



**Integrated  
Depression  
Care  
Pathway**  
**Project Report**

Karen Rea and Grahame Smith



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# Executive Summary - Integrated Depression Care Pathway Report

The Cheshire and Merseyside Mental Health Network wanted to look at developing an Integrated Depression care pathway that was service user focused.

In order to achieve this we applied to the NHS Commissioning Board Regional Innovation Fund for £45,549 to appoint a Project Manager to take this work forward and were successful.

## What We Wanted to Achieve:

To work with service users who have had experience of depression and services in order to build an integrated pathway for depression from mild symptoms through to suicidal thoughts, incorporating social media as a key integrator, and involve the voluntary sector e.g. Samaritans.

To ensure all providers and commissioners are aware of the work being undertaken and kept updated with progress.

To secure sign up commissioning of this care pathway.

## Who we talked to:

The project involved the views and wishes of a wide range of people. We talked to service users and carers who represented a very broad range of lived experiences and situations. We included all services in our communication and the steering group membership represented primary, secondary and third sector service provisions, service users and carers. Lastly it is important to recognise and acknowledge the work of the chair of the sub group for this project who is also a patient accessing health care services.

## What we found out:

Services that are effective, supportive and accessible in Cheshire and Merseyside are highly valued by service users and carers. Combining all the findings of this project, it would appear that more of these are required. Service users and carers reported inequity in resource availability, the quality of services across the patch and service responses to services users and carers needs, including the attitudes of staff. Despite government drivers in increasing access to services for depression, service users and carers perceptions and experiences appear to indicate that these initiatives have not been totally successful. Common themes of long waiting times, poor location and timing of services and experiences of stigma were identified from the different methods of data collection the project used to elicit information to help formulate the Integrated Depression Care Pathway.

## Recommendations:

It is clear that when planning, commissioning or delivering services, service users and carers are very keen to be involved at all stages. Widening access to include self referral and publishing of available services in more imaginative and creative ways is clearly needed, particularly if the needs of hard to reach groups are to be met. Maintaining and developing collaborative relationships and attitudes is essential and the continuing professional development of all support staff to ensure that cultural, social, literacy, emotional and physical health needs of service users in Cheshire and Merseyside are recognised and addressed. Finally, the development of robust Mental Health metrics would be invaluable in identifying need and developing appropriate services within Cheshire and Merseyside.

The recommendations have been created using the 10 rules for perfect care identified by Ed Coffey.

# Acknowledgments and Project Partners

Immense gratitude go to all the service users and carers who gave of their time to share their experiences and comments in support of this project.

**Grateful thanks go to the NHS England Commissioning Board Regional Innovation Fund who funded this innovative project**

Partners involved in this project included the following -

- Cheshire and Merseyside Service Users and Carers
- Mental Health Providers
- CCG Mental Health Commissioners and Clinicians and voluntary providers
- Public Health England and the North west Coast Academic Health Sciences Network
- Tom Gould of the LJMU faculty of Education, Health and Community media department is also acknowledged for his hard work and design skills in the creation of this report.



# Introduction

The Integrated Depression Care Pathway is an excellent example of collaborative working in mental health. A number of key documents have all identified the invaluable role that collaborative working plays in the designing and delivering of safe, effective and high quality service for people experiencing depression and their carers (No Health without Mental Health, 2011). The pathway has been designed by Liverpool John Moores University and the Cheshire and Merseyside Strategic Clinical Network's Mental Health Network in collaboration with: Cheshire and Merseyside Service Users, Mental Health Providers, CCG Mental Health Commissioners and Clinicians and voluntary providers, Public Health England and the North West Coast Academic Health Sciences Network to ensure a whole systems approach.

## The project aims were:

1. To produce baseline data relating to services for depression, that is IAPT, antidepressant prescribing and suicide rates by postcode, evidence of application of NICE guidelines across primary and secondary care and days lost in employment in Cheshire and Merseyside
2. To design with patients and stakeholders a 'perfect depression care pathway' with key outcomes
3. To secure sign up across all providers and commissioners (mental health and dementia and other areas) for commissioning of this care pathway

The benefit of people living with depression being centrally involved in co-creating an integrated pathway is that the eventual solution is more likely to be useful, useable, and compatible with real needs (McKeown et al; 2006; Woods et al; 2013, Hanley et al; 2004; Evans and Jones, 2004).

