DARING TO IMPLEMENT

CASE STUDIES TO INSPIRE COMMISSIONING OF SERVICES FOR DEPRESSION AND ANXIETY

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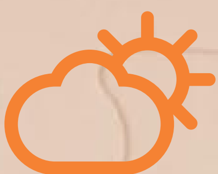

DepressionAlliance

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FOREWORD

Last year we launched 'Daring to Choose: 10 ways to improve choice for people with depression and anxiety' which demonstrated very clearly that people with depression do not have access to choice over treatment or the range of services they can receive locally for depression. The key barriers tended to stem from agencies still working in isolation and delivering a limited range of services and treatments that do not connect.

Based on the high level of interest in the recommendations that came from the Daring to Choose, we wanted to support the implementation of those recommendations through this guide.

I want to express my gratitude to the case study owners in this guide for taking part and sharing their ideas, and their great services. We have learnt so much from our visits and conversations with them. I also want to thank the agencies and individuals who have contributed so much through the consultations we have held and who have read and reviewed the report.

Daring to Implement is a way to recognise and celebrate success in examples of excellence, but more importantly through this guide we hope to inspire and motivate mental health commissioners to move beyond the traditional mindset and consider a diverse range of services for people with depression.

This guide includes just a handful of examples; we know we have missed many other great services that are out there. All the case studies demonstrate that success can be achieved through involving people in the planning and delivery of services, offering real choices in what and how people receive treatments.

We, of course, recognise that there is significant pressure on health services to find efficiency savings and therefore commissioners are having to make tough choices in what is a challenging time for the NHS. Given this climate it may seem now is not the time to invest in new approaches, but by reshaping services to be more inclusive of the people using them and working with other partners such as the voluntary sector, local employers, colleges and the sport and leisure industry, we can develop more effective support structures for depression that help people maintain their recovery.

Furthermore, there is strong evidence that the job losses, home repossessions and high-cost debt that have accompanied the economic downturn are having a profound impact on the UK's mental wellbeing, increasing pressure on mental health services. With finances due to be tightened, now is the time for commissioners to look at the route maps set out in this guide and adapt them according to their local needs.

But success does not just rely on commissioners wanting to reshape services, they need national and local support to implement these changes. That is why we are calling on the Government to make depression a public health priority as well as for primary care trusts to review their provision of depression services.

Emer O'Neill
Chief Executive, Depression Alliance

EXECUTIVE SUMMARY

Depression is one of the most common conditions for which people seek professional help in primary care. One in six adults will have a mental health problem at any one time and for half of these people the problem will last for longer than a year. Depression has a significant impact on the lives of the individuals affected and their families. The total loss of output due to depression and chronic anxiety was estimated to be £12 billion a year - 1% of national income, with a cost to the tax payer of £7 billion.

Traditionally, primary care has not been given the resources or expertise necessary to offer comprehensive treatment to people with depression. However, increasing recognition of the burden of depression on society, the economy and the health service, and an emergence of new thinking has led to new policies and guidance on providing a range of services and treatment options for people suffering from depression and anxiety.

New Horizons, the Government's recently announced mental health strategy, emphasises the importance of effective commissioning, local leadership and partnership working to deliver high-quality services for people with depression.

Depression is often a long-term condition and successful treatment outcomes depend on the range and appropriateness of the treatments and services available. Mental health commissioners have a vital role to play in providing access to a range of services and treatments for people with depression.

The case studies presented in this guide include a range of services and initiatives to deliver high quality services for people with depression. The aim of this guide is to inspire and motivate, giving practitioners involved in commissioning depression services a feel for what is possible.

- **Diverse and innovative services:** In Northamptonshire, the Changing Minds Centre offers 'choice appointments' to service-users based on CBT and motivational interview techniques to ensure the most appropriate intervention.
- **Integrating the care pathway**: A single point of access to services for depression has been established in NHS Kensington and Chelsea.
- **Promoting the use of appropriate and effective treatments:** A guide for General Practitioners on the Full NICE Guidelines is being produced by Bexley PCT.

- **Effective monitoring and evaluation:** At Southwark PCT, the Institute of Psychiatry conducted an audit of the implementation of NICE guidelines followed by training on the guidelines to improve the appropriateness of referrals and treatment options.

- **Working with IAPT:** The Atrium Clinic in Southend offers counselling, guidance and coaching to people with mild to moderate depression and has expanded its service to encompass the Improving Access to Psychological Therapies programme.

- **Supporting people with depression back to work:** Depression Alliance is using the power of peer support and self-help to help through a 'Time Bank' and other peer support groups. The service fills the gap left by medical and psychological treatment options in Croydon.

- **A multidisciplinary approach:** In Ealing PCT, professional barriers have been broken down with the establishment of multidisciplinary teams in three different geographical locations. The teams consist of Cognitive Behavioural Therapists and Vocational Advisors providing individual and group treatments for common mental health problems. All work alongside Mental Health Advocates, Community Development workers, counsellors and Gateway workers who assist those with moderate to severe mental health problems. The teams also benefit from the services of a Fitness and Activity coordinator.

- **Tackling health inequalities:** Age Concern Camden provides talking therapies for black and ethnic minority communities.

To read the Ealing PCT Mental Health & Well-being Service and Age Concern case studies, please visit the Depression Alliance website - www.depressionalliance.org

Commissioning challenges and opportunities

- **Depression should be a public health priority**
  Depression should be a recognised public health priority to the same extent as smoking and obesity. The personal and social burden of depression is significant. Commissioners should consider risk stratification as a means to indicate the level of depression in a local population and its impact on the local health service and also work closely with social services to identify appropriate joint approaches. Promoting mental well-being and supporting vulnerable people are vital in preventing mental illness.

- **The continuing challenge of stigma and discrimination**
  People with depression often find that the stigma and discrimination they face from others are significant obstacles to recovery.

- **The impact of health inequalities on treatment for depression**
  Addressing issues of health inequality is a key challenge for commissioners of mental health services. Significant inequalities between different socio-economic groups remain a regrettable feature of the NHS. Depression, by definition, will affect the ability of individuals to access services.

- **The absence of personal budgets for depression**
  To date, none of the pilots for individual budgets are targeted at people living with depression. The Full NICE Guidelines on depression provide detailed evidence of a broad range of treatments and services, which the case studies in this guide highlight, and may therefore provide the evidence required to establish personal budgets for depression.

- **Developing and maintaining a skilled workforce**
  Highly trained and integrated medical and non-medical staff are required to maintain high clinical standards and effective services for people with depression. The size and training requirements of workforces need to be monitored constantly so they can meet the changing needs of the populations they serve.

RECOMMENDATIONS ON COMMISSIONING SERVICES FOR DEPRESSION AND ANXIETY

This guide makes a number of recommendations to enhance effective commissioning for depression services and ensure that a range of services and treatment options are accessible to people with depression.

1 Effectively pool budgets to develop innovative local services to reflect local needs

In this rapidly changing environment, commissioners may lack up-to-date knowledge and skills, particularly in the realm of promoting partnership. A number of the services presented in this guide have forged creative partnerships enabling professionals to work with individuals on a wide range of factors that will support their journey to recovery including employment, housing, physical health and family, social, psychological and cultural issues. Mental health commissioning is a joint activity for health and social services, which brings together different organisational cultures and presents particular challenges for commissioners.

By working with partner organisations to pool budgets and develop services that reflect local needs which are based on consultation with local people, real progress can be made and projects can impact positively on the lives of those suffering from depression. Some of the most exciting schemes had sought funding from different sectors to facilitate the provision of diverse services.

2 Utilise the wealth of evidence in the Full NICE Guideline on depression

The Full NICE Guideline on depression, which is more detailed and extensive than the NICE Quick Reference Guide and summary of the NICE Guideline, contains a wealth of evidence on treatment options and services. Commissioners should consult the evidence in the Full NICE Guideline when developing and reviewing services for people with depression.
GPs and other practitioners should be encouraged to use the Full NICE Guideline to help

improve consistency and quality of care pathways, as it includes up-to-date information on medical and non-medical interventions.

