



Journal of Children's Services

Emerald Article: An exploration into the effectiveness of self-help CBT for mothers with mild to moderate depression and/or anxiety in the London Borough of Bexley

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Article information:

To cite this document: David Palmer, Sarah Pittaway, Lindsey Cook, Sandra Garner, Sue Holtum, Jackie Sansom, Charu Bassi, (2012), "An exploration into the effectiveness of self-help CBT for mothers with mild to moderate depression and/or anxiety in the London Borough of Bexley", Journal of Children's Services, Vol. 7 Iss: 3 pp. 178 - 190

Permanent link to this document:

<http://dx.doi.org/10.1108/17466661211261361>

Downloaded on: 10-09-2012

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An exploration into the effectiveness of self-help CBT for mothers with mild to moderate depression and/or anxiety in the London Borough of Bexley

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Abstract

Purpose – *The purpose of this paper is to evaluate the impact of guided self-help cognitive behavioural therapy (CBT) for mothers with depression and/or anxiety undertaken in two Sure Start children's centres in the London Borough of Bexley.*

Design/methodology/approach – *A quantitative study was carried out involving 23 participants who attended an initial appointment with a Psychological Well-being Practitioner and who were assessed and allocated to a guided self-help CBT intervention (either workbooks or computer-based). In addition, in-depth interviews were undertaken with nine participants who had completed the programme.*

Findings – *The study finds that guided self-help CBT produced a significant clinical benefit for participants with mild to moderate depression and/or anxiety. Narratives with participants also highlighted improved confidence and self-esteem, positive thinking and better coping strategies, which may have a positive impact on their children and families. This research also demonstrated the importance of a partnership approach to providing therapeutic interventions for vulnerable groups such as those in this study.*

Originality/value – *The findings represent a "snap-shot" of the positive effects of guided self-help CBT for those suffering maternal depression. They demonstrate the need to recognise and support the therapeutic social milieu, particularly in settings that are familiar and accessible. In addition, psychological interventions that include facilitative holistic working and inter-agency working can be particularly effective.*

Keywords *Self-help CBT, Maternal depression, Anxiety, Children's Centres, United Kingdom, Depression, Mental illness*

Paper type *Research paper*

Introduction

Depression is one of the most common mental health disorders, especially common during women's childbearing years (Kessler, 2003). Women with existing mental health problems may have additional difficulties during pregnancy and childbirth, and with some diagnoses there is a strong possibility that their mental health problems will re-emerge following the birth. Mild depression is the most common, usually becoming apparent after the first three months (Kumar and Robson, 1984). Post-natal depression (PND) is potentially a serious health problem, with adverse consequences not only for the mother's mental health and functioning, but also for the psychological health of the partner and, significantly, for the cognitive and social development of the infant (Cooper and Murray, 1997). Maternal depression has been shown to be associated with increased rates of behaviour problems, social/emotional maladjustment and deficits in cognitive functioning in children from infancy through to adolescence (Goodman, 1992). A number of studies have suggested that the

rates of depression in mothers with preschool children are high, with estimates ranging from 12 to 50 percent, depending on the measures used (Garrison and Earls, 1986; Kumar and Robson, 1984).

Women who are isolated or living with stresses such as those associated with raising children on their own on a low income are particularly vulnerable to depression (Oates and Rothera, 2006). Children from urban areas whose mothers suffer from depression during pregnancy are more likely than others to be involved in antisocial behaviour, including violent behaviour, later in life (Hay *et al.*, 2010). Research into treatments that might reduce the burden of PND remains modest, although controlled studies suggest that both pharmacological and psychological interventions can have a discernible impact on clinical outcome (Cooper and Murray, 1997; O'Hara and Swain, 1996).

The National Institute for Clinical Excellence (NICE) guidelines indicate that low-intensity interventions, such as guided self-help through workbooks, computerised cognitive behavioural therapy (cCBT) and internet-based web sites from home, should be used as the primary treatment intervention for people with mild to moderate depression and/or anxiety. These guidelines are based on a number of studies including Proudfoot (2004), Williams (2008), Kaltenthaler *et al.* (2008), Pittaway *et al.* (2009), Titov (2007) and Williams and Martinez (2008). However, there is no known research into the impact of guided self-help and/or cCBT specifically on maternal depression and/or anxiety. A recent meta-analysis of studies looking at self-help interventions for the generic treatment of depression suggests that a range of delivery methods can be used successfully providing that support is effective (Gellatly *et al.*, 2007). Primary care trusts and those commissioning health services need to understand the options available to patients and knowledge of which of these is most beneficial in terms of clinical outcomes and cost-effectiveness.

