Wales Mental Health in Primary Care
(WaMH in PC)
Bursary Bid 2009

Centre for Mindfulness Research and Practice,

School of Psychology

Bangor University

Mindfulness-Based Cognitive Therapy
for
the prevention of relapse in depression

Wales Mental Health in Primary Care (WaMH in PC)

Bursary Bid 2009

Centre for Mindfulness Research and Practice, School of Psychology, Bangor University

Mindfulness-Based Cognitive Therapy for the prevention of relapse in depression

The CMRP will make its application for a WaMH in PC bursary under

Category 5 – Promoting Mental Health and Wellbeing

Eligibility under Category 5

Mindfulness-based cognitive therapy (MBCT) is now recommended in the NICE guidelines as a treatment of choice for patients who repeatedly experience depressive episodes. In practice however, the approach is rarely available to patients for a range of reasons. As a centre developing and promoting the application of mindfulness-based clinical practice we are committed to supporting the integration of MBCT into local service delivery. If successful in securing a bursary we intend to use the funding to deliver an MBCT course in a primary care NHS setting in Caernarfon, to evaluate its feasibility in this setting and to use the course as a catalyst to evaluate options for an ongoing depression prevention service for vulnerable patients in primary care settings in Wales.

The course is delivered in 8 two hour long weekly sessions and is open to up to 15 participants per course. It is specifically targeted at patients who have experienced repeated episodes of depression and are therefore vulnerable to relapse. The approach is highly empowering, enabling participants to understand and influence their own internal reactive patterns which trigger low mood. The course simultaneously enables participants to gain skills in preventing future depression while enhancing personal wellbeing immediately.

The CMRP at Bangor University is recognised as a centre for excellence, was the first university based centre for mindfulness-based clinical practice in the world and is the main centre in the UK for this work. However, the majority of trainees who access the centre's training are from outside of Wales; the groups run for the general public are well attended but participants have to pay a fee to attend and the course is not aimed specifically at people with depression; the groups run by the centre as part of its research programme are available only to a small number of local people due to the strict eligibility criteria for research. Inspired by

the Welsh Declaration for Mental Health and Well-being we are committed to influencing the development of service provision for people with recurrent depression within Wales.

We aim to deliver an MBCT course in collaboration with Dr Gareth Owens at Victoria Doc surgery Caernarfon, Gwynedd. It is our intention to invite local GP practices within a 12 mile radius of Caernarfon to refer patients who fall within the referral criteria.

Financial Statement

Funding from WaHM in PC is being sought to fund:

1. The costs of delivering an MBCT course in collaboration with Dr Gareth Owen and colleagues at Victoria Doc Surgery Caernarfon who are providing premises and a context for the course.
2. The costs of marketing and promoting the course to local primary care staff and other potential referrers. Our intention is that this will also offer an arena for exploring the factors which are barriers to and enablers for future provision of this service.
3. Researching the feasibility of the course – one of the Research Officers who works on the current MBCT research trial within the CMRP will lead research into the feasibility of the MBCT course in a primary care setting.

Course delivery:

- MBCT teacher fees £1680
  (48 hrs @£35 per hr: made up of 16hrs course delivery; 8 hrs of pre/post session set up and informal participant contact; 18hrs individual pre course assessment/orientation; 6 hrs between session individual support via telephone/email)
- Teacher travel £100
- Participant materials (£10 per participant) £180
- Liaison and course promotion £400
- Room hire and surgery administrative costs £300
- Research costs £335

  Total **£2995**

Mindfulness-Based Cognitive Therapy (MBCT) – background

MBCT is based on the Mindfulness-based Stress Reduction (MBSR) eight week program, developed by Jon Kabat Zinn in 1979 at the University of Massachusetts Medical Center. Research shows that MBSR is enormously empowering for patients with chronic pain, hypertension, heart disease, cancer, and gastrointestinal disorders, as well as for psychological problems such as anxiety and panic.