Additionally, identifying a mental health commissioner or GP that is responsible for promoting awareness of the NICE guidelines is recommended, as demonstrated by the Bexley PCT case study.

3 Effectively involving and valuing people with lived experience of depression

By creating effective employment opportunities to value service users through appropriate payment and peer support activities, commissioners can ensure that people with lived experience of depression are able to participate in the planning and running of services. Commissioners should also look to invest in peer support posts within their organisation.

4 Continually improve services through making better use of monitoring and evaluation

While the monitoring of services may seem onerous, the benefits of accumulating good-quality, rigorous data that can be used to gauge the effectiveness of services is widely valued. Rigorous and robust testing of different models of care will help to identify and develop best practice for the future. The government has a set of recommended criteria for monitoring and evaluating IAPT services, which may provide a useful reference point for broader related services, in addition to the data GP's and primary care trusts collect.

THE ROAD TO RECOVERY: A PERSONAL STORY OF DEPRESSION

"There was no single cause for my depression and anxiety. I'm now middle aged and have had different experiences, disappointments and upsets which have accumulated over time. I've experienced a serious assault, redundancy, bereavement, unstable job history... all of these have accumulated and caused anxiety and stress.

What tipped me over the top into serious depression and anxiety was caring for my ill parents. My caring role evolved over many years but it was 4 years of constant caring while they were terminally ill. I gave up my last job to care for them and it was the attitude of health workers and social workers that caused stress - I was fighting the services to get the help Mum and Dad needed. I didn't get a day off in 4 years.

I was trying desperately to find work after my parents died...I kept on applying for jobs and failed at several interviews, which hadn't happened before. I took on a job, but left because I couldn't do even basic tasks.

All this happened over 18 months and I was at rock bottom. I ended up back at the Jobcentre, suicidal - I wanted to die and thought about this a lot. I knew something was wrong with me, I couldn't function at all."

The road to recovery...

"It was the Disability Employment Advisor (DEA) who suggested I join the Employment and Well Being (EWB) Project run by Depression Alliance.

The most important thing is it (EWB) was somewhere physically to go - it literally got me out of the house.

It gave me the chance to meet people who I could talk to, who knew what was happening to me because they'd experienced it themselves. Step-by-step I started coming out of my shell by taking part. I was mixing with other people; I'd not done that for a long time.

It gave me a safe place to talk - I felt that my family would listen for a while but that they judge you based on themselves; they want you to be 'together' like them and don't understand. At EWB you all have similar problems and you don't feel it's just you.

Taking part in the Time Bank gave me a sense of purpose, that I was still useful to society. It showed me that I could help and be helped; it showed me I could still make friends. I was worried about coming in to do the phone calls as part of the Time Bank swap - the experience of my last job had left me feeling a dead loss at talking on the phone. That was one of the things I'd failed at. My anxiety was still definitely there when I started making the phone calls to people, but after making a few calls I realised I was doing ok and the anxiety reduced - I went home feeling much more confident and proud of myself.

At first I was reluctant to let people into my home for any Time Bank swaps. I wanted help with my garden but had a fear that my home wasn't good enough to let people in, that it was too messy. But just letting people into the house and garden broke the ice. It made me get up and tidy my house - I'd not done that for a long time. It restored my pride in myself and my home. I felt I achieved something by helping myself and them - I thought, 'I have to let people help me so they can build confidence and have a reason to leave their homes'. I was facilitating that by having my garden done and I felt proud of myself.

I've used the Time Bank on my CV. It gives me a consistent work history. I say I've been involved in 'telephone and email communications with a mental health charity', and I can get references, use it in interviews too.

Since starting the EWB I've been involved in litter picking volunteering and also now volunteer one day a week at a local hospital in the admin department. It gave me the courage and confidence to try."

INTRODUCTION

During Depression Awareness Week in April 2009, Depression Alliance published Daring to Choose: 10 ways to improve choice for people with depression and anxiety. The report examined the barriers and solutions to achieving choice for people with depression and anxiety. A key recommendation of that report was that commissioners of services for depression must ensure that service users have access to a "diverse range of high-quality services, including culturally sensitive treatments and self-care" to enhance the traditional biomedical model of care.

Depression is a long-term condition and successful treatment outcomes depend on the range and appropriateness of the treatments and services available. This guide showcases high-quality services and treatments for people with depression and initiatives that can be used to improve the provision of appropriate diagnosis and management of depression and that inspire and encourage innovation in services for people with depression. It is a practical guide for mental health commissioners in primary care and Practice Based Commissioning (PBC) setting out key information on the management of depression and anxiety and recommendations for delivering a range of services for people with depression.

As the next section indicates, a significant number of people suffer from both depression and anxiety. Whilst the focus of this guide will be primarily on depression in adults, the principles and recommendations for commissioning in the guide apply to both depression and anxiety. Readers can find further guidance on treatment options for anxiety in the NICE clinical guidelines on anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care (CG22)[1] and the NICE clinical guideline on obsessive-compulsive disorder (OCD) and body dismorphic disorder (BDD) (CG31)[2].

Furthermore, depression should not be regarded as a mental illness in isolation, it is important to note that a variety of factors can impact on a person's mental well-being including debt, homelessness and sleeping disorders. This guide is unable to cover them all, but commissioners should be aware of the wide-ranging social and health issues that contribute to depression.

DEPRESSION: THE DEMOGRAPHIC AND ECONOMIC PICTURE

Depression is one of the most common conditions for which people seek professional help in primary care. One in six adults will have a mental health problem at any one time, and for half of these people the problem will last for longer than a year. The prevalence of depression has been estimated at 2.6% of the UK population and the prevalence of mixed anxiety and depression at between 5.5% and 8.8%[3].

The total loss of output due to depression and chronic anxiety was estimated to be £12 billion[4] - 1% of national income, with a cost to the tax payer of £7 billion. In 2008, The Kings Fund estimated the total cost of services for depression in England in 2007 to be £1.7 billion, whilst the average cost of lost employment was £9,311 per individual[5].

Employment rates for people with a mental health condition are low: with an overall rate of around 21%, compared to around 74% for the overall working age population. Research shows that fewer than 4 in 10 employers said that they would recruit someone with a mental health problem[6].

The social and financial costs of mental health problems are immense. The burden on individuals, families, communities and society includes psychological distress, impact on physical health, and social consequences as well as financial and economic costs. For people who do not get the help they need, depression aggravates their health and social problems, making them increasingly reliant on the benefits system. Appropriate interventions will, in the long term, minimise the need for referral to secondary mental health services while reducing suffering and helping people get back to work.

DEPRESSION IN MENTAL HEALTH POLICY

Traditionally, primary care has not been given the resources or expertise necessary to offer comprehensive treatment to people with depression. In 2008 it was estimated that only around a quarter of people with depression were receiving any type of formal care[7]. Introducing a package of care for depression is now a growing priority for the NHS, as is evident with the launch of the New Horizons strategy in October 2009.

The National Service Framework for Mental Health, published in October 1999, set out a ten-year plan for the modernisation of mental health services for adults of working age. It continues to form the core of many modern services for mental health. However, thinking has moved on considerably over the last decade, with a number of new policies and guidance documents emerging.

A new government vision for mental health services, New Horizons, was launched in December 2009, building on the work of the National Service Framework[8]. The scheme combines service improvement with a new partnership between central and local government, working alongside the third sector and the professions. Its aim is to strengthen the mental health and well-being of the whole population.

While continuing to promote access to psychological therapies, New Horizons prioritises partnerships across sectors, recognising the importance of issues such as returning to work after debilitating mental health episodes. Supporting New Horizon's employment agenda, a joint report by Rachel Perkins, Paul Farmer and Paul Litchfield on behalf of the Department of Work and Pensions was published, 'Realising Ambitions: Better employment support for people with a mental health condition'.

Particular emphasis is given to working environments, with new schemes to improve well-being in the workplace and help people with mental health conditions stay in their jobs. Service priorities are broader too, with prominent themes including health inequalities, the value of carers and dignity in care. The programme talks of "the importance of intervening earlier and more often, focusing on prevention, and offering more personalised care[9]."

