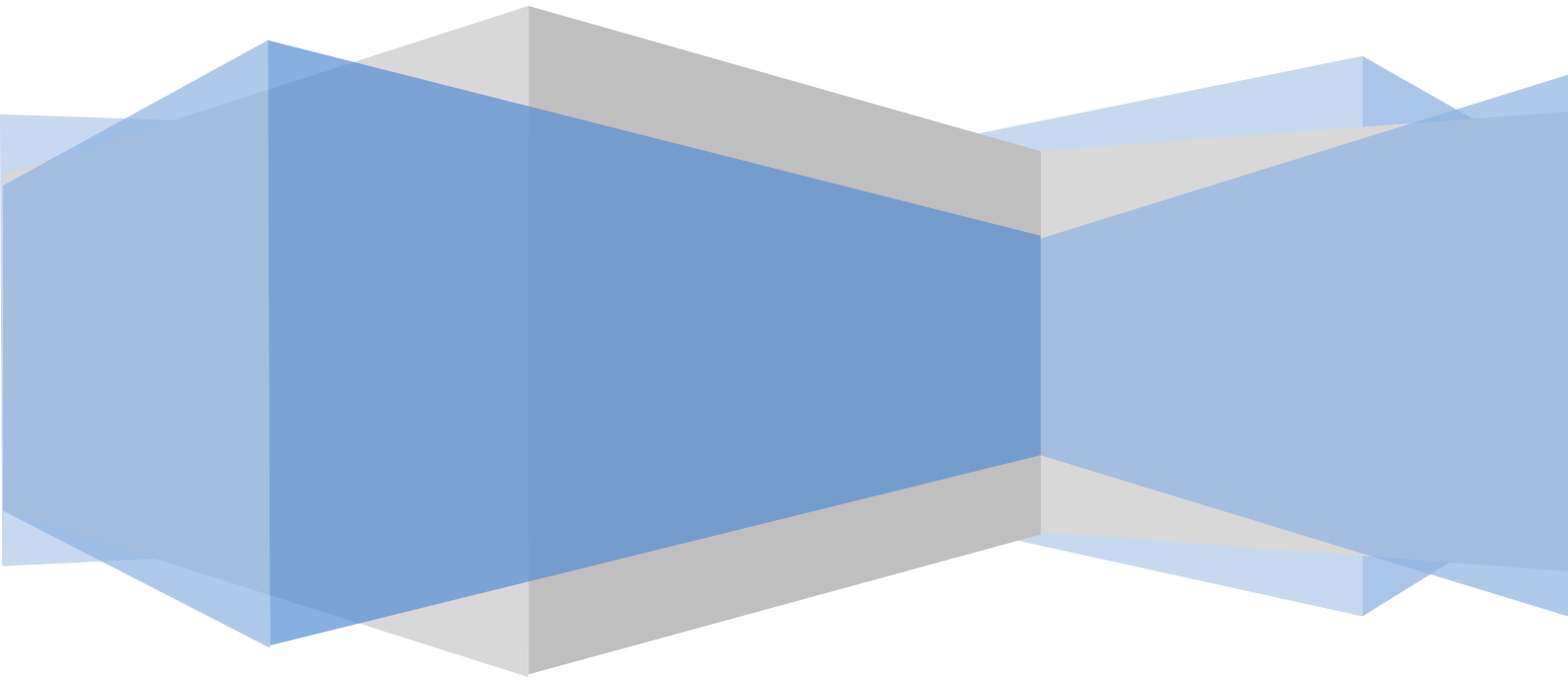
Serenity Programme

Decision support



CCBT - Making Good Decisions

Decision Support for Serenity Programme Helpers

Contents

1 What is the Serenity Programme?

The Serenity Programme [serene.me.uk] provides a blended learning approach to computerised cognitive behaviour therapy (CCBT), allowing users to work with an interactive Internet-based self-help programme with brief support from a trained helper.

This support will most often be delivered by telephone, though may also involve brief face-to-face contact.