Mindfulness-based Cognitive Therapy grew from this work. Zindel Segal Toronto Canada), Mark Williams (then at Bangor University) and John Teasdale (Cambridge UK) adapted the MBSR program so it could be used especially for people who had suffered repeated bouts of depression in their lives. It was developed as a manualised group skills training programme (Segal et al., 2002) based on an integration of aspects of CBT for depression (Beck et al.,

1979) with components of the MBSR programme developed by Kabat-Zinn (1990). It was designed to teach patients in remission from recurrent major depression to become more aware of, and to relate differently to, their negative thoughts, feelings, and bodily sensations, relating to them non-judgementally as passing events in the mind, rather than identifying with them or treating them as necessarily accurate read-outs on reality. The program teaches skills that allow individuals to disengage from habitual ("automatic") dysfunctional cognitive routines, in particular depression-related avoidant and ruminative thought patterns, as a way to reduce future risk of relapse and recurrence of depression.

Depression recurrence

It is estimated by the World Health Organisation that by the year 2020 unipolar major depression will be the disease imposing the second greatest burden of ill health worldwide (Murray & Lopez, 1996), very close behind the top cause, ischaemic heart disease. A key feature of major de3pression is the likelihood that sufferers will experience repeated episodes. It follows therefore that the heightened vulnerability to relapse for people with a history of depression is the aspect of the problem that needs particular attention if the personal and global impact of it are to be lessened (Crane 2008).

The most commonly used treatment for major depression is antidepressant medication. It is relatively cheap, and easy for family practitioners (who treat the majority of depressed people) to use. However, once the episode has past, and medication has ceased depression tends to return. At least 50% of those experiencing their first episode of depression find that depression comes back, despite appearing to have made a full recovery. After a second or third episode, the risk of recurrence rises to between 80 and 90%. Also, those who first became depressed before 20 years of age are particularly likely to suffer a higher risk of relapse and recurrence.

Generally, the main method for preventing this recurrence is the continuation of the medication, but many people do not want to stay on medication for indefinite periods, and when the medication stops, the risk of becoming depressed again returns. MBCT offers an evidenced based alternative to medication in preventing depressive relapse.

How do skills learnt in an MBCT course help reduce the downward mood spirals?

1. The course helps participants to see more clearly patterns of the mind which trigger depression; and to learn how recognise when our mood is beginning to go down.

2. Participants learn to halt the escalation of negative thoughts and to focus on the present moment, rather than reliving the past or pre-living the future.

3. Participants learn to step aside from ruminative patterns of thinking and enter an alternative mode of mind that includes thinking but encompasses other aspects of experiencing. In this way participants can learn to shift from a mode of mind dominated by critical thinking (likely to provoke and accelerate downward mood spirals) to another mode of mind in which the world is experienced directly, non-conceptually, and non-judgementally.

4. Mindfulness reverses the tendency to suppress and avoid unwanted thoughts and memories. It helps develop a willingness to experience emotions, a capacity to be open to

even painful emotions. Participants discover that difficult and unwanted thoughts and feelings can be held in awareness, and seen from an altogether different perspective.

In summary it helps participants

- to understand what depression is
- to discover what makes them vulnerable to downward mood spirals, and why they get stuck at the bottom of the spiral
- to see the connection between downward spirals, and:
    - High standards that oppress us
    - Feelings that we are simply "not good enough"
    - Ways we put pressure on ourselves or make ourselves miserable with overwork
    - Ways we lose touch with what makes life worth living.

Mindfulness-Based Cognitive Therapy (MBCT) – evidence base

Two trials have evaluated the efficacy of MBCT in preventing relapse in depression, showing that in patients with three or more previous episodes of depression, MBCT reduces the rate of recurrence to just over half the corresponding rate without MBCT over the 12 months following the eight-week training (Teasdale, et al., 2000; Ma & Teasdale, 2004).

Economic analysis of the cost of delivering an MBCT course and of prescribing antidepressant medication indicates that they cost a similar amount; while MBCT (with or without antidepressants) was better at preventing relapse than maintenance antidepressant treatment alone, and better at improving quality of life (Kukyen et al 2008).

