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Patients with Minor Mental Disorders

Leading to Sickness Absence: A Feasibility Study for Social Workers' Participation in a Treatment Programme

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SUMMARY
Minor mental disorders are common among patients who visit their general practitioner. In the Netherlands, they are associated with high costs due to absenteeism, disability benefits and medical consumption (consumption of drugs as well as expenditure of medical staff's time). In the Netherlands, a protocol was developed for the treatment of minor mental disorders, based on the principles of brief cognitive behaviour therapy. The cost-effectiveness of this protocol was tested in a group of patients whose minor mental disorders had lead to sickness absence. The protocol was completed by Dutch social workers, one of whose core tasks normally is to provide psychosocial care. The main aims of the protocol are for the patient to regain functionality and to prevent long-term disability. The protocol emphasizes patients' own responsibility and active role in the recovery process, includes homework assignments and stresses the importance of early work resumption. This article focuses on a discussion of the feasibility of this treatment for minor mental disorders. The evidence for or against the protocol's cost-effectiveness will be discussed in future papers. The results show that patients, social workers and general practitioners were motivated to participate and that the protocol was well received by all three groups. If the treatment also proves to be cost-effective, it would appear to be a promising intervention for a frequently encountered problem in primary care.

INTRODUCTION

Minor mental disorders are common among patients who visit their general practitioner (GP) (Verhaak, 1995). In the Netherlands, these disorders are associated with high costs due to absenteeism, disability benefits and medical consumption (consumption of drugs as well as expenditure of medical staff's time) (Terluin, 1994; van der Klink, 2002). A distinction can be made between patients with more severe disorders (e.g. moderately severe or severe depression), who may benefit from medication, and patients with minor mental disorders, who may benefit from a more opportunistic

problem solving approach. With this latter group in mind, Terluin and van der Klink have developed a protocol for the treatment of minor mental disorders in primary care (Terluin and van der Klink, 1995), based on the principles of brief cognitive behaviour therapy. The aim of the present paper is to discuss the feasibility of this treatment for minor mental disorders. The cost-effectiveness of this treatment protocol has also been tested in a randomized controlled trial in the Netherlands, where 98 patients with minor mental disorders were treated according to the new protocol and were compared with 96 patients who received 'care as usual' from their GP. However, the findings from this aspect of the study will be reported in future papers.

In the present study, patients were treated by social workers who had been trained to work according to the treatment protocol. They were considered a suitable professional group to conduct the treatment as, in the Netherlands, about 75 per cent of social workers' workloads already consist of counselling and entails aspects such as seeing patients on a regular basis, giving them emotional support, and helping them to clarify problems (VOG/AMW, 2001). An additional reason why social workers were chosen to test the protocol was that, in contrast to other psycho-social caregivers (e.g. psychologists), patients can consult a social worker free of charge in the Netherlands, and social workers are easily accessible. Furthermore, with the high workload of GPs in the Netherlands and the fact that patients presenting with psychosocial problems receive longer consultations than those presenting with a biomedical problem (Deveugele *et al*., 2002), it can be expected that, in future, GPs will be more and more inclined to refer patients with psychosocial problems to a mental health professional, such as a social worker. Additionally, previous research has shown that primary care patients with emotional difficulties not only find psychological interventions acceptable (Arean *et al.*, 1996) but even prefer brief psychotherapy from a counsellor to care from their GP (Friedli *et al.*, 1997).

Before the study was conducted, there had been concern that social workers might not want to participate in a programme that asks them to work in a more brief and structured manner. According to the protocol under study, treatment was not to exceed 2.5 months, whereas normally, in about 50 per cent of cases, treatment by Dutch social workers lasts longer than three months (VOG/AMW, 2001). Similarly, there had been concern about patients' enthusiasm for a programme that encourages them to be active and, for example, to return to work as soon as possible. Finally, it was also necessary to evaluate whether GPs would be willing to refer patients to such a programme, as most patients with minor mental disorders are seen in primary care (Arean, 1996). Although previous research has shown that GPs value a closer relationship with mental health professionals such as social workers (Thomas and Corney, 1993), they generally treat about 90 per cent of patients with mental problems themselves, in the UK (Hemmings, 2000) as well as in the Netherlands (Verhaak, 1995).