Involving service users, commissioners and clinicians and other key stakeholders in this project facilitated the development of a needs led, value and evidence based pathway which, it is hoped, will inform the decision making process of the commissioners when considering the funding of mental health services for depression.

The development of a needs led pathway for service delivery which utilises a living lab approach could be adopted by commissioners of health and social care services and voluntary, third sector and charitable services, in the same way that this has been identified for depression care in other areas.

This is an abridged version which does not contain Appendices and reference List, the full version is available on request to K.Rea@ljamu.ac.uk

# Background and Context

## The innovation will:

- Build an integrated pathway for depression from mild symptoms through to suicidal thoughts, including social media as a means of facilitating access, and involve the voluntary sector e.g. Samaritans
- Address parity of esteem between mental and physical health - long term conditions are often associated with depression and poorer outcomes
- Public Health mental health data confirms that depression has a global impact on the economy and levels of population wellbeing. The proposed model will provide a framework for commissioners, service providers, service users and carers to use when looking at services for depression
- Build upon the map of medicine for depression across Merseyside

- Utilise the successful work of the Advancing Quality metrics in the programmes of early intervention in psychosis and dementia by creating an equivalent approach that can be applied to depression
- Ensure all providers and commissioners are aware of the work being undertaken and kept updated with progress and voluntary, third sector and charitable services

The Pathway will incorporate the Six Dimensions of perfect care for depression: safe, effective, patient centred, timely, efficient & equitable, as identified by Ed Coffey.

Service users involved in the project questioned the title of the Coffey model and an agreement was reached at an early steering group meeting that the project would be entitled ‘integrated’ depression care pathway. An integrated care pathway is a document that describes a process within health and social care. It is both a tool and a concept which embed guidelines, protocols and locally agreed evidence-based, patient – centred, best practice into everyday use (Davis, 2005).

Whilst this project has adapted the name of the pathway to be more representative of what Cheshire and Merseyside’s integrated depression care pathway should do, the diagram below represents the core themes underpinning the pathway.



Figure 1: The pyramid of perfection: core features of perfect depression care.

The creation of an Integrated Depression Care Pathway supported by the recognition that new, relevant and specific knowledge is co-created by all interested parties. A consensus model of policy making is one way of ensuring this through the creation of a network (focus groups) of consumers, practitioners, policy makers and researchers (Broner, Franczak, Dye and Mc Allister, 2001). Research has shown that supporting people to self-manage their depression improves their quality of life because those people who take an active interest in their own condition are more likely to take steps to lead a healthy lifestyle and improve their health (Torbay Mental Health Trust, 2012). The recovery model takes as its basic premise, that people are capable of recovery rather than as being passive recipients of professional treatments. People should be actively supported to acquire skills, knowledge and strength to reduce the prevalence of harmful experiences in safe, simple and effective ways. A key element of recovery is about people taking control and the move away from a negative mental health system. It is about people taking responsibility for themselves, working out ways of helping themselves and of having hope (Topor, 2006).

Co-creation in health should focus on developing the skills and attitudes of people whilst ensuring that systems and services are designed to support and facilitate self-management (Health Foundation, 2012), and these principles will be embedded in the integrated depression care pathway.

Using the Six Dimensions proposed by Coffey which were adapted from the Crossing The Quality Chasm report of 2001 – The project team developed an integrated care pathway for depression



that met the Six Dimensions, ie:

- **Safe** - that individuals accessing services will feel physically and emotionally safe when being referred, using services and following discharge
- **Effective** - that the individual using mental health services for depression will experience care that helps them on their road to recovery
- **Patient centred** - that the individual and their carers will feel that they are part of a partnership when accessing services for depression and that their role in this partnership is the most important
- **Timely Care** - that services will be available when they are needed, in a timely manner
- **Efficient Care** - that services provided will meet need in a way that recognises individual need and matches this effectively with resources
- **Equitable Care** - all individuals will have equal access to and uptake of services that meet their needs.

In our work, we also want to emphasise the importance of how people access the pathway, with particular reference to those traditionally hard to reach groups.

Supporting people with mental health is an individual process and will vary depending on specific need, however when looking at the management of depression it is important to look at the context within which it sits.