"Services will need to be more based around models of recovery and seek to promote

positive mental health and well-being in a broader public health context."

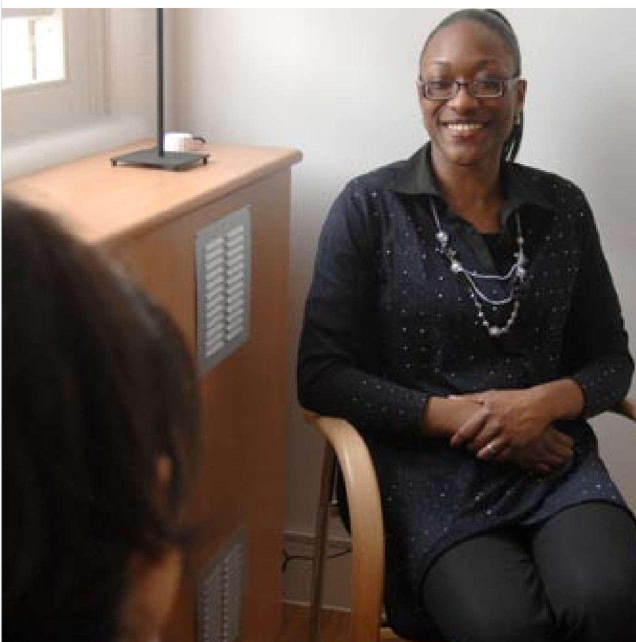
National Mental Health Development Unit, Commissioning friend for mental health services, 2009)

Guidance on the treatment of depression within primary care was published by NICE in February 2006 (Technology Appraisal TA097) and revised in 2009 (Clinical Guidelines 90 and 91). CG90 focuses on the treatment and management of depression in adults[10] and CG91 considers depression alongside chronic physical health problems[11]. The guidelines include the latest evidence base for medication and recommends the use of specific cCBT (computerised Cognitive Behavioural Therapy) products for the management of mild and moderate depression as well as panic and phobias, together with a range of face-to-face CBT interventions.

The government-funded Improving Access to Psychological Therapies (IAPT)[12] scheme was designed to implement this recommendation and broaden the range of treatment choices beyond medication-based solutions. There were two key principles: promoting choice by improving access to different treatment options and allowing service users to take more control of when and where their therapy was delivered; and expanding access to talking therapies.

PCTs were expected to be offering cCBT by March 2007. They were advised that, in addition to acquiring the necessary technology, they would have to undertake local needs assessments and provide appropriate staff training.

In addition to the World Class Commissioning competencies, commissioners need also aspire to meet the Quality, Innovation, Productivity and Prevention Challenge set out by David Nicholson, the NHS Chief Executive in response to the economic climate. He recommends the application of principles of co-production, subsidiarity, clinical leadership and system alignment as well as an evidence based approach to improve quality and productivity in the NHS[13].



MANAGING DEPRESSION: INFORMATION FOR COMMISSIONERS

Depression is a complex long term condition, this section outlines information on the diagnosis and management of depression and references further information for commissioners, notably the NICE guidelines on depression (CG90 and CG91). CG90 focuses on the treatment and management of depression in adults and CG91 considers depression alongside a chronic physical health problem.

Diagnosis of depression

The general practitioner is often the first port of call for people suffering from depression. GPs will base their diagnosis on the presence of a number of symptoms, including low mood (feeling low, unhappy, sad or miserable); fatigue (feeling tired or having little energy); and anhedonia (lack of interest or enjoyment in things).

Depression is ranked as mild, moderate, severe or depression with psychosis, depending on the number of symptoms present. NICE guidelines refer to two common diagnosis tools, DSM-IV and ICD-10, which are complementary. The DSM-IV system, favoured in the most recent NICE guidelines, requires at least five out of nine symptoms for a diagnosis of major depression. These should be present for at least two weeks and each symptom should be present at sufficient severity for most of every day.

Furthermore, the Quality and Outcomes Framework Indicators for depression include assessing patients with diabetes or coronary heart disease for depression, assessing newly diagnosed patients for severity of depression and holding a further assessment for severity 5 -12 weeks after the initial diagnosis[14].

Interventions

While depression is widespread, there are evidence-based treatments - medication, therapy and wider social support, offered either alone or in combination - proven to either aid recovery or alleviate the problem. Short, forward-looking treatments are available that enable people to challenge their negative thinking and build on the positive side of their personalities and situations. The most developed of these is CBT, which along with medication remains pivotal to the recovery of many people engulfed by depression.

The NICE guidelines for the management of depression, published in December 2004 and revised in October 2009, recommend a 'stepped care' approach, with the severity of depression determining the type of intervention (see Appendix 2 and 3). Stepped care has two key components:

a) The recommended treatment should be the least intensive of those currently available but still likely to provide significant health gain.

b) Stepped care is self-correcting, in that the results of treatments and decisions about treatment provision are monitored systematically and changes are made if current treatments are not achieving significant health gain (stepping up care).

The diagram below shows 4 steps of care from the NICE guidelines on depression in adults (CG90). Whilst the case studies presented in this guide may appear broader and more creative than those considered by NICE, all have taken on board the NICE model of stepped care. The Full NICE Guidelines on depression provide detailed evidence of both medical and non-medical interventions. The case studies will reveal the importance of understanding and using the Full NICE Guidelines.

Stepped Care Model for depression

Focus of the intervention		Nature of the intervention
Severe and complex[i] depression; risk to life; severe self neglect	STEP 4	Medication, high-intensity pyschological interventions, electroconvulsive therapy, crisis service, combined treatments, multi professional and inpatient care
Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	STEP 3	Medication, high-intensity pyschological interventions, combined treatments, collaborative care[ii] and referral for further assessment and interventions
Persistent subthreshold depressive symptoms or mild to moderate depression	STEP 2	Low-intensity pyschological and psychosocial interventions, medication and referral for further assessment and interventions
All known and suspected presenations of depression	STEP 1	Assessment, support, pyschoeducation, active monitoring and referral for further assessment and interventions

Note:
Adapted from Depression: the treatment and management of depression in adults, NICE Full Clinical Guideline 90, p118

(i) Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms and/or is associated with significant psychiatric comorbidity or psychosocial factors.

(ii) Only for depression where the person also has a chronic physical health problem and associated functional impairment.

The stepped care model recommends that medication should not be routinely prescribed for people with mild (sub-threshold) depression, as the risk/benefit ratio is poor. The new guideline issued in October 2009 suggests that medication should be considered for people with:

- a past history of moderate or severe depression or
- initial presentation of sub-threshold depressive symptoms that have been present for a long period (typically at least two years) or
- sub-threshold depressive symptoms or mild depression that persist(s) after other interventions.

The guideline also reviews individual medicines in the treatment of depression and includes details of new data on medication and studies for newly licensed medicines.

Furthermore, the NICE Guidelines advise that all interventions for depression should be delivered by competent practitioners, using relevant guidelines and competency frameworks. Psychological and psychosocial interventions should be based on the relevant treatment manual(s). Practitioners should also:

- Be subject to regular, high-quality supervision
- Use routine outcome measures and ensure the person with depression is involved in reviewing the efficacy of the treatment
- Engage in monitoring and evaluation of treatment adherence and practitioner competence
- Make full use of the evidence base and guidance in the NICE documents CG90 and CG91.

The NICE Guidelines make it clear that a diagnosis of depression must be based on more than a symptom count and should take into account both the degree of functional impairment and/or disability associated with the potential depression and the duration of the episode. The final choice of treatment should be influenced by:

- The duration of the episode of depression and the trajectory of symptoms
- The previous course of depression and response to treatment
- The likelihood of adherence to treatment and any potential adverse effects
- The person's treatment preference and priorities.

In addition to diagnosing and treating depression, NICE has produced public health guidance on mental well-being. Mental well-being in older people[15] provides advice on physical activities older people could undertake to promote well-being and mental well-being at work[16] offers advice on productive and healthy working conditions.