TREATMENT PROTOCOL FOR MINOR MENTAL DISORDERS IN PRIMARY CARE

According to the protocol, treatment should commence as early as possible. Patients receive (a maximum of) five sessions of fifty minutes, scheduled over a ten-week period. The main aims of the sessions are (1) to regain functionality and control, in which the acquisition of coping skills plays an important role, and (2) to focus on the most recent and actual problems. The intervention comprised a graded activity approach and was based on a three-stage model resembling stress inoculation training, a highly effective form of cognitive behavioural treatment (van der Klink, 2002). In the first stage, there is emphasis on giving the patient information about the approach and their condition. In the second treatment stage, patients are asked to make a list of stressors and to develop problem-solving strategies for dealing with these causes of their stress and, in the third stage, patients put these problem-solving strategies into practice. In particular, they are encouraged to do homework assignments, and these are evaluated each following session. For example, patients may be asked to write down all their worries in so-called 'rumination sessions', aimed at learning to limit ruminative thoughts to these specific moments, and to perform 'writing sessions' aimed at working through the events that have led to their emotional problems. Furthermore, according to the protocol, participants should be encouraged to make a daily schedule in which there is time for (a) relaxation, rest and physical exercise; (b) working on the problems, e.g. rumination sessions or writing sessions; and (c) other necessary activities such as doing housework, or taking care of children. An additional important aspect of the protocol is that patients are encouraged to return to work as soon as possible, to solve work-related problems actively, and to get in contact with their occupational physician to discuss

reintegration. However, both working hours and workload are supposed to be built up gradually and carefully. The care-giver has a coaching role and helps the patient to clarify problems and to seek solutions, but emphasizes the patient's own responsibility and active role in the recovery process.

To investigate the feasibility of the treatment protocol, two research questions were formulated:

1 To what extent did social workers, patients and GPs participate in the execution of the treatment protocol as planned?

2 What were social workers', patients' and GPs' opinions of the protocol after participation?

SUBJECTS AND METHODS

Social workers

Eleven social workers participated in the study. All were working in health centres in Almere (Netherlands), where the study was conducted. They received a three-day training in the treatment protocol, organized by the researchers. The training consisted of two consecutive days, and two follow-up morning sessions to refresh social workers' knowledge of the protocol and to discuss experiences.

Patients

A total of ninety-four subjects received the treatment. Figure 1 summarizes how the ninety-four subjects were selected.

All patients had been diagnosed by their GP as suffering from minor mental disorders, and were not already receiving psychotherapy. All patients who were invited by their GP to participate in the study were screened prior to participation using the Composite International Diagnostic Interview (World Health Organisation, 1990), and patients with a moderately severe or severe mood or anxiety disorder, according to this instrument, were excluded from the study sample as the focus of the present study was on the treatment of minor mental disorders. According to previously set inclusion criteria, participants were aged between eighteen and sixty, were Dutch speaking, held paid jobs and were on sick leave for a minimum of one day and a maximum of three months. Four patients who had been randomized to the treatment declined, three of them males.

[FIGURE 1]

General practitioners

In total, forty-three GPs from sixteen health centres and two private practices in Almere had referred patients who were randomized to the treatment.

Instruments

Data were gathered in four ways: via a registration form that social workers completed after each session with a patient; a group discussion with social workers; a questionnaire that was completed by patients; and a short questionnaire that was completed by GPs.

Registration forms for social workers

The registration form that social workers completed after each session was used to investigate to what extent they and their patients had participated in the execution of the protocol as planned. Specifically, it examined whether social workers had informed patients about the different aspects of the protocol (e.g. the daily schedule), whether work resumption had been discussed, whether patients had done their homework assignments and whether they had resumed work. It also provided the researchers with information on the number of patients who completed the treatment.