The areas cited below are work in progress and treatments or situations a person with depression may find themselves in. It is important that whatever situation they are in, they have timely and appropriate support which is easily available to them. Any new pathway should include any existing initiatives which are known to be effective and locally, these are:-

## Social Prescribing

Social prescribing is a mechanism for linking people to non-medical sources of psychosocial and/or practical support within the community. This can include arts, books, exercise, learning, befriending, volunteering, supported self-help as well as information and advice, e.g. debt, employment, domestic violence, relationship breakdown, legal advice (Cawston, 2011).

The Social Prescribing commissioning model would establish social prescribing as being integral to a treatment pathway from prevention to maintenance and recovery and scale-up its provision.

A project group was established in 2014 led by Cheshire and Merseyside Public Health Network with support from the Cheshire and Merseyside Clinical Networks to take this work forward.

A final report is due out autumn 2015.

## Suicide Prevention

The Cheshire and Merseyside Suicide Reduction Network was established in 2008 to seek greater co-ordination of responses to and understanding of patterns of suicide and to ensure suicide reduction activity does not get overlooked during the re-shaping of the public sector. The Network has facilitated joint working and is regarded as a national exemplar of good practice.

In June 2014, the Directors of Public Health supported the proposal that the Cheshire & Merseyside Suicide Reduction Network should be aligned to the ChaMPs (Cheshire and Merseyside Public Health) Mental Wellbeing Programme and that a structure be established with an Operational Group and a Partnership Board to become known as Cheshire and Merseyside Suicide Reduction Board.

The purpose of the Board is to provide strong leadership and strategic oversight in advancing support and advocacy for suicide reduction across Cheshire & Merseyside.

The Board receives briefings and reviews the actions of the Operational Group on the following:

- Suicide audit and intelligence
- Postvention pilot is an intervention that is conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). It is known that family and friends of a suicide victim may be at increased risk of suicide themselves
- Suicide awareness training
- Media reporting

Cheshire and Merseyside ***NO MORE zero suicide*** strategy was launched on the 10th September 2015.

The strategy aims to inform stakeholders of the bold vision to eliminate suicide in Cheshire & Merseyside and how this will be achieved. Suicides are not inevitable and there are many effective ways in which services, communities, individuals and society as a whole can help to prevent suicides.

A new suicide liaison service, Amparo, which supports people affected by suicide in Cheshire & Merseyside has been established and there has been a call to action from elected members from each local authority to achieve Suicide Safe Community Accreditation.

## Acute Crisis Care

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. It focused on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

Across Cheshire and Merseyside, in each local area a mental health crisis Declaration was signed, which is an agreement between local services and agencies to commit to improving the care and support for people in crisis and is supported by a comprehensive action plan.

## Primary Care Services for Depression

In response to the national demand to expand the provision of mental health care and psychological therapies for people with mental health problems, a national programme known as Improving Access to Psychological Therapies (IAPT) was established in 2008. A key aim of the programme was to develop a competent workforce to deliver evidence based, NICE approved psychological therapies and interventions (primarily for people with anxiety and depression) to promote recovery and help people return to full social and occupational functioning (DH, 2008a; DH, 2011). Since 2008 there has been a progressive move towards services for depression being located in Primary Care services such as IAPT, and the voluntary and third sectors.



# The Project

There were two phases to this project:

## Phase One

- The production of baseline data of services for depression e.g. IAPT, antidepressant prescribing and suicide rates by postcode, evidence of applying NICE guidelines across primary and secondary care, days lost in employment in Cheshire and Merseyside.

## Phase Two

- The design of a 'perfect depression care pathway' with key outcomes.
- The sign up of providers and commissioners (mental health and dementia and other areas) to commissioning of this care pathway.

This document is therefore split into two parts to mirror the separate phases. The first part of the report focusses on the identification of the required metrics, and the second being more qualitative in nature.

## Relevant literature and local context

Depression is a mood disorder (*DSM V, ICD10*); it refers to a range of mental health problems determined by the lowering of mood and loss of interest or pleasure in usual activities. People experience a range of associated cognitive, behavioural and autonomic symptoms which can typically include lack of interest or pleasure, reduced energy, decrease in activity, reduced concentration and attention, marked tiredness after even minimal effort, poor appetite and disturbed sleep. People often experience feelings of guilt or worthlessness, reduced self-esteem and self-confidence and thoughts of death or suicide (WHO, 1992, 2010; APA 2000).