COMMISSIONING SERVICES FOR PEOPLE WITH DEPRESSION

The aims of commissioning are relatively straightforward: to identify the needs of the local population, commission a range of effective services within defined financial parameters, and monitor the effectiveness of those services to ensure improvements in health and well-being. However, the National Mental Health Development Unit identified a number of factors likely to affect mental health commissioning, such as the World Class Commissioning framework, finite resources, the performance requirements of local NHS bodies and local authorities, the need to tackle stigma and discrimination, and the importance of choice and service user/carer involvement[17]. Moreover, according to QIPP principles mental health commissioners should seek to improve quality and productivity through innovative and preventative services. Additionally, from 2010 onwards, a new standard contract for mental health services, covering agreements between PCTs and providers, aims to end the need for block contracts while enabling greater flexibility and improving the quality of commissioning by defining clear and specific outcomes. Performance imperatives for the commissioned mental health services are now more integrated into broader targets for health and social care.

Depression Alliance held a roundtable discussion with key experts on commissioning services for depression (see Appendix 1 for the participants of the roundtable discussion). The outcome of the meeting was the identification of a number of key challenges that exist in the context of commissioning services for depression, which mental health commissioners should consider when developing services. Participants also made recommendations for mental health commissioners on commissioning of a range of services and treatments for people with depression.

Commissioning challenges and opportunities

Depression should be a public health priority

Depression should be a recognised public health priority to the same extent as health priorities such as smoking and obesity. The personal and social burden of depression is significant. Commissioners should consider risk stratification as a means to indicate the level of depression in a local population and its impact on the local health service, and also work closely with social services to identify appropriate joint approaches. Services that promote mental well-being and support vulnerable people are vital in preventing mental illness.

The continuing challenge of stigma and discrimination

People with depression often find that the stigma and discrimination they face from others are significant obstacles to recovery[18].

The impact of health inequalities on treatment for depression

Addressing issues of health inequality is a key challenge for commissioners of mental health services. Significant inequalities between different socio-economic groups remain a regrettable feature of the NHS. Depression, by definition, will affect the ability of individuals to access services. Innovative approaches to enable culturally-sensitive tailored services for marginalised groups, such as Black and Minority Ethnic (BME) communities, young men and lone parents, are essential.

Age Concern Camden

The Age Concern Talking Therapies project is targeted at older people from BME communities offering a safe place to discuss problems, thoughts, experiences and feelings. The service provides free, mother-tongue counselling and support covering issues such as being diagnosed with dementia, depression and anxiety, bereavement, illness, disability and relationship problems. Langauges offered by the service include Hindi, Tigrinya and Urdu.

The absence of personal budgets for depression

To date, none of the pilots for individual budgets are targeted at people living with depression. The Full NICE Guidelines on depression provide detailed evidence of a broad range of treatments and services, which the case studies in this guide highlight and may therefore provide the evidence required to establish personal budgets for depression.

Developing and maintaining a skilled workforce

Highly trained and integrated medical and non-medical staff are required to maintain high clinical standards and effective services for people with depression. The size and training requirements of workforces need to be monitored constantly so they can meet the changing needs of the population they serve.

1 Effectively pool budgets to develop innovative local services to reflect local needs

In this rapidly changing environment, commissioners may lack up-to-date knowledge and skills, particularly in the realm of promoting partnership. The pathways and relationships between the various statutory and non-statutory bodies are complex. There are some excellent examples of collaborative working between agencies, but for many there is scope still to develop this further.

"Now I understand the landscape and I feel I can do things that have influence. But it took me a long time to get there. I've seen a lot of GPs who have worked really hard to promote particular schemes and ideas but because they don't have the links or networks they've not managed to secure funding."
(Dr Fiona Butler, PBC Mental Health Lead)

A number of the services presented in this guide have forged creative partnerships enabling professionals to work with individuals on a wide range of factors that may affect their mental health, including employment, housing, physical health and family, social, psychological and cultural issues. Furthermore, commissioning needs to be more tailored to specific demographic segments, such as older people with depression, BME groups, people with co-morbidities and vulnerable adults. Some of the most exciting schemes had sought funding from different sectors to facilitate the provision of diverse services.

Services benefit from flexibility of provision, fostered by good partnerships. The revised Commissioning Friend for Mental Health Services (2009) noted that the landscape for commissioners had changed significantly over the previous decade, with a broader focus "reflecting the need to view mental health as a whole population issue. This includes moving towards a more holistic approach to service delivery and through such an approach enabling service users to experience positive mental health and well-being[19]."

As such, there is increasing onus on successful and innovative partnership across statutory services and the third sector. Mental health commissioning is a joint activity for health and social services, which brings together different organisational cultures and presents particular challenges for commissioners[20]. Furthermore, New Horizons calls for 'local leadership' from

local authorities and health commissioners working in local strategic partnerships (LSPs) and professional leadership to drive quality across the pathways and to empower frontline staff to improve the quality of services.

Mental health issues need adequate representation in all joint partnership forums and bodies, including Joint Strategic Needs Assessments, Local Area Agreements, Local Strategic Partnerships, Joint Commissioning Boards and Practice Based Commissioning consortia.

There is also growing emphasis on good communication and partnership with key stakeholders, such as user groups and their families/carers; clinicians and other professionals; local providers including the NHS and voluntary sector; the police and criminal justice system; local authorities; and SHAs. The term 'co-production' is used to describe working together to maximise the potential of mental health services by actively engaging service users and the local community as partners in the design and delivery of services[21].

2 Utilise the wealth of evidence in the Full NICE Guideline on depression

The Full NICE Guideline on depression, which is more detailed and extensive than the NICE Quick Reference Guide and summary of the NICE Guideline, contains a wealth of evidence on treatment options and services. Commissioners should consult the evidence in the Full NICE Guideline when developing and reviewing services for people with depression. GPs and other practitioners should be encouraged to use the Full NICE Guideline to help improve consistency and quality of care pathways, as it includes up-to-date information on medical and non-medical interventions.

Additionally, identifying a mental health commissioner or GP that is responsible for promoting awareness of the NICE guidelines is recommended, as demonstrated by the Bexley PCT case study.

3 Effectively involve and value people with lived experience of depression

By creating effective employment opportunities to value service users through appropriate payment and peer support activities, commissioners can ensure that people with lived experience of depression are able to participate in the planning and running of services. Commissioners should also look to invest in peer support posts within their organisation.

4 Continually improve services through making better use of monitoring and evaluation

While monitoring of services may seem onerous, the benefits of accumulating good-quality, rigorous data that can be used to gauge the effectiveness of services is widely valued. Rigorous and robust testing of different models of care will help to identify and develop best practice for the future. The government has a set of recommended criteria for monitoring and evaluating IAPT services, which may provide a useful reference point for broader related services.

CASE STUDIES

First and foremost, the case studies included here are intended to inspire and motivate, giving practitioners involved in commissioning depression services a feel for what is possible and encouraging them to think about broad-based and creative solutions.

The case studies were selected on the basis that they met some or all of the following criteria:

- Services should demonstrate innovative and diverse commissioning practice.
- They should highlight/emphasise different aspects of the care pathway, from education to identification of symptoms, support, pharmacological treatments, psychotherapies and self-care packages.
- Services should include an element of monitoring and evaluation, with quality indicators against which measurements could be made.
- Service users should be involved in the development and evaluation of services.
- Services should seek to empower users and to fight stigma and discrimination.
- They should seek to improve access for excluded/marginalised groups.

CASE STUDY ONE:
DIVERSE AND INNOVATIVE SERVICES

Changing Minds Centre, Northamptonshire

Set up in 2006, the Changing Minds Centre provides support and therapy for people in mental distress, together with a range of training opportunities. The philosophy is patient-centred, with services informed, developed and delivered by people with a real understanding of what mental distress feels like.

The Centre is an independent company that works with service users, carers, health professionals and partner organisations. It offers a broad range of services, focused on well-being and prevention as well as mental health and its treatment. Clients should normally be scoring more than 8 on the Hospital Anxiety and Depression Scale, although in practice the Centre will see anyone whose well-being is at risk.