In response to the NICE recommendations and in light of the recent research into self-help CBT, this current research programme was proposed. Following a short self-help CBT pilot project funded by Sure Start at North End Children's Centre and provided by the mental health charity Mind in Bexley, a successful funding bid was made to the London Borough of Bexley Sure Start programme. The bid successfully resulted in one-year's research funding into the effectiveness of self-help CBT for those referred to the programme who were experiencing mild to moderate maternal depression. This innovative study was to carry out qualitative and quantitative research into the provision of self-help CBT within North End and North Cray Children's Centres in the London Borough of Bexley. This pilot study research was undertaken by Mind in Bexley and was carried out from April 2009 to March 2010. This paper reports on the findings of this study.

Guided self-help CBT

The number of people that are experiencing mental health problems has risen over the last few years (Appleby, 2007). Depression and anxiety are now two of the most common psychological and psychosocial diagnoses that general practitioners (GPs) will make. This increase in diagnoses inevitably results in a greater demand for psychological therapies such as counselling and CBT. In response to this growing demand, the National Health Service created a stepped care model that is now known as "Improving Access to Psychological Therapies" (IAPT). This incorporates different levels of psychological intervention including GPs, low-intensity interventions (guided self-help), therapist-led interventions (counselling and one-to-one CBT) and secondary mental health services. Patients are referred to the most suitable level of care for their needs. Mild to moderate depression and/or anxiety is usually referred to step "two" and these people will receive guided self-help interventions. NICE have set the guidelines for the National Health Service IAPT service.

The small amount of research that has been conducted into the use of guided self-help focuses on its use with people experiencing mild to moderate depression and/or anxiety. Proudfoot (2004) carried out a randomised controlled trial (RCT) study using cCBT (the Beating the Blues (BtB) programme) on a population of 274 people with mixed depression and anxiety. The results showed that there was a significant effect in reducing self-reported

depression scores as measured on the *Beck's Depression Inventory* (BDI) (Beck *et al.*, 1996), when they compared the results of participants receiving cCBT to those participants that had received non-CBT interventions. The study also found that there was a high probability that the cCBT approach was also a more cost-effective treatment for anxiety and/or depression. In 2008, Kaltenhaler and colleagues undertook an economic analysis designed to compare and thus evaluate three of the available cCBT programmes used with individuals experiencing all levels of depression (minimal to severe). The programmes analysed were "BtB", "Overcoming Depression" and "Cope". This 18-month study found that cCBT was more effective than non-CBT interventions; however as there was only one programme that had an RCT (BtB), the researchers recommended the "BtB" package. NICE guidelines, based on this research, reported that BtB is more cost-effective than standard care and therefore recommended it as a treatment option for individuals with depression (NICE, 2006). However, the guidelines also acknowledge that the clinical effectiveness of other cCBT packages were comparable to BtB and would therefore be similarly effective in treating people with depression.

Pittaway *et al.* (2009) carried out a comparative clinical feasibility study into comparable guided self-help materials. It was found that cCBT programmes "BtB" and "Living-life-to-the-full" (a free web-based programme) and the self-help workbooks *Overcoming Depression* and *Overcoming Anxiety* showed no significant differences in relation to the reduction of self-reported depression and anxiety scores on the rating scale Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM). This study concludes that all three forms of self-help CBT produced significant clinical benefit for adults with mild to moderate depression and anxiety and that none of the modalities for delivering self-help CBT appeared superior to another (Pittaway *et al.*, 2009).

A naturalistic, open research study undertaken by Learmonth and Rai (2008) aimed to demonstrate that cCBT can be taken beyond primary care. In their study, 104 participants experiencing chronic levels of depression and/or anxiety were given cCBT while on the waiting list for face-to-face CBT. It was found that almost half (48.6 percent) of completers were considered to have reliable and clinically significant change, which means they were perceived to have "recovered" from their depression and/or anxiety.

A paper by Titov (2007) reviews the implementation and efficacy of using cCBT as a treatment method for people experiencing depression and anxiety. It summarises eight of the RCTs of cCBT for depression and 13 studies for anxiety disorders. The paper reports that cCBT for depression with therapist contact is as effective as face-to-face therapy, the associated "effect sizes" observed for both therapies are comparable (Titov, 2007). The research that is evaluated in Titov's study shows that results favour therapist-led cCBT, although it appears that as few as three sessions of non-therapist cCBT can result in a reduction of symptoms in some participants (Titov, 2007).