Depression is the leading cause of disability in developed countries, and depression results in substantial medical care expenditures, lost productivity, and absenteeism (Coffey, 2015). Depression accounts for the largest proportion of the burden associated with all the mental and neurological disorders. In 2010, the World Health Organisation (WHO) predicted it to become the second leading cause of global burden of disease by 2020. It is a chronic condition and one that is associated with tremendous comorbidity from multiple chronic general medical conditions, including congestive heart failure, coronary artery disease, and diabetes (Druss, 2011). Moreover, the presence of depression has deleterious effects on the outcomes of those comorbid conditions (op cit).

It was identified by McManus et al in 2009 (The Centre for Economic Performance's Mental Health Policy Group, 2006), that only one in four adults experiencing depression or anxiety were receiving any kind of treatment. Although most service users preferred psychological interventions to medication (Prins et al, 2008), until the rollout of IAPT in 2008, the most common form of treatment was medication only, followed eventually by psychological intervention alone or in combination with medication. Psychological therapies were not readily available for all due to the limited number of trained psychological therapists; waiting lists for therapy were typically over nine months if a therapist was available at all. The IAPT programme was established in 2008 in order to improve access to Psychological Therapies for people with Depression and Anxiety Disorders. The NHS Mandate commits NHS England to playing "a full part in delivering the commitments that at least 15% of adults with relevant disorders will have timely access to services, with a recovery rate of 50% by 2015" (IAPT, 2014). Recovery rates have steadily improved from 17% to over 45% over the first three years of the programme, indicating that services are becoming increasingly effective (DoH, 2012). The indicator of prevalence rates is currently under review and is likely to increase in order to more accurately reflect the incidence of depression.

The National Institute for health and Care Excellence NICE (2009) also reported that people were not seeking timely help for depressive and anxiety symptoms due to their reluctance to ask for help and the failure of health professionals to recognise mental health problems, particularly in primary care.

In order to provide services that people will value and use, it is also important to be aware of a number of related issues. Vulnerable groups in society whilst having individual experiences and needs also appear to have common problems in relation to access, stigma and availability of helpful, caring and supportive services. For example, Van Bergen et al (2008) suggest that policies need to be created that improve the interaction between mental health services and black and other ethnic minority groups in order to deliver better clinical outcomes. Differences in suicide risk by age and sex for Black and Ethnic Minorities BME may be important for future mental health strategies. Van Bergen (op cit) recommended that efforts should be directed at targeting prevention towards young people in contact with mental health services and by developing culturally appropriate and effective strategies to assess the risk of suicide among ethnic minority groups and to engage these groups in treatment.

The proportion of homeless people who are mentally ill from BME groups is disproportionate in relation to the number of homeless in the general population. Refugees and asylum seekers also have high rates of mental disorder and are at risk of being in unstable housing (Crisis, 2009).

It is also commonly accepted that mental health problems are much more prevalent among homeless and vulnerably housed people than in the general population.

In many instances, mental health problems play a significant part in the circumstances which caused those people to lose their accommodation. The mental health problem may then be exacerbated by the stresses associated with being homeless, which in turn will make it even harder for that person to achieve stability in their housing (Crisis, 2009) creating a vicious cycle.

Research suggests that vulnerable groups including homeless people may place a low value on health generally in the face of poverty and their day-to-day difficulties. They often do not access health services, few are registered with GPs and many use emergency services for both physical and mental health care.

Women experience some risk factors (such as physical and sexual violence as a child) for both mental illness and homelessness to a greater extent than men. The rates of mental health problems including deliberate self-harm (DSH) and suicidal ideation also seem to be higher in homeless women than in men. The World Health Organisation (2010) acknowledges the gender stereotyping and imbalance in the diagnosis and treatment of depression but current statistics indicate that women do have higher prevalence rates of depression than men. Their adult roles are often that of primary carer and increasingly wage earner, so their access to services for depression are frequently influenced by this.

“..a woman’s work doesn’t stop, when the man comes back he’s finished really, more or less, I think a woman don’t finish until it’s bed time and then I’m up all night with the kids”.

“ .since I lost my mother . . . I’m not the same girl I used to be, I’ve changed, you know what I mean, like when I get upset and start crying with mesel.”