Group discussion for social workers

In order to examine how the treatment protocol was received by social workers, a group discussion was organized. Four social workers were unable to attend the meeting because they were ill (n = 2), had changed jobs and moved (n = 1) or because of other obligations (n = 1). Social workers were asked whether they thought it was an effective treatment, which parts of the new method they liked and disliked, and to what extent it had been difficult for them to keep to the guidelines of the protocol.

Moreover, they were asked whether they expected there to be subgroups of patients for whom the new method would be especially effective or not effective at all.

Questionnaire for patients

Patient satisfaction surveys often report remarkably high satisfaction scores (Cohen *et al*., 1996), but their relevance with respect to quality management and improvement has often been questioned because of methodological problems (e.g. reliability and validity) (Sixma *et al*., 1998). Therefore, in a pilot study, the researchers had developed a new questionnaire, aimed at measuring the discrepancy between patients' needs with regard to care in the treatment of minor mental disorders, and their experiences. This questionnaire consisted of eight statements about the ideal treatment for minor mental disorders, each starting with 'In treatment for minor mental disorders, it is important that …' followed by statements such as, for example, '… the caregiver understands what you mean' or '… the caregiver tells you what to do'. Before subjects received the new intervention, they scored on a four-point scale how important they considered the eight items to be: not important, fairly important, important, or highly important. After the treatment, they were asked to indicate on a four-point scale to what extent the same eight items described the therapy they had received: no, not really, to some extent yes, and yes (e.g. 'The social worker understood me' or 'The social worker told me what to do'). In the pilot study, reliability analysis resulted in an alpha of 0.75. For a description of the eight items, see Table 1. Patient satisfaction was measured by the researchers, not by the social workers or GPs.

Questionnaire for general practitioners

The GPs' role in the study was to invite patients with minor mental disorders to participate in the study, and to treat their own patients if they were randomized to the control group. GPs were supposed to treat patients in the control group as usual ('care as usual'). Therefore, they had received only minimal information on what the experimental treatment performed by social workers entailed. A short questionnaire was sent to forty-one GPs who had referred patients to a social worker trained in the technique, to evaluate their experiences. Two GPs had left the practice where they used to work and could not be retraced. The questionnaire for GPs measured how they felt about referring patients instead of treating them themselves, whether the referral had affected their relationship with the patient and whether, in future, they would rather treat the patient themselves or refer the patient to a social worker trained in the technique. They were also asked to assign a mark to the quality of the feedback they received about the patient from the social worker on a ten-point scale, 1 meaning 'worthless' and 10 meaning 'excellent'.

[TABLE 1]

RESULTS

Social workers

Eleven social workers carried out the treatment. Their ages ranged from thirty to fifty-seven (mean forty-seven, SD nine), and their number of years of work experience in counselling ranged from three to twenty-two years (mean twelve, SD seven). Eight of the social workers were female. The mean number of patients they treated each was six (SD three) patients. One social worker lost a registration form, which is why data refer to ninety-three instead of ninety-four patients.

As can be seen in Table 2, the mean number of weeks between the first and fifth session was 10.6 (SD 3.0). During the first session, 98 per cent of all patients were informed about the active participation that was expected of them, and 94 per cent were given information about homework assignments. Also, 80 per cent of patients received information about what minor mental disorders are and how they can develop, and in 70 per cent of the first sessions, the importance of work resumption at an early stage was discussed. The mean number of sessions per patient was 4.5, although this does not include additional sessions by psychologists or psychiatrists if the patient was referred on by the social worker. Sixty-nine per cent of patients completed the five sessions. Reasons for not completing the five sessions could be positive (the problems were solved and functionality was

regained) or negative (the patient did not think the therapy was useful). Of the group of patients who completed the five sessions, in 65 per cent of cases, social workers indicated after completion that the patient's situation and complaints had improved so much that according to these social workers, the patient did not need treatment any more. In the registration form, after the first and the fifth sessions, social workers were asked how the patient had reacted to the new method. Whereas after the first session, they indicated that 14 per cent of patients had reacted positively, 4 per cent negatively and 83 per cent similarly to their usual treatment, after the fifth session, the figures regarding all sessions together were 37, 13 and 51 per cent, respectively.