The use of cCBT and guided self-help for PND is growing in popularity (NICE, 2007, 2009). This may possibly be due to the ease of access and flexibility of the programmes that suit the changes in routine experienced by new mothers. The NICE clinical guidelines recommend that PND should be treated according to the same NICE guidelines (the "Stepped Care Approach") as non-puerperal depression, with the exception that there is a lower depression threshold for non-drug management when the patient is breastfeeding (NICE, 2004). However, if PND is treated in the same way as "normal" depression, as recommended by the NICE guidelines, this suggests that clinical outcomes for people with PND should closely match those with regular depression and as such this is certainly an area that warrants further research.

The research that has been reviewed in this paper clearly establishes the benefits of guided self-help. It shows that accessing guided self-help CBT results in a decrease in self-reported depression or anxiety symptoms as well as reductions in scores on a number of measures, such as the CORE-OM, Work and Social Adjustment Scale and BDI. The research also shows that these interventions can be as effective as "therapist-only" interventions and are usually found to be more cost-effective than one-to-one therapy while producing similar

results in the target population. The use of guided self-help CBT is still relatively recent and there is obviously a need for more research in a number of areas, some of which have been mentioned above, but some issues will only be highlighted as the NHS IAPT scheme is fully implemented.

Study method and data collection

The study was based in two Sure Start Children's Centres, North End and North Cray in the London Borough of Bexley. Bexley has a population of 218,307 and lies to the South East of Greater London, one of those boroughs referred to as "Outer London". The Mental Illness Needs Index 2000 (MINI 2K) score for Bexley is 0.79, indicating low-average mental health needs of the population[1]. At the 2001 census, 87.93 percent of Bexley residents reported themselves as White British, 3.47 percent as White Other, 1.3 percent as Mixed, 3.38 percent as Asian, 2.87 percent as Black, 0.71 percent as Chinese and 0.34 percent as being from other ethnic groups. North Cray Children's Centre is based in Sidcup, an area targeted for regeneration. North End Children's Centre is a full day care provision run by the Pre-School Learning Alliance and is based in Slade Green, which is in the North of the Borough. The ward is one of the most deprived in the Borough and has many problems that would be associated with Inner London Boroughs (www.londonboroughofbexley.gov.uk).

Participants in the programme were referred from healthcare practitioners who worked with service users at the Children's Centres. The cCBT programme was provided for four hours per week across both sites.

Participants were referred to the programme by the healthcare practitioner if they were:

- Suffering from mild to moderate depression, mixed anxiety and depression or anxiety disorder.
- Aged 18+ years.
- Responsible for a child 0-5 years.

Patients were not suitable if they had:

- Active suicidal ideas.
- A current or lifetime diagnosis of psychosis, personality disorder or organic mental disorder.
- Alcohol and/or drug dependence.

The counsellor for Women's and Children's Care Group based at Queen Mary's Hospital and GPs had clinical responsibility for all referrals to the scheme.

This research employs qualitative and quantitative data. Quantitative data were based on the information on those accessing the guided self-help CBT scheme at the Children's Centres. Individuals had a choice of accessing the computerised "Living-life-to-the-full" internet web site or using bibliotherapy (workbooks). "Living-life-to-the-full" is a free-to-access self-help CBT internet web site that consists of 13 45-60 minute modules – the first module is compulsory; the other modules are chosen to suit the needs of the individual. Participants attended an introductory appointment with the Psychological Well-being Practitioner (PWP) where they were helped to sign up to the programme and shown how to use it. They were then given two support phone calls at weeks two and four. They also had a final appointment at week eight to discuss and assess their progress on the programme. The *Overcoming Depression/Anxiety* workbooks are based on a structured self-help CBT approach. Participants were required to attend an initial session where the PWP introduced them to the first workbook, which contained some tasks to complete and bring back the following week. The second appointment involved discussing any completed tasks with the PWP in order to decide which further workbooks they would take away to complete during the course of the programme. Participants were then given a supportive phone call at week four. They also had a final appointment at week eight to discuss and assess their progress on the programme.