Although designed for the treatment of anxiety disorders, specifically Generalised Anxiety Disorder (GAD), social anxiety and panic disorder, the programme has been found to be beneficial for people with Mixed Anxiety and Depressive Disorder (ICD-10 F41.2) and unipolar depression of 'mild to moderate' severity.

2 Choosing participants for the Serenity Programme

People most likely to benefit from psychological approaches meet the following criteria:

	Criteria for a successful psychological approach
1	Desire for a psychological approach
2	Positive experience / expectation of talking therapy
3	Psychological mindedness
4	Introspective ability
5	Ability to form a trusting relationship

Table 1

People most likely to benefit from CCBT meet the criteria in Table 1, plus …

	Criteria for a successful CCBT approach
1	Familiarity with computers [1, 2]
2	Desire to work with CCBT
3	Desire and ability to work independently
4	Symptoms make face-to-face working distressing or unfeasible
5	Pressing need (isolation, mobility or service access issues)

Table 2

1 Because of the limitations of the software in Android and in iOS (Apple iPhone, iPod and iPad) devices; tablet computers and smartphones are not, at the time of writing, able to use all features of interactive PDF files.

2 Interactive tests and the workbooks work as intended only in desktop versions of Adobe Reader® ideally version XI or better. This version is a free download for desktop and laptop computers by Apple® and those running Microsoft Windows® or Linux.

People least likely to benefit from CCBT have the following characteristics.

Any one of the following is likely to exclude the person from CCBT treatment:

	Factors mitigating against effective CCBT treatment
1	Severely reduced concentration or other cognitive impairment
2	Hearing loss making telephone work impractical [3]
3	Dangerously impulsive or risky behaviour
4	Therapy-interfering behaviour e.g. low participation or motivation
5	Severe or intrusive symptoms affecting functioning
6	Active, intrusive psychotic symptoms
7	Suicidal intent (especially in the presence of plans to act)
8	Severe depression with incapacitating symptoms
9	Intrusive current or repeated ongoing crises
10	Pessimism or skepticism which inhibits productive working
11	Inability to speak or read English (unless interpreter available)
12	Primary problem is neither anxiety nor depression
13	No accessible problem thoughts ('hot cognitions') or behaviours
14	Severe personality problems [4]
15	Lack of access to either computer or telephone

Table 3

3 Hearing loss does not necessarily mean affected people cannot use the programme. Lip readers may communicate using Skype or similar, assistive technology or face-to-face meetings may be used instead of the telephone.

4 People with a high level of impulsivity, low tolerance of frustration, sensitivity to working without visual cues or chaotic behaviour may find working with the programme less helpful than face-to-face work.

3 Assessment criteria

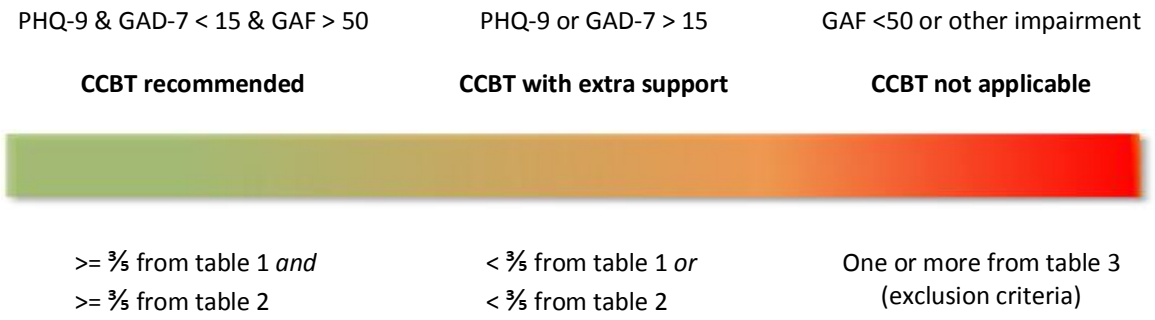


Figure 1

The maximum score possible in the PHQ-9 is 27. A score of less than 15 signifies a depression score in the 'none or minimal'; 'mild' or 'moderate' range (< 4, 5 - 9 and 10 - 14 respectively, see page 15 for further details). For the GAD-7, a score of 15 or above signifies symptoms in the 'severe anxiety' range.