This was originally a 'trailblazer project', established by a small team who saw a gap in mental health provision. An audit found that that some 6,000 people a year in Northamptonshire were referred to secondary care with mental health problems, then returned to primary care as their problems were difficult to assess or were not considered serious enough. Last year the Centre assessed around the same number of people, with 70% going on to receive some form of intervention. Subsequently, 76% of clients with depression and 70% with anxiety moved from 'clinical caseness' to recovery.

Initial funding for mental health education and training in primary care came from the PCT, which now funds one-to-one therapy and peer support, while educational group courses (Learn 2B) are jointly funded by Adult Learning, Changing Minds Northamptonshire, the County Council and the Mental Health Foundation. The Department of Health has chosen Changing Minds to provide the IAPT service across Northamptonshire, which brought in an extra 20 staff from September 2009.

Everyone referred to the Centre is offered a 'choice appointment'. "The first appointment is based on a CBT model though staff also incorporate techniques from motivational interviewing. Everyone is asked the question 'What are your thoughts on coming to see us today?' The interview is gentle and clients are encouraged to think about what form of action/treatment will best fit their needs. They are empowered to make choices. If, following discussion, we decide together that they don't need one

to one therapy then we will signpost them onto other services either within the centre or beyond."

(Mike Scanlan, Nurse Consultant)

Around 30% of clients will then decide they either don't want or don't need to go any further. More complex cases may be signposted to other services. Step 2 interventions include one-to-one or group therapy, available under the Wellbeing Service and modelled on CBT, Solution Focused Therapy or Motivational Interviewing. Clients who are not improving move to step 3, which is more intensive and may include CBT, Eye Movement Desensitisation and Reprocessing, and Interpersonal Therapy.

The aim of all interventions is to guide people through the wealth of information, resources and support available and give them choices to help them make positive lifestyle changes. This is done by Well Being Teams, divided into four clusters and working across Northamptonshire in partnership with primary care colleagues. A number of specialist services are provided within the Wellbeing Teams:

Parental Mental Health and Wellbeing Service

This is offered in primary care to women and their partners during the perinatal period and beyond. Teams work closely with health visitors, GPs, midwives and specialist mental health services, as well as partners in children's centres, higher education, libraries, and children and families services.

Core services include New Beginnings, an eight-week course that helps parents to understand post-natal depression and explore coping strategies; and Read Yourself Well, which promotes reading as a means to address personal issues.

Peer Support Team

Peer Supporters both offer local people the chance to talk about their feelings and help them to plan their recovery. Peer Supporters do not have clinical qualifications but have lived experience of mental health distress. They work one-to-one and offer group sessions within the community.

Learn2B

This partnership between Changing Minds, Northamptonshire PCT, Northamptonshire County Council, Adult Learning Service and the Mental Health Foundation offers a range of creative, social, recreational and therapeutic groups, covering topics such as 'sleep', 'self-esteem' and 'anger'. Non-medical interventions include; courses on Healthy Living (e.g. yoga, food and mood); Creative Expression (creative writing, painting); and Wellbeing (dealing with distressing experiences such as anxiety).

Since IAPT was introduced, there has been a more rigorous procedure for monitoring and evaluation. Changing Minds also has its own tailored evaluation form. Patient satisfaction data indicate that 97% of clients are "happy" with the service received.

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CASE STUDY TWO: INTEGRATING THE CARE PATHWAY

Primary Care Mental Health Services - NHS Kensington & Chelsea

Three years ago the counselling service for NHS Kensington and Chelsea (NHS K&C) was patchy and inconsistent, covering only around one third of all practices. It employed a large number of part-time counsellors whose functions overlapped with those of Primary Care Liaison Nurses employed by the Mental Health Trust.

Dr Fiona Butler, the Mental Health Lead at NHS K&C and a Practice Based Commissioner was acutely aware of the inconsistent service and its impact on patients. She set out to develop and implement a new model for primary care mental health with a single access point for patients with depression, offering good assessment and referral systems as well as flexible, easy access to therapy and support across a range of settings.

With support from Helen Dunford, Practice Based Commissioning Manager, Dr Butler was able to clinically drive the new model forward. Investment was made in service provision by mental health professionals and in creating space for therapy in GP practices and specialist centres.

An estimated 1,800 patients in NHS K&C have common mental health symptoms too complex to manage without additional support in primary care, yet are ineligible for referral to secondary care. Among the total population, up to 50% of patients with a Severe Mental Illness are looked after solely in primary care.

GPs refer patients to the service, where they are assessed by a high-level therapist and triaged to one of three possible routes: 1) low level support (self-help); 2) Step 3a or 3b (Cognitive Behavioural Therapy); 3) Step 3c (Intermediate Care, for patients with complex depression and anxiety who were previously 'bounced around' the system).

Two specialist centres are up and running, offering a choice of appointment times; a single point of access and assessment for CMH problems; a better range of therapies; intermediate care with proactive follow up and case management for patients with more complex problems; and improved governance. There is a linked Locally Enhanced Service for depression in NHS K&C, which works across Personal Medical Services and General Medical Services, focusing on enhanced management, data recording and pro-active follow-up for patients. It also reinforces the care pathway for the new model in terms of treatment options.

PBC savings were used to support the project set-up. Additional funding came from NHS K&C investment income. An application for IAPT funds was turned down on the grounds that the project was an integrated rather than a 'stand-alone' service.

The BME communities, young men and older people were identified as having particular difficulties accessing mental health services. Four community development workers and a specialist counsellor have particular responsibility for hard-to-reach communities, while therapies are provided in pleasant buildings removed from the clinical environment.

A number of factors were crucial to the success of the NHS K&C model. One was Dr Butler's vision and commitment as a GP Practice Based Commissioner and mental health lead with dedicated management support. Dr Butler says she has learnt to navigate the funding pathway to make the NHS K&C service happen:

"I've learnt over the years that if I want to get something to happen I have to ensure that it fits into a funded pathway - such as Quality Outcomes Framework (QOF) or a Locally Enhanced Service (LES). Unless you can identify a lever it just doesn't happen... I've seen a lot of GPs who have worked really hard to promote particular schemes and ideas but because they don't have the links or networks they've not managed to secure funding."
(Dr Fiona Butler, PBC Mental Health Lead)

Another factor was development of a clear vision through good understanding of procedures and referral pathways between primary and secondary care. Referrals cannot be made directly from secondary care but must come through a GP. GPs were given training in appropriate treatment options through 'protected time for learning', and a named therapist was assigned to each practice for outreach and liaison work.

Good information systems are key to empowering patients and ensuring that both patients and professionals can optimise available services and care pathways. NHS K&C have pioneered a Signposting Data Base for Psychological Health and Well Being, with information on available services and resources from every local and national voluntary group as well as a range of statutory bodies working in mental health.

A new clinical information system will support routine collection of service activity and outcomes for all patients referred to the service. Monitoring and evaluation is carried out against a series of performance indicators covering health and well-being outcomes, patient experience, waiting times and clinical governance.

CASE STUDY THREE: PROMOTING USE OF APPROPRIATE AND EFFECTIVE TREATMENTS

Managing Mental Health in Bexley: A Guide

Dr Wallat is a GP based in Bexley PCT with a special interest in mental health. He is the author of a forthcoming guide for GPs and related mental health professionals working in the Bexley area. Dr Wallat is also one of a group of GPs currently setting up Bexley Community and Mental Health Services Ltd, a company commissioned by Bexley Care Trust to establish IAPT in the borough.

The impetus for the guide was the realisation that GPs increasingly adopt particular areas of interest or specialism and may consequently feel sidelined or lack information in other areas. It also addresses the growing number of inappropriate referrals to secondary care in mental health. The guide was facilitated by Lundbeck Limited, a pharmaceutical company, who provided help with collating the information and publishing the guide.