Quantitative data for the study was collected from 1 April 2009 to March 2010 using the CORE-OM[2] (©MHF & CORE System Group) and the data were analysed using the SPSS statistical package. The CORE-OM consists of 34 questions, which are designed to measure levels of psychological distress. Participants completed the CORE-OM during their initial session on the programme, which includes six risk assessment questions that indicate whether the respondent was at risk of harming themselves or others. For example, the participant was asked whether they had been violent to others or had made plans to end their own life. The PWP informed the Psychological Well-being Co-ordinator at Mind in Bexley if a participant scored on any of these risk assessment questions and they then made a joint decision as to whether it was suitable for him or her to continue with the programme. If the participant scored very highly on any of the risk assessment questions (a score of 3 or 4), the counsellor for Women's and Children's Care Group based at Queen Mary's Hospital was informed that the programme's would not be suitable and that they should discuss alternative treatment with the person involved. Participants completed the CORE-OM again after the final week eight session. Their before and after treatment scores were compared in order to assess any improvement and also to indicate whether any change was clinically significant. In addition, participants had a structured interview with the PWP at week eight, in order for them to share their experiences of taking part in the programme.

To gain insights into the impact of the scheme for participants, a qualitative research design was employed. Mind in Bexley staff had developed networks and understanding of local provision at Sure Start Centres through a six-month guided self-help CBT programme on an earlier project conducted at North End Children's Centre. This foundation allowed for a more rapid start-up of the project than would normally be the case for qualitative research on maternal mental health. Various qualitative methods were used including ethnographic observations, participations at Sure Start meetings and in-depth semi-structured interviews with participants. These allowed for "thick description" (Geertz, 1973) of the narratives that emerged. Most of the findings reported here are based on the more substantial interviews conducted with participants who had concluded the programme and were based on several topics related to the research that included: reasons for depression, the impact of depression on the child, accessing support and their use and experience of participating in the guided self-help CBT programme. Participants self-selected into the study. The interviews took the form of a conversation, the interview environment was informal, enabling those women interviewed to converse on the topics in a leisurely way, and they typically lasted between one to two hours. All interviews were taped and transcribed. Ethical issues were considered by a steering group, which met bi-monthly and held discussions with stakeholders. We note the particular ethical issues arising from research into mental health. Great care was taken to ensure that this study was non-obtrusive and supportive. Voluntary participation and confidentiality were emphasised and researchers made it clear that participants could withdraw at any stage. Informed consent was obtained from all involved. The names of participants have been changed in order to protect their identity.

Data analysis

Data analysis followed the "Framework" approach (Ritchie and Lewis, 2003), a content analysis technique widely used in qualitative research. Each of the transcripts was read and re-read by the authors, following which a coded framework was devised. Thematic categories were applied to each transcript and then "charted", a process by which key points of each data were summarised and documented on an EXCEL matrix. This produced a set of categories that described the main themes arising from the interviews.

Quantitative findings and discussion

Referrals to the programme

The eligible study population consisted of 53 adults referred over a 12-month period, all of whom were female. Of these 53 adults, 25 attended an initial appointment. The number who did not attend ($n = 28$) were contacted when the referral was received but had decided that they did not want to take part in the programme. Reasons for this were not recorded.

Of the 53 originally referred, age bands ranged from 18-24 to 45-64; 17 were aged 18-24 (32 percent); 35 were 25-44 (66 percent) and one was 45-64 (2 percent). The modal age band for those who were originally referred into the programme and who completed it was 25-44 years. The modal age for those who attended an initial appointment was the same age band as those who did not. Healthcare practitioners referred 43 (81 percent) for depression, five (9.5 percent) for anxiety and five (9.5 percent) for mixed anxiety and depression. Of the 15 who completed the programme, 12 were referred for depression, two for anxiety and one for mixed anxiety and depression. Data on ethnicity were available for 44 referrals and the ethnic breakdown was similar to that of the Bexley Borough, with the majority (86.4 percent) white British.

Following their agreement to participate, each person attended an initial assessment session where they were helped to decide whether to undertake the workbook or the internet programme. Two of those who had an initial assessment did not continue, one because she was assessed as more suitable for one-to-one counselling and the other because she declined treatment. The number of people who started and completed each intervention was as follows: workbook – 15 started and nine completed; internet – eight started and six completed (Figure 1).

