Computerised Cognitive Therapy for Depression

Biographical Questionnaire

1. What is your date of birth?
(please write your date of birth)

		/			/				
day			*month*			*year*			

2. Are you?
(please cross one box)

Male ☐

Female ☐

3. Are you?
(please cross one box)

White – British	☐ 1
White – Irish	☐ 2
Any other White background	☐ 3
Mixed – White and Black Caribbean	☐ 4
Mixed – White and Black African	☐ 5
Mixed – White and Asian	☐ 6
Any other mixed background	☐ 7
Asian or Asian British – Indian	☐ 8
Asian or Asian British – Pakistani	☐ 9
Asian or Asian British – Bangladeshi	☐ 10
Any other Asian background	☐ 11
Black or Black British - Caribbean	☐ 12
Black or Black British - African	☐ 13
Chinese	☐ 14
Other, please specify here _____	☐ 15

4. What is your highest educational qualification?

GCSE/ O level	1
GCE A/AS level or Scottish Higher	2
NVQ/SVQ levels 1-3	3
GNVQ (Advanced)	4
B Tec Certificate	5
B Tec Diploma	7
National Certificate or Diploma (ONC/ OND/ HNC/HND)	8
Qualified Teacher Status	9
Higher Education Diploma	10
Degree (First Degree/ Ordinary Degree)	11
Post Graduate Certificate	12
Post Graduate Diploma	13
Masters Degree	14
PhD	15
Other	16
Don’t know/no response	17

5. Are you?
(please cross the box that describes you best)

Employed part-time	☐ 1
Employed full-time	☐ 2
Self-employed	☐ 3
Retired	☐ 4
Looking after family or home	☐ 5
Not employed but seeking work	☐ 6
Not employed but **not** seeking work because of ill health	☐ 7
Not employed, but **not** seeking work for some other reason	☐ 8
Other, please specify here _____	☐ 9

6. If employed, or self employed, are you currently off sick because of your depression?

Yes	☐ 1
No	☐ 2
Don't know/no response	☐ 3

7. If unemployed, how long have you been unemployed?

< 3 months	1
4-12 months	2
1-2 years	3
2-5 years	4
>5 years	5
Don't know/no response	6

8. Please give details of your most recent job

Is/was your position that of?
(please cross the box that describes you best)

Foreman/ supervisor	1
Manager	2
Self-employed with employees	3
Self-employed without employees	4
Other employee	5
I have never been in paid employment	6

9. What is your marital status?

Married	1
Living with a partner	2
Divorced/separated	3
Widowed	4
Never married	5
Other (please specify)	7
Don't know/no response	8

10. If married, does your spouse live with you?

Yes	1
No	2
Don't know/no response	3

11. Do you have other people living with you?

Yes	1
No	2
Don't know/no response	3

11a. If yes to question 11, how many?

1	1
2	2
3	3
4	4
5	5
6	6
7 or more	7
Don't know/no response	8

11b. How many of the people in question 11a are under 18?

1	1
2	2
3	3
4	4
5	5
6	6
7 or more	7
Don't know/no response	8

12. Have you had any previous episodes of depression for which you sought help?

Yes	1
No	2
Don't know/no response	3

12a. If yes to question 12, how many episodes of treated depression have you had?

1	1
2	2
3	3
4	4
5 or more	5
Chronically depressed	6
Don't know	7

12b. If yes to question 12, were you prescribed antidepressants for a previous episode?

Yes	1
No	2
Don't know	3

12c. If yes, to question 12, Have you ever seen anyone other than your GP for help with depression?

Yes	1
No	2
Don't know	3

12d. If yes to question 12c, who did you see?

Psychiatrist	1
Psychologist	2
Counsellor	3
Community psychiatric nurse	4
Social worker	5
CAB	6
Other statutory/voluntary agency	7
Don't know	8

13. Would you prefer to be randomised to receive computerised CBT?

Yes	1
No /Don't mind	2
Don't know	3

13a. If yes to Question 13, how strongly do you feel about your preference?

Not particularly strongly	1
Quite strongly	2
Very strongly	3
Extremely strongly	4

REEACT

Economic patient questionnaire

SECTION 1: SERVICE RECEIPT

1.1 Please record any use of inpatient hospital services over the last 6 months

*(**Note 1**: Please enter '0' if the service has not been used; **Note 2**: See manual for definitions)*

Service	No. of admissions	Total no. of inpatient days
Acute psychiatric ward	[APW_AD0]	[APW_DAY0]
Psychiatric rehabilitation ward	[PRW_AD0]	[PRW_DAY0]
Long-stay ward	[LSW_AD0]	[LSW_DAY0]
Psychiatric Intensive Care Unit (ICU)	[ICU_AD0]	[ICU_DAY0]
General Medical Ward	[GMW_AD0]	[GMW_DAY0]
Other …… [OT1_OHS0]	[OT1_AD0]	[OT1_DAY0]
Other …… [OT1_OHS0]	[OT2_AD0]	[OT2_DAY0]