For people using the Hospital Anxiety and Depression Scale (HADS), a score of 16 or above is in the 'severe' range for either anxiety or depression symptoms.

Some participants, especially those suffering from anxiety disorders, can rate their symptoms as severe, yet be able to maintain their social and occupational role functioning. In the case of such relatively low functional impairment, a symptom score in the 'severe' range will not, on its own, contraindicate CCBT treatment.

As the programme involves behavioural assignments (facing up to the things we avoid while learning to better regulate our emotions), participants must be able to make time for the programme and its associated tasks.

Potential users are encouraged to compare the level of distress or inconvenience associated with the problem with the distress and inconvenience that could result from exposure to the avoided object or situation.

The above is intended as a guide to supplement, not replace, clinical judgement.

3.1 Entry to the programme

People suitable for the Serenity Programme meet most of the criteria in Table 1 and Table 2. Any one of the exclusion criteria in Table 3 contraindicates CCBT treatment, unless exceptional circumstances apply.

3.2 Stepped care

The Serenity Programme can be provided at a foundation level, tiers 1 or 2 with appropriate levels of support (Figure 2).

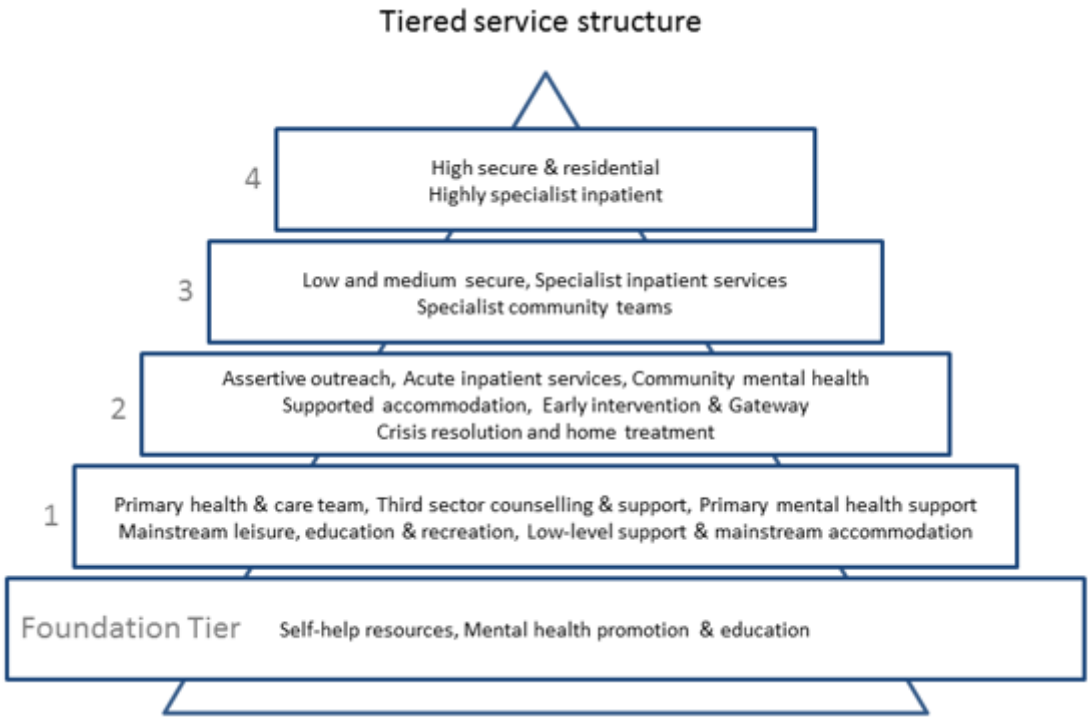


Figure 2

4 Sole, guided or adjunctive treatment

The duration and frequency of contact with the helper can be varied according to the client's needs and preferences. The Serenity Programme can be used as the sole intervention for Generalised Anxiety Disorder (GAD), social anxiety, panic disorder and phobic avoidance. However, it can also be used as an adjunctive or psychoeducational intervention alongside other approaches.

