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Summary

Title: Accessibility and implementation in UK services of an effective depression relapse prevention programme: Mindfulness-based cognitive therapy (ASPIRE)
REC Ref: 13/SW/0226
Chief Investigators: Prof Willem Kuyken and Prof Jo Rycroft-Malone

Summary of Research

Mindfulness-based cognitive therapy (MBCT) is a cost effective psychosocial prevention programme that helps people with recurrent depression stay well in the long term. It was singled out in the 2009 National Institute for Health and Clinical Excellence (NICE) Depression Guideline as a key priority for implementation[1]. However, its accessibility across the UK is both limited and inequitably distributed[2].

Depression is a major public health problem that, like other chronic conditions, typically runs a relapsing and recurrent course, producing substantial decrements in health and considerable human suffering[3]. In terms of disability-adjusted life years, the World Health Organization consistently lists depression in the top five disabling conditions and forecasts that this will worsen over time[4]. While mental health problems are as common and debilitating as physical health problems, unlike physical health problems only ¼ of those who suffer mental health problems receive treatment. Indeed, while 23% of the total burden of disease is attributable to mental health problems, only 13% of NHS health expenditure is spent on mental health[5]. Without effective treatment, people suffering recurrent depression have a high risk of repeated lifetime depressive episodes. Major inroads into the substantial health burden attributable to depression could be offset through making accessible evidence-based

[1] National Institutes for Clinical Excellence. Depression: the treatment and management of depression in adults (update). Clinical Guideline 90. 2009.
[2] Crane R, Kuyken W. The implementation of mindfulness-based cognitive therapy: Learning from the UK health service experience. Mindfulness. 2012:8. Epub 22/06/2012.
[3] Collins PY, Patel V, Joestl SS, March D, Insel TR, Daar AS, et al. Grand challenges in global mental health. Nature. 2011;475(7354):27-30.
[4] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. Lancet. 2007;370:851-8.
[5] Layard R, Banerjee S, Bell S, Clark DM, Field S, Knapp M, et al. How mental illness loses out in the NHS. London: Centre for Economic Performance, London School of Economics and Political Science, 2012.

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interventions that prevent depressive relapse among people at high risk of recurrent episodes[6].

To stay well NICE recommends that people with a history of recurrent depression continue antidepressants for at least two years. However, there are many drivers for psychosocial interventions that provide long-term protection against relapse[7]. There is significant interest in a promising psychosocial intervention: mindfulness-based cognitive therapy (MBCT), which was developed to teach people with a history of depression the skills to stay well in the long term[8]. A recent systematic review[9] and the 2009 NICE depression guideline[10] suggest MBCT is an effective depression relapse prevention programme.

Even if a psychosocial intervention has compelling aims, has been shown to work, is cost-effective and is recommended by a government advisory body, its value is determined by how widely available it is in the health service. Feasibility work for this application shows that NHS provision of MBCT falls well short of that envisaged in the UK national guidance[11]. A recent British Medical Journal editorial suggests that research is needed to answer the questions "What are the facilitators and barriers to implementation of NICE's recommendations for MBCT in the UK's health services? Can this knowledge be used to develop an Implementation Plan for introducing MBCT consistently into NHS service delivery?"[12].

Research aims

The proposed research will ascertain the current state of MBCT implementation across the UK and develop an Implementation Plan. Specifically we will:

[6] Munoz RF, Cuijpers P, Smit F, Barrera AZ, Leykin Y. Prevention of Major Depression. Annual Review of Clinical Psychology, Vol 6. 2010;6:181-212.
[7] Hunot VM, Horne R, Leese MN, Churchill RC. A cohort study of adherence to antidepressants in primary care: the influence of antidepressant concerns and treatment preferences. Primary care companion to the Journal of clinical psychiatry. 2007;9(2):91-9. Epub 2007/07/04.
[8] Williams JMG, Kuyken W. Mindfulness-based cognitive therapy: a promising new approach to preventing depressive relapse. British Journal of Psychiatry. 2012;200(5):359-60.
[9] Piet J, Hougaard E. The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. Clin Psychol Rev. 2011;31(6):1032-40.
[10] National Institutes for Clinical Excellence. Depression: the treatment and management of depression in adults (update). Clinical Guideline 90. 2009.
[11] Crane R, Kuyken W. The implementation of mindfulness-based cognitive therapy: Learning from the UK health service experience. Mindfulness. 2012:8. Epub 22/06/2012.
[12] Kuyken W, Crane R, Dalgleish T. Does mindfulness based cognitive therapy prevent relapse of depression? BMJ. 2012;345:e7194. Epub 2012/11/13.

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- Scope existing provision of MBCT in the health service across England, Northern Ireland, Scotland and Wales.
- Develop an understanding of the perceived benefits and costs of embedding MBCT in mental health services.
- Explore facilitators that have enabled services to deliver MBCT.
- Explore barriers that have prevented MBCT being delivered in services.
- Articulate the critical success factors for the routine and successful use of MBCT as recommended by NICE.
- Synthesize the evidence from these data sources, and in consultation with stakeholders, develop an Implementation Plan that services can use to facilitate the implementation of MBCT.

Study Framework

We will use the Promoting Action on the Implementation of Research in Health Services (PARIHS) to underpin this study[13,14]. The work will involve a two-phase exploratory and explanatory research study, using an interview survey and in depth case studies.

Phase 1 will provide a broad overview of current implementation across the UK using an interview survey. Up to 70 purposively sampled semi-structured telephone or face-to-face interviews with a range of stakeholders across UK services will be conducted. We will scope existing provision and focus on perceptions about MBCT, ascertain views about embedding MBCT into service delivery, including models of teacher training, facilitators, barriers, costs and benefits.

Phase 2 will provide a contextually rich picture of MBCT service delivery through 10 in-depth case studies using exploratory and interpretive methods. A 'case' is defined as an NHS Trust, Health Board or commissioned organization[15] where NICE recommendations would suggest there should be MBCT provision. We are interested in uncovering what the critical success factors are for the routine and successful use of MBCT as recommended by NICE for people with recurring depression in service delivery. Additionally, we want to know what impedes the routine use of MBCT. In

[13] Kitson AL, Rycroft-Malone J, Harvey G, McCormack B, Seers K, Titchen A. Evaluating the successful implementation of evidence into practice using the PARiHS framework: theoretical and practical challenges. Implement Sci. 2008;3.
[14] Rycroft-Malone J. The PARIHS framework - A framework for guiding the implementation of evidence-based practice. J Nurs Care Qual. 2004;19(4):297-304.
[15] The Health and Social Care Act 2012 requires Primary Care Trusts to transfer clinical service contracts to new commissioning organizations and we will refer to the services commissioned by these new groups.

each case study we will conduct semi-structured interviews with service users, managers, commissioners, and practitioners, non-participant observation of relevant meetings, and document analysis.

Across both phases purposive sampling will ensure each key UK geographical region is represented. Moreover, within each region we will sample across different levels of implementation and key contextual variables and from the available cases sample randomly.

Data will be analyzed using a thematic analysis approach informed by Ritchie and Spencer[16], and Yin[17].

Synthesis and outcomes: Guided by the study's conceptual PARIHS framework and located within the MRC Complex Interventions Framework, data will be synthesized across phase 1 and phase 2 to provide a rich and robust explanation about MBCT implementation in UK health services. The output of this will be an MBCT Implementation Plan, which will include a toolkit (i.e., strategies for successful implementation, implementation approaches, training manuals, measurement/evaluation tools) for service providers to use to facilitate more successful implementation of MBCT into service delivery. This will include tools for evaluating the impact of implementation on key outcomes.

[16] Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess T, editors. Analysing qualitative data. London: Routledge; 1994. p. 173-94.
[17] Yin RK. Case study research: Design and methods. Fourth edition. ed. New York: Sage Publications, Inc.; 2008.