1.2 Please record any use of outpatient hospital services over the last 6 months

*(**Note 1**: Please enter '0' if the service has not been used; **Note 2**: See manual for definitions)*

Service	Unit of measurement	Total no. of appoint/attend.
Psychiatric outpatient visit	**Appointment**	[POV_NUM0]
Clinical psychology outpatient visit	**Appointment**	[CP_NUM0]
Other outpatient visit (excl. A&E)	**Appointment**	[OV_NUM0]
A&E attendance	**Attendance**	[AE_NUM0]
Day hospital attendance	**Attendance**	[DH_NUM0]
Other …… [OT1_OHS0]		[OT1_NUM0]
Other …… [OT1_OHS0]		[OT2_NUM0]

1.3 Please record any use of any community-based day services over the last 6 months

*(**Note 1**: Please enter '0' if the service has not been used; **Note 2**: See manual for definitions)*

Service	No. of attendances	Average duration of attendance(minutes)
Day care centre	[DCC_A0]	[DCC_DUR0]
Drop-in centre	[DIC_A0]	[DIC_DUR0]
Sheltered workshop	[SW_A0]	[SW_DUR0]
Other …… [OT1_OHS0]	[O1CDS_A0]	[O1CDS_D0]
Other …… [OT1_OHS0]	[O2CDS_A0]	[O2CDS_D0]

SECTION 1: SERVICE RECEIPT

1.4 Please record any other primary and community care contacts over the last 6 months

*(**Note 1**: Please enter '0' if the service has not been used; **Note 2**: See manual for definitions)*

Service	Total number of contacts over the last 6 months	Average duration of contact (minutes)
General Practitioner (at GP surgery)	[ ][ ] **[C1_NUM0]**	[ ][ ] **[C1_TM0]**
General Practitioner (at patient's home)	[ ][ ] **[C2_NUM0]**	[ ][ ] **[C2_TM0]**
Practice nurse (at GP surgery)	[ ][ ] **[C3_NUM0]**	[ ][ ] **[C3_TM0]**
Counsellor	[ ][ ] [C4_NUM0]	[ ][ ] [C4_TM0]
District Nurse	[ ][ ] [C5_NUM0]	[ ][ ] [C5_TM0]
Community Psychiatric Nurse / Case Manager	[ ][ ] [C6_NUM0]	[ ][ ] [C6_TM0]
Social Worker / Care Manager	[ ][ ] [C7_NUM0]	[ ][ ] [C7_TM0]
Occupational Therapist	[ ][ ] [C8_NUM0]	[ ][ ] [C8_TM0]
Advocate (e.g. Creative Support)	[ ][ ] **[C9_NUM0]**	[ ][ ] **[C9_TM0]**
Home help/ Care worker	[ ][ ] [C10_NUM0]	[ ][ ] [C10_TM0]
Other (e.g. dentist)		
---------- **[C11_TYP0]**	[ ][ ] **[C11_NUM0]**	[ ][ ] **[C11_TM0]**
Other		
---------- **[C12_TYP0]**	[ ][ ] **[C12_NUM0]**	[ ][ ] **[C12_TM0]**
Other		
---------- **[C12_TYP0]**	[ ][ ] **[C13_NUM0]**	[ ][ ] **[C13_TM0]**

1.5 ***To be answered at follow-up interviews only.*** **Please record any use of computerised Cognitive Behaviour Therapy since the last REEACT interview**

*(**Note 1**: Please enter '0' if the service has not been used; **Note 2**: See manual for definitions)*

Computerised CBT Program	Total number of times used	Average duration of contact (minutes)
Name of Program **…….**	☐☐	☐☐
Where did you access this program? ***(Please tick all that apply)*** **At Home** **GP Surgery** **Community Location (e.g. Library)** **Other** **…….**	☐ ☐ ☐ ☐	
Name of Program **…….**	☐☐	☐☐
Where did you access this program? ***(Please tick all that apply)*** **At Home** **GP Surgery** **Community Location (e.g. Library)** **Other** **……**	☐ ☐ ☐ ☐	

1.6 ***To be answered at follow-up interviews only.*** **Please record any use of other self-help materials since the last REEACT interview**

*(**Note 1**: Please enter '0' if the service has not been used; **Note 2**: See manual for definitions)*