When provided without interpersonal support, the attrition rate for all models of CCBT tends to be higher and user satisfaction low.

4.1 Blending computer and face-to-face time

The duration and frequency of telephone support can be varied according to client need. Additional contact time is best allocated as a positive reinforcer for goals achieved or progress made, in order to avoid inadvertently reinforcing lack of engagement of progress with the programme.

Some clients may need more interpersonal support than others, which is provided at the therapist's discretion based on clinical judgement.

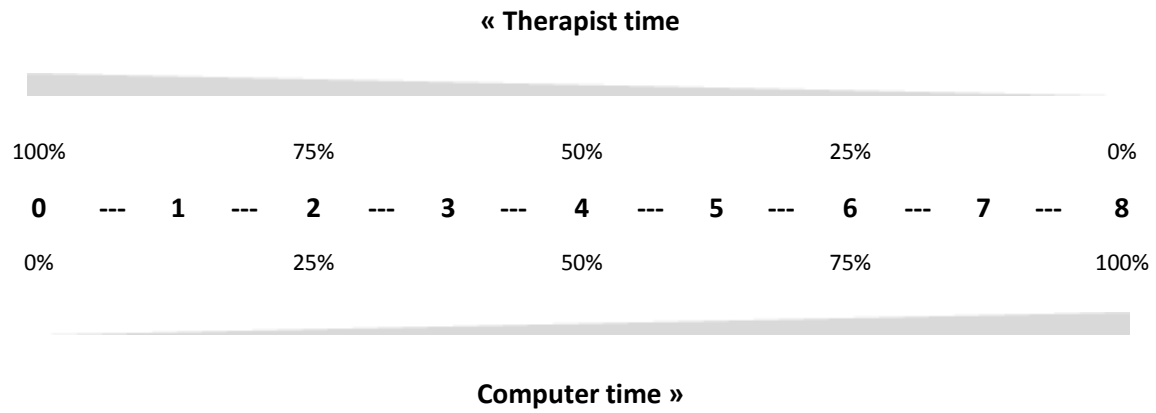


Figure 3

5 The working alliance

The pattern of contact with the Serenity Programme participant is brief, but typically extends for a longer duration than six to eight face-to-face CBT sessions might. It is not unusual for participants to take 9 – 12 months to complete the programme.

Each 'phone contact lasts an average of ten minutes and is focussed on issues from the programme. Helpers work alongside the client in a way which is akin to coaching or mentorship. Catalytic or exploratory work is rarely indicated with the programme, whose stance is primarily educational and 'skills' based.

Helper and participant work collaboratively and are equal partners in working towards the participant's goals. Face-to-face work can supplement telephone contact if required, and is often needed to help with goal setting (module 3).

6 Five important guidelines

Should a participant in the programme be difficult to reach, helpers can spend a great deal of time in 'phone calls, letters and messaging in an effort to help them re-engage. For some participants, it's not clear whether this effort is valued or whether they may be intentionally withdrawing from the programme.

Experience suggests there to be five important principles which can save much effort and which may usefully be shared with participants:

6.1 Three missed appointments

If three consecutive attempts to make contact with the participant fail, the participant will normally be discharged from the programme (unless exceptional circumstances apply).

6.2 'If you break it, you remake it'

The person who misses or cancels an appointment, either helper or participant, takes responsibility for re-establishing contact with the other.

6.3 Helpers (nearly) always initiate

Except in 6.2 above, the helper always initiates contact with the participant. Helper's do not say: 'Call me when you have finished a module.' Helpers say: 'I will call you at (time and date), after which 6.1 above applies.