The UK *National Institute of Clinical Excellence* (NICE) has endorsed MBCT as an effective treatment for prevention of relapse – 'Research has shown that people who have been clinically depressed 3 or more times (sometimes for twenty years or more) find that taking the program and learning these skills helps to reduce considerably their chances that depression will return' (NICE, 2004 p. 76). In the most recent NICE publication (Oct 2009) MBCT is a recognised and recommended treatment option for recurrent depression

The Implementation of MBCT in the Primary Care Setting

The current research on MBCT for the prevention of depressive relapse offers gold standard evidence of its efficacy. However, to date there has been little roll out of this evidence into everyday clinical practice. A handful of areas within the UK offer MBCT and there have been some exploratory studies (e.g. Finucane & Mercer 2006; Soulsby et al, 2002). There are a range of factors which may be impeding the implementation of MBCT including lack of trained therapists, current service delivery structures and lack of awareness of the potential of the approach. A further factor may be that the model of targeting the group delivery to the specific group of people who have had three or more episodes of depression limits the applicability of the approach. Given that there is a strong evidence base for the closely related Mindfulness-Based Stress Reduction approach in successfully working with participants with

a wide range of psychological challenge including general anxiety, panic disorders, OCD and mild to moderate depression (e.g. Baer 2003; Grossman et al, 2004; Orsillo et al, 2005; Fairfax, 2008) there is support for expanding the criteria for eligibility to the groups and testing out the feasibility of this in an NHS primary care setting. We therefore intend to open the group to patients with:

- recurrent depression presently in remission
- residual depression
- current episode of mild depression
- anxiety related disorders including generalised anxiety, recurrent panic attacks and obsessive compulsive disorder
- chronic fatigue

The teacher will be a clinician with training and experience in working with patients with mental health challenge and will fulfil the minimum training standards and good practice guidelines adhered to by the CMRP, Bangor University (www.bangor.ac.uk/mindfulness). In line with usual procedures patients will be individually assessed by the teacher prior to commencing the course.

The Centre for Mindfulness Research and Practice at Bangor University

The Centre for Mindfulness Research and Practice (CMRP) was founded in 2001 by Professor Mark Williams and aims to alleviate the effects of ill health and encourage physical and mental well being, by promoting good practice in the teaching and researching of approaches based on mindfulness meditation practice as the central part of clinical treatments, in health care and a range of contemporary settings. It also promotes the incorporation of mindfulness training and practice into staff and service development.

The CMRP has two arms – training and research. On the training side it delivers a full Master's programme in mindfulness-based clinical practice, offers professional development trainings to professionals and 8-session mindfulness-based courses for the general public. We have a team of 11 trained MBCT teachers and supervise and support a group of mental health clinicians using mindfulness-based approaches in the North Wales area. On the research side the CMRP is engaged in a large scale randomised control trial of MBCT for people with suicidal depression in collaboration with Professor Mark Williams (now of Oxford University) and his team.

Researching the feasibility of MBCT for the prevention of depressive relapse in primary care settings

Given the growing evidence for the effectiveness of MBCT in eliciting clinical outcomes the proposed project turns its attention to the issues around delivering MBCT in a primary care rather than a research based setting. It aims to identify any potential barriers in the referral and deliverance of the programme as well as gaining insight into patient and practitioner

experiences and perceptions. The project will rely predominantly on qualitative methodologies to understand issues summarised in the points below

Referral

How feasible and is it to identify and refer patients suitable for the MBCT?

- Clinician and service providers' understanding and perception of MBCT prior to the programme and their amenability to referring patients
- Practical issues surrounding the identification and contact of patients.
- Patients' response to referral and attitudes to the course prior to engagement
- The main barriers to referral

Delivery

How feasible is it to deliver MBCT in a primary care setting?

- Patients attendance and perceptions following the programme
- The main barriers to attendance
- Clinician and service provider experience of the programme and perceptions of MBCT following delivery.

The research will form a project for a small group of undergraduate psychology students who will work under the close supervision of a CMRP Research Officer.

<u>Quotes from previous MBCT participants</u>

It has given me the tools that have helped me get my life back together.

It should be more widely available; I don't like the idea of people missing out on the opportunity to do it.

Being able to slow down the process and observe what is going on in my mind rather than being caught up in automatic ways of thinking

An overriding sense of hope from realising that there is something that really does work and it's just a matter of putting it into practice.

What really sank in for me this time was that this class is not about relaxation and that the object is not to feel different after the mediation but to realise how you are actually feeling.

Before I had always expected that I would do the meditation and feel better immediately. I find now that when things are stressful I do the practice just to see what's going on and not having a target really helps.

Having the discipline of doing the homework gave me motivation
I got up and practiced on days that otherwise I would not have got out of bed.