"This guide is intended to give GPs increased confidence in effectively treating patients suffering mental health problems, rather than immediately offloading them on to secondary care."
(Dr Wallat)

Due to the pressures of workload and other local and national health priorities, GPs may find it helpful to receive support on understanding the range of effective treatment options and services as outlined by the Full NICE Guidelines. An effective and appropriate response to depression is essential in ensuring that people with depression can maintain their recovery and do not place additional demands on already over-stretched mental health services.

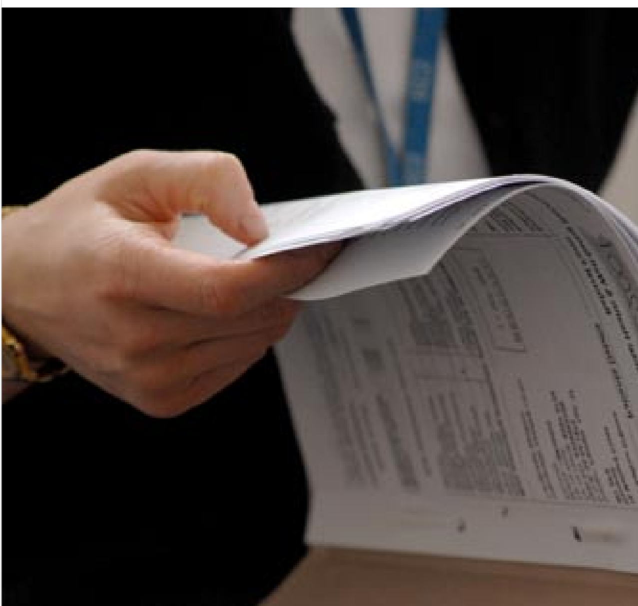
The Bexley guide draws on detailed advice set out in the most recent NICE guidelines and is fully compatible with these guidelines. It includes links to relevant websites as well as guidance from voluntary and statutory agencies. Among the areas covered are:

- How to diagnose different forms of depression and anxiety. This includes screening questionnaires like GAD-7, DSM-IV and ICD-10, as well as a flow chart on conditions such as Obsessive Compulsive Disorder and various phobia.
- Assessing co-morbidity of depression and chronic physical health problems.

- Guidance on different treatment options and pathways.
- The electronic version of the guide can be loaded onto the clinician's desktop. Links throughout the document aid navigation and direct GPs to online resources such as symptom scoring and matching treatment recommendations.
- A flow chart detailing pharmacological treatment options for depression. There are specific therapy recommendations as well as guidance on reviewing treatment and switching between different antidepressants.
- A section on psychological therapies, with links to local voluntary mental health groups such as Mind, together with information on referral/treatment criteria.
- General information on Serious Mental Illness, including contacts for advice on referrals into secondary care and an outline of different referral pathways.
- Related information on local substance abuse services, homelessness groups and peer support.
- Detailed information on diagnosing dementia, together with guidance on referrals and pharmacological treatment options.
- Related community resources for mental health and a list of local self help groups, websites and books which may help people with depression.

The first draft of the guide is out for consultation with a range of key primary care commissioners and mental health professionals. The final version will be available as a booklet, and online through BEXNET.

The PCT is keen that methods are found to monitor and evaluate the impact the Guide has on GP practice. Dr Wallat is exploring potential evaluation strategies, such as following up with GPs after a set period of distribution (e.g. 6 months) or looking at referral patterns into secondary care (i.e. to Oxleas Care Trust).



CASE STUDY FOUR: EFFECTIVE MONITORING AND EVALUATION

Effective monitoring and evaluation on improving the implementation of the NICE Guidelines for Depression in Southwark - Institute of Psychiatry and South London and Maudsley Mental Health Foundation Trust

Dr June Brown, Southwark Head of Psychology and Louisa Rhodes set out to monitor how well services in the London borough of Southwark were implementing the NICE Guidelines for Depression and Anxiety Disorders. The aim was then to identify any gaps in the implementation of the Guidelines; improve implementation, particularly of stepped care; and encourage services to offer more evidence-based treatments such as CBT.

An audit conducted from October 2007 to March 2008 had shown the NICE Guidelines were not being fully implemented within Southwark community services. For example, 20% of patients referred to the Assessment & Brief Treatment (ABT) secondary care teams (Step 4) were judged unsuitable and referred back to their GP. The data also showed that severity of depression was not always being documented as part of patients' diagnoses, which could be making it difficult for clinicians to determine which guidelines to follow. The results showed that the GPs were not the only ones finding it difficult to consistently implement stepped-care; based on a strict interpretation of the NICE Guidelines for depression (2004), about half of patients treated by the ABT teams and about a quarter of those treated by the Southwark Primary Care Psychology Service were receiving treatment at the incorrect level. Further, only 20% of those treated by the ABT teams were offered combined treatments (psychiatric medical review and CBT), recommended for Step 4, against 96% of patients at the psychology service being offered CBT, a first line psychological treatment for step 3.

There were three main implementation projects:

- Dissemination of the findings from the first audit. A report and executive summary were circulated to service leads. The results were also presented to a wide range of audiences, including GPs, ABT staff, psychologists and counsellors.
- Training and Link-working. ABT staff, counsellors, psychologists and primary care mental health workers were invited to one of five training events, with the aim of

encouraging collaboration between staff working at different levels of stepped care. GP surgeries were visited to inform them about the project and conduct an initial survey of guideline knowledge. Follow-up visits were organised to share preliminary findings and offer training.

- Assessment Manual. A manual was developed by Debbie Garlick and Louisa Rhodes for the ABT teams, encouraging them to perform a comprehensive assessment before making decisions about referrals.

A second audit is underway, using the same methodology as the first but covering the period from February to October 2009. Preliminary findings show:

- More diagnoses were recorded and staff were identifying different severities of depression.
- Only 9% of patients assessed by the ABT teams were referred back to their GP.
- Stepped care significantly improved. Using the definitions provided by the updated Guidelines (NICE 2009) for the audit 1 data, the proportion of people who were on the correct step of the stepped care model was 76% for the ABT teams and 87% for Community Clinical Psychology Service (CCPS). For the audit 2 data the proportion of people who are at the right step of the stepped care model (NICE, 2009) had significantly increased to 96% for ABT teams and 100% for the Southwark Primary Care Psychology Service.
- The ABT teams were offering combined medical and psychological treatment to slightly more patients (29%) and 98% of patients treated at the Southwark Primary Care Psychology Service were offered a CBT intervention.

In addition, Southwark successfully obtained Department of Health funding to introduce the IAPT programme, which has significantly increased the availability of Guided Self-Help, CCBT, CBT therapy and mindfulness groups at levels 2 and 3 of the stepped care model.

In summary, there have been clear changes as a result of the project in better diagnoses, fewer people being referred back to the GP and better use of the stepped care model. The offer of CBT and of CBT/medication could be improved, and this is something that they are trying to work on further.

Learning Points

The most significant learning point was the importance of working with staff at a local level, so their support and interest were harnessed throughout. Many staff contributed to the implementation of the initiatives, from completing the staff questionnaires and attending training sessions to piloting the assessment manual and helping with amendments.

The first audit enabled the team to pinpoint gaps in implementation of the NICE Guidelines and was a valuable starting point in determining what changes were needed in the services. Surveys of ABT staff and GPs meant the audit results could be put into context and some of the implementation work tailored to staff needs.

Training not only increased awareness of the Guidelines but gave staff a tool they could use in deciding on the appropriateness of referrals to their service. Many ABT staff now refer to the Guidelines in their letter back to the GP when rejecting a referral because the patient should be receiving treatment in primary care.

Finally, dissemination of the findings helped provide justification for changes and staff responded positively to both the training sessions and the assessment manual. The manual has been an important factor in helping to ensure all patients are given a thorough assessment before treatment decisions are made and that staff are using the same framework for each patient.

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The Atrium Clinic and Therapy Centre, Southend

Based in Southend, the Atrium Clinic and Therapy Centre was set up by GPs and a consultant psychiatrist in 1999 to address perceived gaps in provision for people going through periods of mild to moderate depression:

"In between those described as the 'worried well' and people at the upper end of the scale ... there appeared to be a lot of people who fell through the support and treatment net. Secondary care offers a more intense and comprehensive service, and consequently is more expensive. Services like ours can keep people out of secondary care."