Completers and non-completers of the programmes

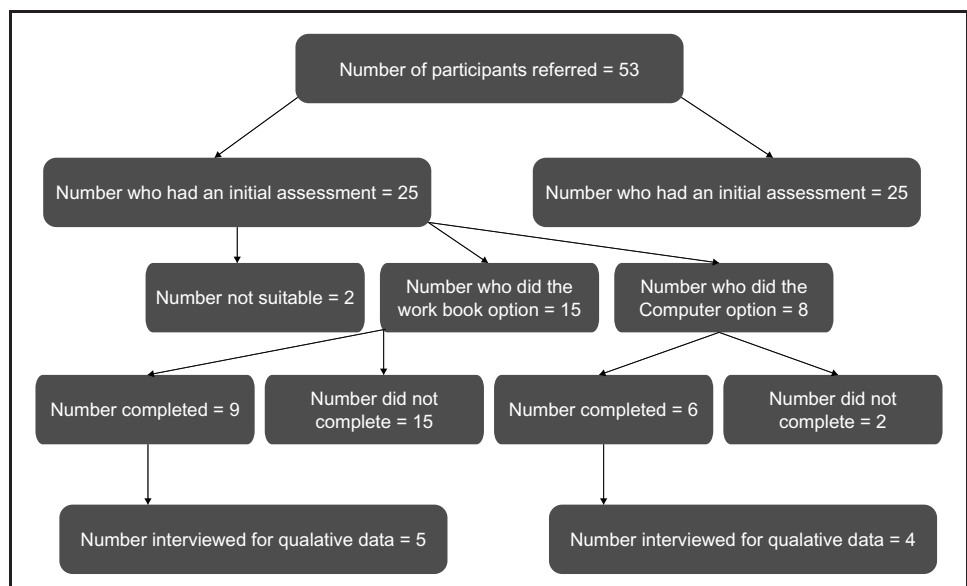
Of the 23 participants who started the programme, eight did not complete, leaving data for 15 participants (65 percent completed the programme). The eight participants, who did not complete, did not attend pre-arranged appointments and did not respond to follow-up calls or letters. We are therefore not able to say why they dropped out of the programme. However, the drop-out rate for psychological therapies is usually much higher than this; one meta-analysis of 125 studies concluded that the mean drop-out rate was 46.86 percent (Wierzbicki and Pekarik, 1993).

Outcome (quantitative measures) at eight weeks for the whole sample of participants completing a programme

A paired *t*-test indicated that for the completers there was a highly significant reduction in CORE-OM scores at week eight compared to entry ($t = 4.63$, $df = 14$, $p < 0.001$). The effect size was calculated as follows:

$$d = \frac{\text{Mean 1} - \text{Mean 2}}{(\text{SD 1} + \text{SD 2})/2} = \frac{1.87 - 1.27}{(0.71 + 1.72)/2} = 0.82$$

Figure 1 Referrals to the programme



The effect size was $d = 0.82$, which is almost one standard deviation, and hence a large effect. At week eight, 13 out of the 15 participants who completed (87 percent) showed a decrease in CORE-OM score, indicating an improvement in their mental health, with five moving from a clinical score on the CORE-OM to a non-clinical score (i.e. dropping below the established mean clinical cut-off scores for all non-risk items on the CORE-OM of 1.36 for men and 1.50 for women). Of these 15 participants, 12 had a clinical score before treatment with seven of these still scoring in the clinical region after treatment. However, six of the seven participants still scoring in the clinical region after treatment had a reduction in their CORE-OM score, indicating an improvement in their mental health. The reduction in mean score was statistically significant at the 1 percent level, a very strong result.

The narratives of participants

A total of nine women who had completed the CBT programme were interviewed as part of the study. Of these, four had accessed the service at North End Children's Centre. Eight had a diagnosis of depression while one suffered from anxiety. Five completed the workbook version of the programme while four participated in the "Living-life-to-the-full" computerised web site programme.

Reasons for depression

In response to an open question, the women described the main reasons for their poor mental health. Family, marriage/relationship breakdown, inadequate social support and isolation were most frequently mentioned:

I was in a bad relationship, and with kids and all that. I used to be put down all the time and felt very low, no self-esteem or confidence (Mary, participant at North End Children's Centre).

Another said:

I felt really isolated. I didn't live near family, I had few friends, some wouldn't come near me now that I had a baby and my marriage was over. I was really struggling. . . couldn't get out of bed, no motivation and crying all the time (Sarah, participant at North End Children's Centre).

Problems in her relationship were viewed by one participant as a result of her depression and in circular fashion contributed to the mother's depression:

I've got a 20-month-old little boy. I suffered with post-natal depression when I had him. My relationship then broke down because of the post-natal depression and then a lot of it was me feeling the way I was feeling. I felt even worse after we split. Very bad some days (Hazel, participant at North End Children's Centre).