Computerised CBT Program	Total number of times used	Average duration of contact (minutes)
…….	☐☐	☐☐
Where did you use this material ***(Please tick all that apply)*** **At Home** **GP Surgery** **Community Location** **Other** **……..**	☐ ☐ ☐ ☐	
…….	☐☐	☐☐
Where did you use this material ***(Please tick all that apply)*** **At Home** **GP Surgery** **Community Location** **Other** **……**	☐ ☐ ☐ ☐	

SECTION 2: EXTRA COSTS

2.1 **How much have you had to pay for any medication or over the counter drugs (OTC) during the last 6 months?** [ ][ ][ ] [EXCST1_0]

2.2 **How much have you had to pay for any child-care during the last 6 months? (e.g. employing a child minder while attending hospital)** [ ][ ][ ] [EXCST2_0]

2.3 **How much have you had to pay for travel costs (e.g. bus fare, parking fees) to attend any appointments (e.g. hosp., GP, day care) during the last 6 months?** [ ][ ][ ] [EXCST3_0]

If you have taken any medication to help with your depression please give details: (please include both prescription medicine and any you may have bought yourself)

Name of medication …… Dose ……..

Name of medication …… Dose ……..

How long have you been / were you taking the medicine(s) ……..……..

SECTION 3: EMPLOYMENT

3.1 **What is your current occupational status?**

1 = Full-time paid or self-employment
2 = Part-time paid or self-employment
3 = Voluntary employment
4 = Sheltered employment
5 = Unemployed
6 = Student
7 = Housewife/husband
8 = Retired
9 = Other (specify) …… [OTH_EMP0] [ ] [EMP0]

3.2 **<u>If employed:</u>**

Please state your occupation
1= Manager/administrator
2 = Professional (e.g. health, teaching, legal)
3 = Associate professional (e.g. technical, nursing)
4 = Clerical worker/secretary
5 = Services/sales (e.g. retail)
6 = Skilled agricultural/fishery worker
7 = Skilled labourer/craftsman (e.g. building, electrical etc.)
8 = Elementary occupation (e.g. domestic, caretaker, labourer)
9= Armed Forces
10 = Other (specify) …… [OCC_NAM0] [ ][ ] [OCC0]

3.3 **How many hours do you work (on average) per week?** [ ][ ] [HRWRK0]

3.4 **How many days have you been absent from work owing to all illness in the last 6 months?** [ ][ ][ ] [AB_ALL0]

*(**<u>Note</u>**: See manual for definitions)*

3.5 **If unemployed:**

Please state reason for unemployment

*(**Note**: If more than 1 reason, please state primary reason)*

1 = Psychological problems
2 = Physical Disability
3 = General Employment Situation
4 = Redundancy
5 = Other (specify) …… **[UNR1_0]**

☐ [UNR2_0]

3.6 **Number of weeks unemployed in the last 6 months?** ☐☐ **[WEEK_UN0]**

reeact

Health Events Questionnaire

We are interested in finding out about any problems with your health that you may have experienced since you last filled in REEACT questionnaires, or were interviewed. We'd especially like to know about any problems or events that may be related to your depression.

Have you experienced any health problems since you last completed REEACT questionnaires, or were interviewed?

Yes ☐
No ☐

If yes, please could you describe these? Please give as much information as you can, including when the problem or event happened.

reeact

reeact

THE UNIVERSITY of York

SERIOUS ADVERSE EVENT/REACTION FORM
Computerised Cognitive Behaviour Therapy for Depression

REEACT is required to report quickly to our main Research Ethics Committee **any serious adverse events that may be related to the trial treatment**. We also need to know about serious adverse events that are not related to the trial treatment. To enable us to do this, please let us know **as soon as possible** of any serious events experienced by trial participants so that we can judge if they are trial related. Please complete this form as fully as you can and fax to your local REEACT centre on *<insert fax number>.*

Serious events/reactions are defined as fatal; life-threatening; resulting in persistent or significant disability or incapacity; resulting in or prolonging hospitalisation; resulting in a congenital anomaly or birth defect; or those which are deemed by the reporter as medically significant.

Patient Details

REEACT ID Number: GP Patient Number:

Sex (please circle): **M / F** Date of Birth:

Patient Initials: Weight (kgs) Height (cms)

Event Details

Please describe the event, any treatment given and the outcome:

Date event started: Date event stopped (if applicable):

Please indicate **why** you consider this event to be serious (please tick all that apply)

Patient died ☐ Involved inpatient hospitalisation ☐

Life-threatening ☐ Involved persistent or significant disability of incapacity ☐

Resulted in a congenital anomaly or birth defect ☐

Relationship of Event to Treatment (tick one box only)

Unrelated	Unlikely to be related	Possibly related	Probably related	Definitely related	Not able to assess if related
☐	☐	☐	☐	☐	☐

Your Details

Name, position and professional address

Tel No: Profession (Specialty)

Signature ..... Date

Please FAX this form to REEACT on <*insert fax number*>