6.4 Permission to leave messages

Before leaving a participant a message of any kind for – voice, text or email – helpers must have permission from the participant for messages to be left.

6.5 Single session time frame

Each contact with the client should be treated as though it were the only contact you have. Each contact should have some closure and ideally, some benefit achieved. Aim to increase the health and wellbeing of the participant within one session rather than planning to continue or conclude a piece of work at the next contact. Due to the extent of attrition and independent working associated with CCBT, one session may be all you have.

7 Stepping up

The following issues may indicate the need to 'step up' from CCBT to face-to-face work:

	Factors which suggest the need to increase treatment intensity
1	Sudden crisis which reduces functioning
2	Sudden exacerbation of symptoms
3	Ongoing dissatisfaction with CCBT approach
4	Failure to achieve symptom reduction
5	Continued inability or reluctance to participate

Table 4

8 Discharge and / or termination of treatment

8.1 Discharge on completion

'Normal' discharge occurs on programme completion. It is recommended that the duration of CCBT treatment not exceed 12 months unless exceptional circumstances apply.

8.2 Discharge prior to completion

Discharge may be applied in the following circumstances:

- Participant's expressed desire to end CCBT
- Successful symptom alleviation
- Participants ongoing lack of commitment to the programme (as evidence by three or more consecutive missed contacts without explanation)
- Behaviour likely to adversely affect the programme or other users
- Any of the issues in Table 3 or Table 4 apply, in which case the helper may decide to 'step up' treatment intensity by referral to other services or discharge, as clinical judgement indicates

9 Outcome evaluation

Outcomes are normally evaluated on completion or termination using the same measures used at initial assessment. This will normally be the 34 item CORE-OM alongside PHQ-9 and GAD-7.

Some providers may use other outcome measures more in keeping with their organisational ethos, for example the Recovery Star.

PHQ-9

Identifier Date

Please read each statement and write a response which indicates how often you have been bothered by the following problems **over the last two weeks**. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis.

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1	Little interest or pleasure in doing things	
2	Feeling down, depressed, or hopeless	
3	Trouble falling or staying asleep, or sleeping too much	
4	Feeling tired or having little energy	
5	Poor appetite or overeating	
6	Feeling bad about yourself, or that you are a failure or have let yourself or your family down	
7	Trouble concentrating on things, such as reading the newspaper or watching television	
8	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	
9	Thoughts that you would be better off dead or of hurting yourself in some way	
10	If you identified any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	

Total PHQ-9 score =

Please note - these results are intended as a guide to your health and are presented for educational purposes only. They are not intended to be a clinical diagnosis. If you are concerned in any way about your health, please consult with a qualified health professional.

PHQ-9 Scoring Guide

None	Mild	Moderate	Moderately severe	Severe
0 - 4	5 - 9	10 - 14	15 - 19	20 - 27

The maximum score of the PHQ-9 is 27, lower scores are better. Depression severity is calculated by assigning scores of 0, 1, 2 and 3, to the response categories of: 'not at all'; 'several days'; 'more than half the days' and 'nearly every day' respectively. **Only the first nine questions are scored** by adding the scores of the individual items.

The final question, the 'difficulty' item, is not used in calculating any score or diagnosis; but rather represents the patient's global impression of symptom-related impairment. It is strongly associated with both psychiatric symptom severity and health-related quality of life. Scores of 5, 10, 15, and 20 represent thresholds for 'mild', 'moderate', 'moderately severe' and 'severe' depression respectively.