I went from being a separate person with an illness to realising I was part of a bigger community of people with similar problems all practicing in the same way. Finding this peer

group that you did not think existed and going from feeling that the problem was exclusively yours to the exact opposite was amazing.

To be honest I felt a little awkward and embarrassed to open up to the group at first but finding out that everyone is in the same boat and their positive attitude helped me relax.

The teachers dealt with the group in a very sensitive way if people were going of point or talking too much. That's important in a group, anyone can ask a group to come together but not everyone can string things along.

I had an initial reluctance to disclose at the start but this did not last long.
Once the hurdle of the embarrassment was over I found it really helpful being in a group situation

Planned Outcomes

1. To offer access to an MBCT course for 18 patients who are vulnerable to depression but are currently in remission in a primary care setting in Caernarfon.
2. To develop links with local primary care clinicians to:
    - Promote referral to this current group
    - Raise awareness of the potential of MBCT in primary care
    - Explore the potential barriers to the ongoing delivery of MBCT in primary care
    - Explore potential openings for ongoing delivery of MBCT in primary care
3. Research the feasibility of delivering MBCT in this context.

References

Beck, A.T., Rush, A.J., Shaw, B.F., Emery, G., (1979) Cognitive Therapy of Depression, New York: Guildford Press.

Baer, R.A. (2003) Mindfulness Training as a Clinical Intervention: A Conceptual and Empirical Review, Clinical Psychology: Science and Practice, 10(2): 125-143.

Crane R.S. (2008) Mindfulness-Based Cognitive Therapy: Distinctive Features Routledge.

Fairfax, H, 2008, The use of mindfulness in obsessive complulsive disorder: suggestions for its application and integration in existing treatment. Clinical Psychology and Psychotherapy, 15(1), 53-59

Finucane, A. & Mercer, S.W., 2006, An exploratory mixed method study of the acceptability and efectiveness of mindfulness-basee cognitive therapy for patients with active depression and anxiety in primary care. BMC Psychiatry, 6,14

Grossman, P., Niemann, M.A., Schmidt, S., Walach, H., 2004, Mindfulness-based stress reduction and health benefits: A meta analysis. Journal of Psychosomatic Medicine, 57, 35-43.

Kabat-Zinn, J., (1990) Full Catastrophe Living:Using the wisdom of your body and mind to face stress, pain and illness, New York:Delacorte.

Kenny, M.A.& Williams J.M.G., 2007, Treatment resistant depressed patients show a good response to Mindfulness-Based Cognitive Therapy, Behaviour Research and Therapy.

Kuyken, W., Byford, S., Taylor, R. S., Watkins, E. R., Holden, E. R., White, K. et al. (2007). Relapse Prevention in Recurrent Depression: Mindfulness-based Cognitive Therapy versus Maintenance Anti-depressant Medications. Manuscript submitted for publication.

Ma, S.H., Teasdale, J.D., (2004) Mindfulness-Based Cognitive Therapy for depression: replication and exploration of differential relapse prevention effects, J Consulting and Clinical Psychology.

Murray, C.J.L., Lopez, A.D. (1996), The global burden of disease: A comprehensive assessment of mortality, injuries and risk factors in 1990 and projected to 2000, Cambridge, Mass.: Harvard School of Public Health and the World Health Organisation.

National Institute for Clinical Excellence (NICE), (2004) Depression: Management in primary and secondary care, Guideline 23 p.76.

Orsillo, S.M., Roemer, L., & Holowka, D.W., 2005, Acceptance-based behavioural therapies for anxiety, New York Springer

Segal, Z.V., Williams, J.M.G., Teasdale, J.D., (2002) Mindfulness-Based Cognitive Therapy for Depression: a new approach to preventing relapse, New York: Guilford Press.

Soulsby, J.G., Williams, J.M.G., Silverton, S., Crane, R., 2002, 'Further evaluation of Mindfulness-Based Cognitive Therapy: for Community Mental Health Team clients', Report for the North Wales Research Committee, unpublished.

Teasdale, J.D., Segal, Z.V., Williams J.M.G., (2000) Prevention of relapse/recurrence in major depression by Mindfulness-Based Cognitive Therapy, J Consulting and Clinical Psychology, 68 (4): 615-23.