[TABLE 2]

During the group discussion, the seven attending social workers indicated that the main advantage of the new method was the structured way of working, which they regarded as beneficial to the client as well as to themselves. Moreover, they liked the fact that they did not always have to go into problems in great depth, but that regaining functionality had become the main goal. A disadvantage of the new method was that they found five sessions too short and the schedule of ten weeks in which those five sessions were to take place too tight. Another disadvantage was that working according to the protocol was different from their routine way of working. As they were motivated to comply, they felt they had to check the protocol before and after each session, which was considered inconvenient. They were unable to tell whether they thought the treatment was more effective than their usual treatment for minor mental disorders. According to the social workers, no more people dropped out of therapy than usual. They expected the new method to be especially effective in patients with higher intelligence and self-reflection levels, and in adolescents, as they would often have a faster and more goal-oriented lifestyle. They expected the treatment to be less suited to migrant workers as, in their experience, this group frequently had the idea they could not influence aspects of work, often had lower educational levels (and jobs), and did not always see the benefits of a structured treatment. However, all participating social workers were Dutch, well educated and of Caucasian descent, which raises the possibility that stereotyping may have played a role in their attitudes.

Patients

Sixty-one per cent of patients who received the treatment were female. Age ranged from twenty to fifty-eight (mean 39.2, SD nine). Ninety per cent of the subjects had Dutch nationality and had parents of Dutch nationality.

Patient participation was high, as indicated by Table 3: 96 per cent of patients completed some homework assignments during the treatment period. The most popular assignments were those that fitted periods of planned relaxation, rest or physical exercise into the daily schedule. Patients made least use of rumination sessions (44 per cent of patients).

Scores on the questionnaire used to evaluate patient satisfaction indicated that all eight items were regarded as 'important' or 'highly important' by over 90 per cent of patients, with the exception of the item 'In the treatment of minor mental disorders, it is important that the caregiver makes you feel more relaxed', which was considered 'important' or 'highly important' by 82 per cent of patients.

Regarding patients' experience, the results indicated a high level of satisfaction with the treatment as indicated by Table 1. More than 75 per cent of all patients had positive experiences with all items. The statements most patients (98 per cent) agreed with were: 'The social worker understood me' and 'The social worker and I could talk well'.

General practitioners

As mentioned earlier, the GPs' role in the study was to invite patients with minor mental disorders to participate in the study, and to treat their own patients if they were randomized to the control group. After one reminder, the response rate to the questionnaire they were sent was 70 per cent. About half (52 per cent) of the respondents were female. Their ages ranged from thirtythree to fifty-six (mean forty-four, SD six) and the number of years of work experience as a GP ranged from 1.5 to twenty-three (mean eleven, SD seven).

[TABLE 3]

[TABLE 4]

Although they were still unaware of the exact contents of the treatment, GPs' experiences with it were very positive as is summarized in Table 4. None of the GPs believed that the treatment had adversely affected their relationship with the patient. In contrast, 15 per cent indicated it had improved their relationship with the patient, whereas 85 per cent thought it had not affected the relationship. On a ten-point scale (1 meaning 'worthless' and 10 meaning 'excellent'), GPs appreciated the quality of feedback they received from social workers with a 7.2 (SD one), although 33 per cent had not received any feedback. Given their experience, 74 per cent of the GPs indicated that in future, they would rather refer patients with minor mental disorders to a social worker trained in the technique than treat them themselves.

DISCUSSION

Results from the study show that patients, social workers and GPs were motivated to participate. For example, the social workers adhered closely to the treatment guidelines, most patients completed the treatment and almost all did homework assignments, and GPs had a positive attitude towards the treatment. In particular, the structured work approach was well received by the social workers. Treatment was shorter than usual, yet could still prove effective; in 65 per cent of cases, the social worker indicated after the fifth session that the patient did not need any further treatment. As mentioned, some therapies were terminated before the fifth session, meaning that the overall effectiveness may be even higher.

In addition to the finding that patients, social workers and GPs were motivated to participate in the treatment programme, the results of the study also show that participation resulted in mainly positive experiences. For example, prior to the start of treatment, over 90 per cent of patients rated the eight statements about the treatment of minor mental disorders as important or highly important. After treatment, more than 75 per cent of patients recorded positive experiences with all eight items, indicating a high level of patient satisfaction.