'Major depression' is suggested if questions (1) or (2), and five or more of questions (1) to (9) are scored as at least 'more than half the days'. 'Other depression' is suggested if questions (1) or (2) and two, three or four of questions (1) to (9) are scored as at least 'more than half the days'. **Any response other than 'not at all' to question 9 requires immediate further follow-up.**

PHQ-9 Score	Depression Severity	Proposed Treatment Actions [1]
00 – 04	None or minimal	None
05 – 09	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan considering counselling, follow-up and / or pharmacotherapy
15 – 19	Moderately severe	Active treatment with pharmacotherapy and / or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and / or collaborative management

1 Kroenke, K. & Spitzer, R.L. (2002) Psychiatric Annals 32 pp. 509-521.

GAD-7

Identifier Date

Please read each statement and record a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1	Feeling nervous, anxious or on edge	
2	Not being able to stop or control worrying	
3	Worrying too much about different things	
4	Trouble relaxing	
5	Being so restless that it is hard to sit still	
6	Becoming easily annoyed or irritable	
7	Feeling afraid as if something awful might happen	

Total GAD-7 score =

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GAD-7 Scoring guide

Normal	Mild	Moderate	Severe
0 - 4	5 - 9	10 - 14	15 - 21

The maximum score of the GAD-7 is 21, lower scores are better. Scores are assigned in the following manner:

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

The total score is simply the sum of question items one through seven. Scores of 5, 10 and 15 are taken as the cut off points for mild, moderate, and severe anxiety respectively. When used as a screening tool, further evaluation is recommended should the score be ten or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalised anxiety disorder. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

GAF - Global Assessment of Functioning

Identifier		Date	

100 - 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms	
90 - 81	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns	
80 - 71	If symptoms are present they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning	
70 - 61	Some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships	
60 - 51	Moderate symptoms or moderate difficulty in social, occupational, or school functioning	
50 - 41	Serious symptoms or any serious impairment in social, occupational, or school functioning	
40 - 31	Some impairment in reality testing or communication or major impairment in several areas, such as work or school, family relations, judgment, thinking or mood	
30 - 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment or inability to function in almost all areas	
20 - 11	Some danger of hurting self or others or occasionally fails to maintain minimal person hygiene or gross impairment in communication	
10 - 01	Persistent danger of severely hurting self or others or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death	

1. Starting at the top level of the scale, ask yourself: 'Is either the client's symptom severity or the client's level of functioning worse than indicated in the range?'

2. Move down the scale until you find a range which matches the client's symptom severity or the level of functioning, whichever is the worst.

3. Double check your selection of a range in the following manner: The range immediately below the one you have chosen should have examples which are too severe on both symptom severity and level of functioning. If not both, keep moving down the scale.

4. Determine the specific number within the range selected - a score of '5' or above suggest the symptomatology and level of functioning to be nearer the next highest range on the scale, while a Score of '4' or below suggest the symptomatology and level of functioning to be nearer to the next lowest range on the scale.

DSM IV Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome. The reporting of overall functioning on Axis V is done using the Global Assessment of Functioning (GAF) Scale. The GAF scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify:

'Do not include impairment in functioning due to physical (or environmental) limitations.'

In most instances, ratings on the GAF Scale should be for the current period (i.e. the level of functioning at the time of the evaluation).

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10 References

Gega, L., Kenwright, M., Mataix-Cols, D., Cameron, R. & Marks, I.M. (2005). Screening people with anxiety / depression for suitability for guided self-help. Cognitive Behaviour Therapy vol. 34:1, pp. 16–21.

Department of Health, NICE. Improving Access to Psychological Therapies Programme (2007). Computerised Cognitive Behavioural Therapy (cCBT) Implementation Guidance.

National Collaborating Centre for Mental Health, NICE Guideline 123 (2011). Common Mental Health Disorders: Identification and Pathways to Care.

The Mental Health Recovery Star. Available from: http://www.mhpf.org.uk/programmes-and-projects/mental-health-and-recovery/recovery-star Accessed on 30 October 2012.

Kroenke, K., Spitzer, R.L., Williams, J.B. *et al* (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. Annals of Internal Medicine Mar 6; 146(5) pp. 317-25.

Spitzer, R.L, Kroenke, K. & Williams, J.B. *et al* (2006). A brief measure for assessing generalised anxiety disorder: the GAD-7. Archives of Internal Medicine 166 pp. 1092-7.

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