One woman attributed her depression to her crying baby and tiredness:

Mainly my depression. . . my daughter cries and doesn't sleep well at night and its making me feel quite down. I just lost a lot of confidence in myself. I'd love to go back to work but I keep telling myself no one will ever want me again. . . that's probably the depression that does that. I think that's the crux of it. . . I'm really really tired (Jenny, participant at North Cray Children's Centre).

Socio-economic adversity, lack of occupational opportunities and poor housing were also significant factors contributing to depression and the poor mental health of the participants who accessed the service. Housing issues were clearly identified by two participants, which affected their behavioural and psychological processes. One participant said:

I live in one of those big blocks near the Centre. I don't like it, don't feel safe, it's cramped and not at all nice. It really gets me down (Mary, participant at North End Children's Centre).

The impact of depression on the child

The impact of the mother's depression on the child was viewed as significant. The lack of attachment was viewed as the main effect of mental ill health on the child:

I just didn't have any motivation. I didn't respond to him, didn't care for his needs, didn't stimulate him. I was critical and did not have any real interest in his development (Hazel, participant at North End Children's Centre).

Disruptions to family processes, including parenting and inter-parental conflict, were documented as a pathway through which the mother's depression affected her child:

I was arguing, we were shouting a lot. I'd no confidence and wouldn't go out alone. I had difficulties concentrating and it definitely affected the kids (Gale, participant at North Cray Children's Centre).

Accessing support

Seven participants reported that they accessed the service through the Health Visitor, one via their midwife and one from a Children's Centre Worker in Sidcup:

I'd spoken to her that I was suffering from post-natal depression and then she contacted whoever to arrange it for me (Jenny, participant at North Cray Children's Centre).

Participants commented on their experience of using the particular method of self-help CBT to which they were assigned. One participant particularly benefited from accessing the interactive computerised programme:

It's more easier because they talk to you on the computer as well, rather than try to read it yourself (Theresa, participant at North Cray Children's Centre).

Some individuals were "put-off" by the idea of having to use a computer. One participant did not want to use the computer programme because of her dyslexia:

Because I'm dyslexic and I wasn't sure I could do the computer on my own... and I wouldn't want to ask for help all the time I'd rather do the books and read it for myself (Myrian, participant at North Cray Children's Centre).

For others, they used the workbooks because they thought they were more accessible, convenient and easier to concentrate and focus on:

I think because it was easier and more acceptable for me to sit and read. As soon as I get the laptop out the little ones want to press the buttons. It was easier, if she was having a sleep I could take it upstairs and read it (Mary, participant at North End Children's Centre).

Participants who were allocated to the computer programme commented on the fact that they felt that this was a good option for them as coming in each week for a session helped with motivation to complete the course:

I enjoyed coming in for my weekly sessions. I feel that it has been beneficial to come in weekly as it makes you complete the homework for each session and it helps with motivation (Hazel, participant at North End Children's Centre).

Coming in for a scheduled session once a week has been really beneficial as it has made me find the time, rather than putting other things before it (Sam, participant at North End Children's Centre).

Influence on behaviour

Participants talked favourably about the self-help CBT intervention when asked how they had benefited from the scheme. Improved confidence and self-esteem, positive thinking and better coping strategies were the most frequently mentioned:

I liked it. I recognised myself in a lot of the quotations of how other people are feeling. It was nice to feel that it wasn't just me. It's made me more of a positive person. I'd like to say I'm not looking at everything so negatively now (Sam, participant at North End Children's Centre).

One respondent described similar issues:

It made me confident, even my friends said I speak out more now and I'm able to rationalise things better than before (Mary, participant at North End Children's Centre).

Another individual benefited from the step-by-step approach, which made her individual goals easier to achieve:

It made me feel I wasn't alone. I started off slowly and gradually some of things you wouldn't usually do, like go to the corner shop became easier, and then the supermarket. I felt really good about myself afterwards (Sarah, participant at North End Children's Centre).

Participants were asked how the extent of the intervention had improved their home and family life. Better relationships within the home were reported:

Yeah, it gave me more confidence and at home with my husband (Gale, participant at North Cray Children's Centre).

Several reported how their confidence and self-esteem had improved whereby they were more confident in attending everyday places such as parks and playgrounds for social interaction, which created reliable networks of support and which had a positive effect on their children. One woman specifically highlighted the positive impact that the approach had on her two-year-old son:

Before I didn't interact and wouldn't go anywhere. Now I've done the programme I feel more assured, confident and better able to cope and I'm more keen and confident to do things and go out. I am now fine to take my two-year-old son to the local parks and playgrounds, go places, meet people and to be honest he is really thriving. My relationship with my husband is also much much better now. I've made some friends, am able to cope, have some support and feel a lot better (Mary, participant at North End Children's Centre).