The fact that patient satisfaction with the treatment was high is a promising finding, considering that work resumption was already discussed during the first session in almost 70 per cent of cases. Prior to the start of the study, social workers voiced their concern that discussing work resumption at such an early stage might discourage patients from continuing the treatment. However, during the group discussion, they indicated that no more patients had dropped out of therapy than usual. The mean time between referral to the social worker and the first session was two weeks. Normally, only a minority (34 per cent) of social work patients are helped this quickly (VOG/AMW, 2001) and if the treatment proves to be effective, this should be kept in mind.

In discussing the results of the study, several issues need to be addressed. First, in keeping with the inclusion criteria of the study, all subjects were employed. Although this means that some groups of patients (e.g. students, unemployed people, men or women who look after the home) were not represented in the sample, there is no reason to assume that they would be less motivated to participate. A second issue is that the social workers expected the intervention to be less effective for migrant workers. In the Netherlands, migrant workers (especially Turkish and Moroccan) are over-represented among those who receive social benefit payments for disability (Copinga and Selten, 2003). If the treatment proves to be cost-effective, it may be worthwhile to study whether these social workers' assumptions are true or not, and if so, to consider culture-specific adaptations for these groups. Third, it should be noted that patients in the present study were selected on the basis of an absence of moderately severe and severe mood disorders and anxiety disorders, which is not the case in the general population of social work patients. Nevertheless, even though patients with (moderately) severe depression and anxiety disorders were excluded from the study sample, cognitive behaviour therapy has proved successful in the treatment of anxiety (Chambless and Gillis, 1993; Eng *et al*., 2001) as well as depression (Gloaguen *et al*., 1998; Scott, 2001). It can, therefore, be expected that some of the excluded patients might still have benefited from the treatment. A final limitation is that,

as is almost inevitable, the group of patients, social workers and GPs participated on a voluntary basis and therefore a selection of motivated participants may have taken place.

In conclusion, social workers, patients and GPs participated well in the execution of the treatment protocol as planned, and their experiences with it were mainly positive. If this treatment approach also proves to be cost-effective, it would appear to be a promising intervention for a frequently encountered problem in primary care.