(Caroline Elias)

Its first contracts were with two South Essex PCTs commissioning primary care counselling services in non-clinical settings. The Atrium was selected to provide educational group work and individual one to one counselling. Initially, the clinic was set up with private funds and located within accommodation adjacent to one of the director's surgeries. However upon securing additional contracts, the centre was able to move to a more central and serviceable location.

Counselling services have been provided both to NHS patients referred through their GP, and to private clients. The Atrium is also involved in the Condition Management Programme (CMP), a joint partnership between Essex PCTs and Jobcentre Plus.

The centre provides counselling, guidance and coaching, as well as workshops aimed at resolving issues where shared experience can bring support and encouragement. Staff work in calm, safe environments that recognise the difficulties associated with depression and anxiety. There are 12 qualified and experienced counsellors from a wide range of specialisms.

The pattern of service provision has changed considerably since the introduction of IAPT in 2009. A lot of work and resources have gone into training and set-up, so levels of effectiveness should become more apparent over the next year or so. Pre-IAPT, around 60% of referrals came through local GPs. The procedures varied enormously: some GPs simply described patients as "stressed" while others followed more standard assessment tools such as CORE Net. Now GPs refer on to the centrally based IAPT triage service, thereafter a therapist based in the surgery will contact the patient to discuss his/her care package. If appropriate,

the patient may be referred to an Atrium therapist for a course of up to six counselling sessions.

It is hoped in the future that a benefit of IAPT will be an increase in patient throughput and reduced waiting lists for counselling services. At the Atrium at this moment in time, the ratio of NHS to private clients has shifted dramatically, with only 10% of the client base now seen privately.

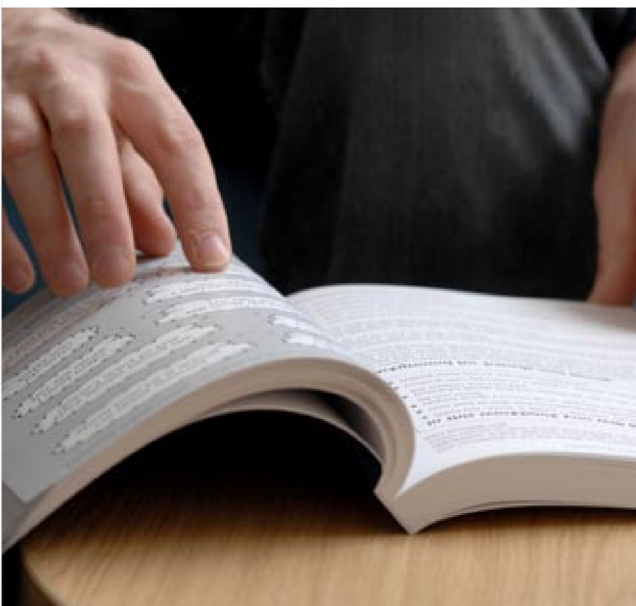
All the same, there is a sense that the centre has lost something of its old flexibility. Previously it offered many different types and styles of therapy including 'person-centred' and 'psycho-dynamic' counselling. The focus of IAPT, however, is almost exclusively on Cognitive Behavioural Therapy:

"The trouble to date with IAPT is that the specifications for delivery are so rigorous that a big chunk of the funding has gone on training staff and putting things in place, rather than seeing clients. Our funding is much less than was originally promised, so the throughput of clients is reduced." **(Caroline Elias)**

The wide range of specialist services offered at the centre include anger management; bereavement and loss; stress management; self-harm and eating disorders; perinatal depression; chronic fatigue syndrome; depression (mild to moderate); obsessive compulsive disorder; phobias/panic attacks; and sexual/physical abuse issues. Treatment involves a confidential and non-judgemental dialogue, whereby the counsellor and client establish what the issues are and work towards solutions in a therapeutic alliance.

The CMP has operated since August 2004, helping people who want to get back to work but are restrained by a health condition. The focus is on promoting health rather than treating illness. In Essex there are three strands: a lifestyle programme; a mental health programme; and musculoskeletal support. The Atrium provides the second component in the form of group sessions addressing specific mental health barriers to working. Data demontrates that on completing the programme, 30% of those attending do return to work.

The centre monitors clients at the start and finish of treatment through CORE 34 assessment forms. Data from 2009 is currently being analysed. The Atrium also routinely asks clients to fill in 'Happy Sheets'/ Evaluations upon completing treatment.



CASE STUDY SIX: SUPPORTING PEOPLE WITH DEPRESSION BACK TO WORK

Employment and Well Being Project, Depression Alliance

Established by Depression Alliance in June 2008, the Employment and Well Being (EWB) Project in Croydon was developed based on feedback from Depression Alliance members who felt there was often a gap in provision for people with depression, either following treatment from their GP or when criteria for psychological services were not met.

The project supports people with non medical interventions and compliments medical treatments available for depression. People are referred from the local psychological therapies service in Croydon, GPs, Job Centre Plus and can self refer. The projects builds on Depression Alliances self help ethos, we believe whole heartedly in the power of peer support in maintaining recovery. Members of the project work alongside professionals as partners in delivering mental health services. The goals are maintaining recovery, preventing relapse, limiting social isolation and improving employment outcomes.

Funded by a three-year grant from the Department of Health, the project complements moves towards better mental health treatment through wider choice and Improving Access to Psychological Therapies. The services offered are:

A Specialist Time Bank

The aim is to build supportive, interdependent communities by establishing local links between people with depression and anxiety through exchange of time and skills. Hours spent are deposited at the Time Bank and can be used for services offered by other members, such as gardening, ironing, reflexology or IT training.

The Time Bank can aid recovery by promoting self-help strategies; encouraging self-esteem; developing work skills; reducing social isolation; building a local peer-support network; and providing access to help that may otherwise be unaffordable. Although Time Banks have been around for a long time, this is the only Time Bank where people are united by the fact that they all have depression or have had depression and by meeting to exchange skills people build a close network of local people with depression.

"As part of the Time Bank, project members interested in the therapeutic merits of creativity formed a group to create hand-

crafted Christmas cards. Depression Alliance paid members with credits for each hour given to the project. The group was loaned an initial sum of money by Depression Alliance and then worked on the design, production, marketing and sale of the cards keeping account of expenditure and profit. One member has moved on to hand-crafting cards beyond the remit of the project, bringing not only financial reward but feelings of value and empowerment following many years of ill health."

(Hannah Manser, Employment and Well Being Team Leader)

Employment Information Advice and Guidance

Two Information Advice and Guidance personal assistants work within the project hub, offering support to members who want to develop their time-banking skills and move into education, volunteer work or paid employment. The service is also available to people facing difficulties in the workplace due to mental health issues.

Exercise and Fitness Events

People with depression can lose the motivation to maintain their mental health through diet and regular exercise. The coordinators encourage project members to take part in different exercise events run locally and to form groups of like-minded people who can support each other in maintaining physical activity.

Social Events Calendar

Often it is the loneliness people feel when well that can trigger depression, while chronic depression may leave people without an active social life. Project members coordinate a range of social events, from regular nights in the pub to dinner events, fishing and cinema trips.

The qualifying criteria for the project are symptoms related to or clinical diagnosis of, depression and/or anxiety in adults aged18 and over. The majority of referrals come from The Priory (Croydon NHS Psychological Therapies team). A formal partnership has also been established with Job Centre Plus in Croydon, whereby the EWB acts as an intermediary service for JCP customers who experience mental health difficulties.

The project works hard at networking and disseminating information to keep as many referral pathways open as possible. Following referral, an informal assessment is made by telephone within days. Those contacted are encouraged to attend a group referral meeting or can be met on a one-to-one basis if the level of need is higher.

The project has been running for 18 months and has over 160 active members. It is evolving all the time as people get more involved. From trading skills through the Time Bank small early stage social enterprises are evolving and other support groups.