The ability to rationalise had an influence on thinking and behaviour and also contributed to relationship-building:

I've definitely benefited. I was a mess before. I'm more in control now. That's helping all of us...my husband, our daughter and of course me. I'm more flexible (Joan, participant at North Cray Children's Centre).

The future

Another comment, which was common to all respondents was that they all liked the fact that they had something to look back on and review if they were to experience similar problems in the future:

I just sit, think things through and if I really have a bad day I just get the books out and read them through again (Myrian, participant at North Cray Children's Centre).

Having the programme on the Internet is very useful as you can re-visit the parts that have been helpful at any time (Hazel, participant at North End Children's Centre).

Partnership working

The study was a partnership project between Mind in Bexley, Sure Start North End and North Cray Children's Centres. It was suggested, and anecdotally supported by participants and steering group members, that hosting the study in a non-health setting (Children's Centres) reduced the potential for both a lengthy referral process and the possible stigma attached to receiving such support:

It was quick and easy to get referred to the programme. I didn't have to wait long and what I also liked was that I didn't have to use local mental health services. The service was professional and private and because it was not in a mental health centre I didn't have to worry about people walking past and seeing me (Sarah, referring to accessing the service at North End Children Centre).

In addition, Mind in Bexley was perhaps able to provide a more flexible service, which may not have been achievable within statutory NHS structures and referral procedures. This may have been more appealing to some participants with regards to stigma, primarily because the project was delivered within a community setting. This meant that participants did not become part of the mental health "system", or become unnecessarily identified with it, while still benefiting from the service provided.

Conclusion

The importance of IAPT in mental health has long been recognised and has received increasing impetus in recent years with the publication of NICE guidance and IAPT being a key NHS priority area. Although depression and/or anxiety can be a long-term disabling condition, a large proportion of individuals can recover without any serious or statutory

intervention. However, many vulnerable groups, such as people experiencing maternal depression and/or anxiety, will require treatment and, even for those who would otherwise recover with time, appropriate treatment may accelerate this process.

Although significant, the research findings reported here cannot claim to be representative of the wider population and, as such, it is necessary to acknowledge the limitations of the study in terms of sample size and the lack of a comparison or control group. This small-scale study, located in two Children's Centres in the London Borough of Bexley, can only claim to be valid for those who participated in the programme. As in most qualitative research, the findings of this study are limited by the background characteristics of the participants. In addition, the narratives only include those who completed the programme and this group may differ in some way from non-completers. In terms of future research, it would be useful for the CORE-OM to be completed and follow-up interviews to be undertaken at six months in order to establish the longer-term outcomes of the intervention. However, the findings of this research do offer an important "snap-shot" of the likely positive effects of guided self-help CBT for those suffering maternal depression. This research has also demonstrated the importance of a partnership approach to providing therapeutic interventions for vulnerable groups such as those highlighted in this study. Undoubtedly the children's centres in this study were a vital key resource providing a safe, familiar and supportive environment as well as the necessary access point for participants. Furthermore, the centres facilitated participation as participants were more likely to engage with the programme when many of the barriers to participation, such as trust and access, had already been established by the commitment of the centre to the programme.

The research found significant positive results for those who participated in the programme. The significant decrease in mean CORE-OM score at week eight for the completers represents a large effect size ($d = 0.82$). The findings indicate a significant improvement in mental health, with 87 percent of those who completed showing a decrease in CORE-OM score, and 33.3 percent moving from a clinical score on the CORE-OM to a non-clinical one. The size of effect for those who completed the eight week self-help CBT programme is in line with other studies concerning the effectiveness of self-help CBT interventions. For example, Cavanagh *et al.* (2006) reported an effect size of 1.00 for research completers in a naturalistic non-randomised trial of the self-help CBT package "BtB". Similarly, Carlbring *et al.* (2006) reported an effect size of 1.10 at post-treatment in a randomised trial of internet-based CBT supplemented with telephone calls. These findings seem unlikely to be due to spontaneous remission of symptoms over the eight-week period, since other studies have indicated that the short-term spontaneous remission rates for mild-moderate depression are low. For example, Hegel *et al.* (2006) reported that remission rates over a one-month period ranged from 9 to 13 percent. The present study therefore adds to the body of research, which has found supported self-help CBT to be effective for the treatment of mild-moderate depression and anxiety in other target populations.