TABLES AND FIGURES

Figure 1: Selection of the study sample

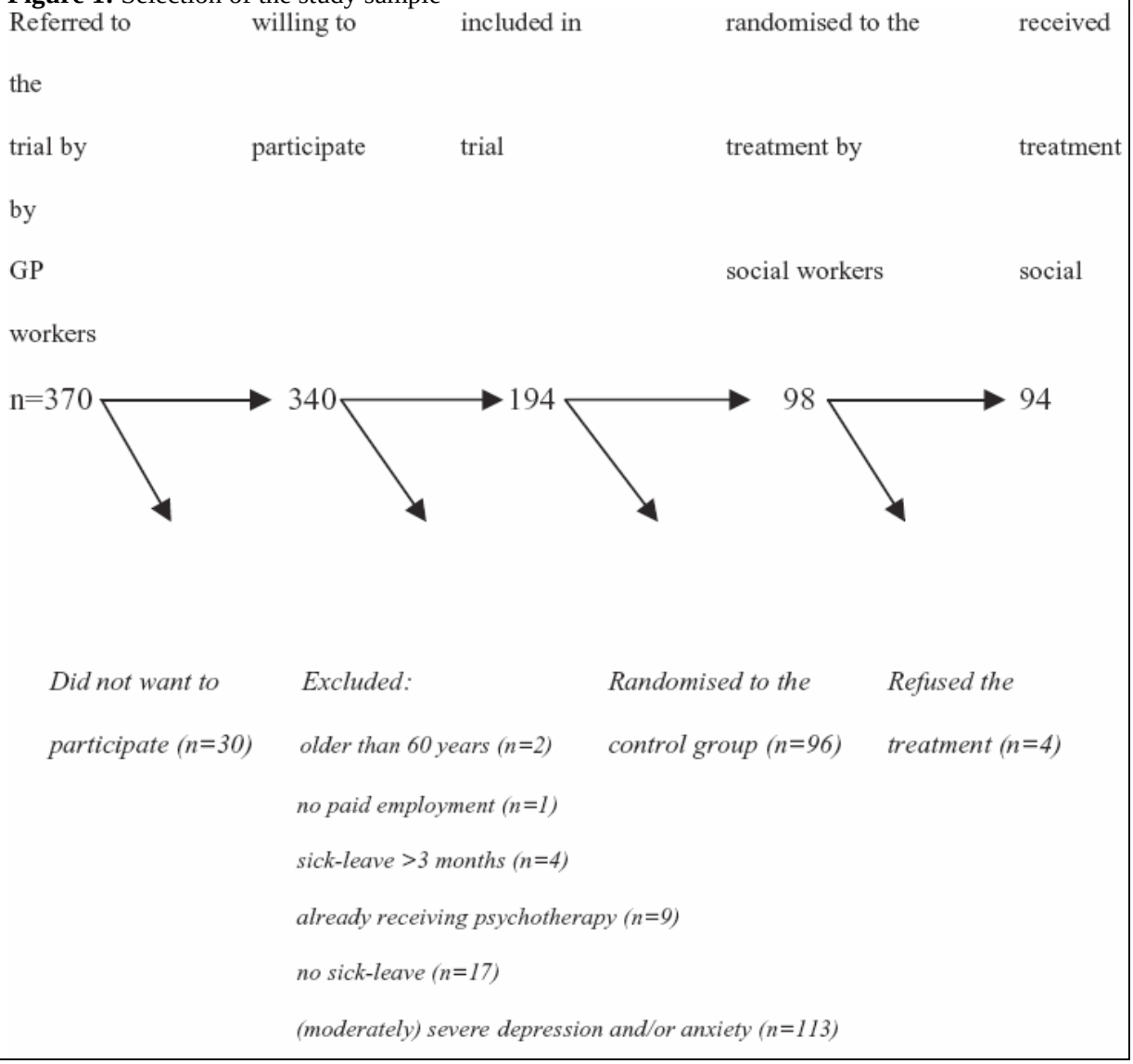

Table 1 Patients' experiences with the treatment

Patients (n = 93)	% agree (partially or fully)
The social worker understood me	98
– The social worker and I could talk well	98
– The social worker had time for me	91
– The social worker told me what to do	88
– The social worker made me feel more relaxed	82
– The treatment has helped me to get insight in the way I handle problems	82
– The social worker taught me how to deal with problems in future	77
– The social worker explained how my symptoms had developed	76

Table 2 Compliance of social workers to the treatment protocol, as reported in the registration forms for social workers

Social workers (n = 11)	
Time between referral and first session in weeks (SD)	2.1 (1.4)
Time between first and fifth sessions in weeks (SD)*	10.6 (3.0)
Mean number of sessions completed (SD)	4.5 (1.0)
During the first session the social worker has:	n (%)
– explained that an active participation of the patient was expected	89 (98)
– given (information about) homework assignments	85 (94)
– given information about what minor mental disorders are and how they can develop	74 (80)
– discussed the importance of work resumption	65 (70)
Number of patients referred by social worker to psychologist or psychiatrist	8 (9)

* of patients who completed the five sessions, n = 64.

Table 3 Patient participation, as reported in the registration forms for social workers

Patients (n = 93)	
Number of patients who had:	n (%)
– completed some homework assignments	89 (96)
– held planned periods of relaxation and rest	86 (93)
– held planned periods of physical exercise	79 (85)
– held writing sessions	66 (71)
– resumed work during the treatment	64 (69)
– held rumination sessions	41 (44)

Table 4 General practitioners' experiences with the treatment

GPs (n = 30)	% agree (partially or fully)
I think that the treatment …	
– was time-saving for me	85
– has been a positive experience for my patients	85
– has fulfilled my patients' needs	85
– is an effective treatment	72
– had added value to my own treatment	58
– was more effective than social workers' regular treatment	42

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