Depression Alliance is working in partnership with the Institute of Psychiatry to evaluate the effectiveness of the EWB project in improving psychological well-being and promoting routes to employment. Over the next year the project hopes to provide more empirical evidence of success. Anecdotal evidence to date suggests real progress, much of it credited to the flexible and open style in which the project is conducted:

"We are free of red tape and we endeavour to break down any boundaries which may exist. The beauty of the project is that it's about building a community - coming together and making things possible."

(Employment and Well Being Team Leader)

RESOURCES

Depression Alliance:
www.depressionalliance.org

New Horizons strategy:
www.newhorizons.dh.gov.uk

National Mental Health Development Unit:
www.nmhdu.org.uk

NHS Evidence - commissioning:
www.library.nhs.uk/commissioning

National Institute for Health and Clinical Excellence:
Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. Clinical Guidelines 22
http://guidance.nice.org.uk/CG22

Obsessive-compulsive disorder (OCD) and body dismorphic disorder (BDD). Clinical Guidelines 31
http://www.nice.org.uk/CG031

Depression: the treatment and management of depression in adults. Clinical Guidelines 90
http://guidance.nice.org.uk/CG90

Depression: the treatment and management of depression in adults: Full Guideline
http://www.nice.org.uk/nicemedia/live/12329/45896/45896.pdf

Depression: the treatment and management of depression in adults with chronic physical health problems. Clinical Guidelines 91
http://guidance.nice.org.uk/CG91

Mental wellbeing and older people. Public Health Guidance 16
http://guidance.nice.org.uk/PH16

Mental wellbeing at work. Public Health Guidance 22
http://www.nice.org.uk/PH22

APPENDIX 1: CONTRIBUTORS TO THE REPORT

Membership of the steering group

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Expert contributors

The following individuals participated in the roundtable discussion on commissioning services for depression in January 2010.

Simon Lawton-Smith, Head of Policy, Mental Health Foundation

Samantha Nicklin, Senior Campaigns Officer, Age UK (Help the Aged and Age Concern)

Hannah Manser, Employment and Well-Being Team Leader, Depression Alliance

Jim Symington, Programme Lead for Improving Mental Health Care Pathways, National Mental Health Development Unit

Kevin Lewis, Programme Lead for Personalisation in Mental Health, National Mental Health Development Unit

Andy Bell, Deputy Chief Executive, Sainsbury Centre for Mental Health

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APPENDIX 2: TREATMENT GUIDANCE FOR PATIENTS SUFFERING DIFFERENT LEVELS OF DEPRESSIVE SYMPTOMS

Taken from "Depression: The treatment and management of depression in adults." A partial update of NICE clinical guideline 23. NICE October 2009.

Low-intensity psychosocial interventions

- For people with persistent sub-threshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference:
  - individual guided self-help based on the principles of cognitive behavioural therapy
  - computerised cognitive behavioural therapy (CCBT)
  - a structured group physical activity programme

Pharmalogical treatment

- Do not use antidepressants routinely to treat persistent sub-threshold depressive symptoms or mild depression because the risk-benefit ratio is poor, but consider them for people with:
  - a past history of moderate or severe depression or
  - initial presentation of sub-threshold depressive symptoms that have been present for a long period (typically at least 2 years) or
  - sub-threshold depressive symptoms or mild depression that persist(s) after other interventions.

Treatment for moderate or severe depression

For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT).

Continuation and relapse prevention

Support and encourage a person who has benefited from taking an antidepressant to continue medication for at least 6 months after remission of an episode of depression. Discuss with the person that:

- this greatly reduces the risk of relapse
- antidepressants are not associated with addiction.

Psychological interventions for relapse prevention

People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment), or who have residual symptoms, should be offered one of the following psychological interventions:

- individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment
- mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.

APPENDIX 3: TREATMENTS AVAILABLE FOR MILD TO MODERATE DEPRESSION

All of the treatments listed below may form an appropriate part of Steps 2 and 3 of the NICE (October 2009) stepped care pathway.

Medication

To date, over 30 different kinds of antidepressants are available in the UK. They work by influencing the balance of chemicals or 'neurotransmitters' in the brain thought to be important in depression - serotonin and noradrenaline being the best understood. Medication should only be used if specific criteria are met and alongside other forms of treatment (counselling, therapy, social support).

Counselling and Talking Treatments - both low and high intensity psychosocial and psychological interventions

There many different psychological therapies, including cognitive, behavioural, interpersonal, arts or psychodynamic therapy and counselling. Therapy can be offered to individuals, groups or couples. Couple counselling can be beneficial for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit. In less severe cases, computer based packages for CBT can also be offered.

These types of talking treatments are carried out by people trained in the field. NHS access to talking treatments will depend on what services are locally available.

Cognitive Behavioural Therapy

CBT is the therapy currently favoured under the IAPT scheme. While it will not suit everyone, it has been shown to be a highly effective treatment (Whitfield, G and Williams, C. 2003). The aim of CBT is not to analyse and explore a patient's history but to help people work out why they feel as they do. Patients are encouraged to look at how their problems are affecting them in five key areas of their life:

1) Their relationships (whether supportive, unsupportive or absent), life situations and challenges, coupled with the various practical resources and difficulties they have.
2) Their thinking - in times of distress, people's minds can become dominated by negative and upsetting thoughts that make them feel worse.
3) Emotionally - for example, feeling anxious, low, ashamed, guilty or angry.
4) Physically - as we are whole people, depression affects our bodies as well as our emotions.

5) Activity levels and how people live their lives. They may reduce or avoid doing things, or start doing things like drinking to block out how they feel. However, these responses sometimes backfire and become part of the problem.

Mindfulness

Mindfulness is another approach to well-being that has been the subject of growing attention and interest in recent years. It is increasingly shown to be effective in the treatment of many mental and phys ical health problems (MHF 2010).

While situated in the cognitive behavioural tradition, mindfulness interventions also have roots in the practice of meditation. They differ from traditional CBT in that they don't encourage people to challenge their thoughts and are not goal-orientated. Instead, they teach acceptance without unhelpful identification.

Research shows that interventions based on the Mindfulness model have achieved a number of beneficial results (MHF 2010), yet it appears that few of the people who might benefit are currently offered Mindfulness courses. This is despite NICE's recommendation that MBCT should be used for people at risk of repeated relapse into depression (MHF 2010).

It has been suggested that an expansion of MBCT services could be facilitated through the existing IAPT programme. To prepare the necessary infrastructure, though, staff training through appropriate teacher training courses and the identification of qualified leaders would need to be made available.

Changes in Lifestyle

There is good evidence that improvements in diet and regular exercise can be crucial in improving depressive symptoms. Alcohol can have a depressive effect and should therefore be avoided, as should all other recreational drugs. People at risk should also try to avoid unnecessary stress or commitments and, where possible, get adequate rest and sleep.

Complimentary Treatments

These treatments can support or, with mild depression, replace conventional treatments. Acupuncture, reflexology, aromatherapy and herbal medicines including St Johns Wort[iii] have been shown to reduce anxiety and alleviate mild depression.

Light

Some people get depressed every winter but cheer up when the days are sunnier. This is called Seasonal Affective Disorder. Treatment with a light box can be helpful.

Self-help

Self-help support groups that link up with people who have had similar experiences, and who can share hints and tips on coping with depression, can be beneficial. Joining a group can help people to feel less isolated and alone. Depression Alliance is a voluntary organisation working in this field that organises self-help groups.

Research

Encourage patients to be active agents in the research and management of their own illness.

(iii) The Full NICE guideline on depression states that although there is evidence that St John's Wort may be of benefit in mild or moderate depression, practitioners should not prescribe or advise its use for people with depression because of uncertainty about appropriate doses, persistence of effect, variation in the nature of preparations and potential serious interactions with other drugs.

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Abbreviations

BME	Black and Minority Ethnic
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
IAPT	Improving Access to Psychological Therapies
NICE	National Institute of Clinical Excellence
NMHDU	National Mental Health Development Unit
PBC	Practice Based Commissioning
PCT	Primary Care Trust

DepressionAlliance