It is important to acknowledge the context within which this guided self-help CBT programme, and this research, has been undertaken, in order to understand the possible future implications for such innovative approaches. In the UK, the recent economic crisis combined with the agenda (including that of the "Big Society") of the new coalition government is having a major impact on health policy. All services will be affected by the changes to service commissioning, development and provision and the budgetary cuts effecting national and local government, including of course mental health and social care services. Naturally, as professionals working in the mental health sector, we should be concerned about these proposed changes. However, it is also important to be aware, and concerned, about other "reorganisations" and cuts that are likely to impact adversely upon the determinants of good mental well-being, including housing, welfare and employment, in addition to the impact on innovative inter-agency partnerships such as the one highlighted here. The participants in this research highlighted the negative impact that adverse socio-economic factors can have on individual mental health and well-being. Undoubtedly, the fear of unemployment, losing one's accommodation or not being able to afford the much-needed family home and having various welfare benefits cut puts enormous stress on individuals and families, particularly those with young children. It has been well established that a breakdown in the determinants of mental health and well-being invariably has a cascading effect leading to higher levels of poverty and

deprivation (Brown and Harris, 1978; Subramanian and Kawachi, 2004; Wilkinson and Pickett, 2009). The need for innovative, appropriate, accessible and cost effective mental health support services is therefore paramount within the current economic and political climate.

The current political move towards the “de-centralisation” of services and the rhetoric of the “Big Society”, far from representing a coherent programme of reform, has in fact been criticised for its apparent lack of theoretical foundation or clear framework with which to bring about its implementation. This theoretical vacuum and the contradictory frenzy of public service and welfare cuts have created a climate of fear, confusion and insecurity. Within such a time of shifting of ideological boundaries and rhetoric of the “Big Society”, current politics threaten to ignore, fail to recognise, or deny the essential, extensive and excellent work already being carried out by the voluntary sector which has operated a realistic, organised and in most cases, funded, “Big Society” (or community) vision for many years. The innovative approach reported in this paper demonstrates the successful community partnership working between Children’s centres and Mind in Bexley, a mental health charity.

Making services equitable is an essential task for commissioners, funders and providers. This ensures that the services provided meet needs effectively, are accessible and do not disadvantage vulnerable groups in how they are designed and promoted. It is therefore important to involve a wide variety of stakeholders in their development. Engaging the local community, voluntary sector agencies and “service users” in this process is essential. It is also essential that the value of a therapeutic social milieu, particularly in settings that are familiar and accessible, is recognised and further supported. In addition, this small study suggests that psychological interventions, which demonstrate a facilitative holistic working and inter-agency working can be most effective. In this way, it is hoped that such co-operative preventative approaches to health care will continue to be funded and researched by those commissioning mental health services.

Summary of policy and practice implications

- This study adds to the limited body of research that has found guided self-help CBT to be effective for the treatment of mild-moderate depression and anxiety in target populations.
- The research has demonstrated the importance of a partnership approach to providing therapeutic interventions that can be most effective for those experiencing maternal depression and/or anxiety.
- The need for innovative, appropriate, accessible and cost-effective mental health support services is paramount within the current climate of economic recession and it is hoped that such co-operative preventative approaches to health care will continue to be funded and researched by those commissioning mental health services.
- It would be beneficial for research if measures and follow-up interviews were undertaken at six months in order to explore the longer-term effects of the intervention.

Notes

1. MINI is a score based on local area census data and can be used to estimate levels of need for primary care services to treat common mental disorders. Decisions for the allocation of resources can then be made in an open and fair way to reduce variations in services, address differences in access to care and ensure those suffering with chronic diseases are recognised when planning healthcare. The MINI 2K score for Bexley is 0.79, indicating low-average mental health needs for the population, and this is associated with a high rate of referrals to secondary mental health services that are considered by these services to be inappropriate (48 percent). The MINI 2K score is a ratio against the England average, Bexley’s score is 0.79 which means that Bexley is predicted to have 0.79 times the admission rate of England.
2. The CORE-OM is a validated scale that is widely used in local mental health services and consists of 34 questions which are designed to measure levels of psychological distress. This was used as participants were referred with both depression and/or anxiety problems. Therefore, this more generic measure was deemed to be most appropriate as comparisons could be made regardless of the specific presenting problem.

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Further reading

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