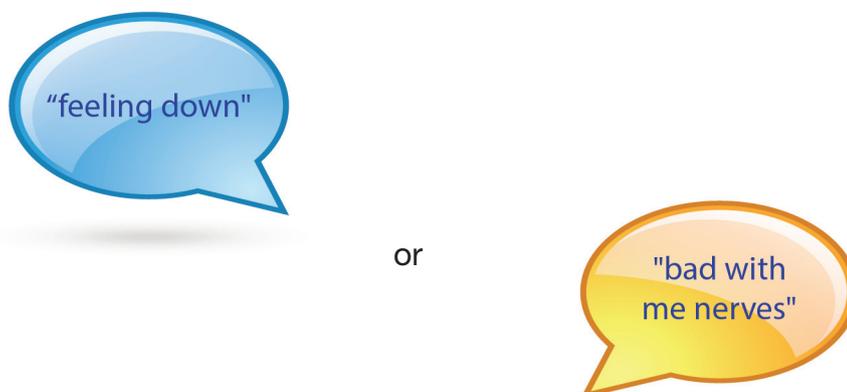
Despite different cultural and ethnic backgrounds, the participants of a study of pregnant women by Raymond in 2006 shared similar feelings of emotional isolation that seemed to contribute largely to their experience of antenatal depression. Some women do not disclose their feelings of depression during pregnancy, with potentially damaging effects on both the family and the baby. Feelings of loss and emotional isolation may occur (Dave, 2010). Potentially helpful mechanisms for support were identified by the participants and were judged to be relatively simple to introduce, involving connecting with other women via peer support and having 'somewhere to go' to meet others during pregnancy. Many 'low tech' interventions aimed at supporting women with antenatal depression could be developed, including peer support, which may offer realistic models of social, capital and community empowerment.

It has also been identified that lesbian, gay and bisexual (LGB) people appear to be at greater risk than heterosexual people of mental disorders and suicidal behaviour (King et al, 2008). King also reported evidence of lifetime prevalence of depression. These findings highlight the need for consideration to be given to sexual minorities such as LGB when planning public health and clinical services.

Another identified vulnerable group are people with learning disabilities. The emotional lives and difficulties of people with learning disabilities have been much neglected (DoH, 2001, Arthur, 2003) and they are '... one of the most ignored populations in terms of receiving mental health services' (DoH, 2001, Reed 1997; p. 53). Bicknell (2011) has identified the emotional problems faced by learning- disabled people and their need for psychological therapy.

Adolescents with a learning disability may be at increased risk of suicide for two reasons, (a) they suffer from increased rates of depression or (b) the other correlates of learning disabilities (e.g., impulsivity, deficits in social skills, etc.) may predispose them to higher rates of suicide. The data indicate that certain subgroups of adolescents with learning disabilities (i.e., those with nonverbal learning disabilities and/or those who are less academically adept) manifest higher rates of depression (Bender, Rosenkrantz & Krane, 1999).

Gypsies and Travellers are recognized as a "hard to reach" group (Howard et al, 2006), who often find statutory services inaccessible and unacceptable. In parts of the United Kingdom efforts have been made to improve access to services by developing the role of specialist health visitors (Feder et al, 1989) who forge personal relationships so that health problems are confided, and health care is accepted. Although health visitors are not trained to identify or meet mental health needs, it is they who have raised concerns about high levels of mental health problems among Gypsies and Travellers (Pahl & Vaile, 1986; Anderson, 1997; Van Cleemput, 2000). Questions remain about the extent and nature of mental health problems amongst Gypsy and Traveller communities, and the ways in which services meet them (Goward et al, 2006). In this study, most of the individuals interviewed talked about



at least some of the time. When asked about the factors associated with feeling low, interviewees tended to focus on socio-economic stressors. Literature by Worrell and Remer (2003) tells us that

marginalised individuals are best supported through models of care that empower them to:

- a) become aware of sources of oppression in their environment
- b) gain a sense of control over the basic facets of their lives and
- c) work to create positive change not only for themselves but also for others in their community

Evidence from this paper suggests that a combination of empowerment interventions with psychological intervention/clinical treatment would be beneficial to people experiencing depression. The work of Ridge and Ziebland (2006) and Elmslie et al, (2006) suggest that recovery stories are linked to the availability and uptake of adequate tools which also supports this view.

One core strategy for Perfect Depression Care is organising care according to a planned care model (Coleman et al, 2009). There is then a need to develop a clear vision for how each service user's care would change in a system of Perfect Depression Care. Coleman et al (2009) then went on to show how they partnered with service users to ensure that they had a voice in the redesign of depression care services. They then conceptualised, designed, and tested strategies for improvement in 4 high-leverage domains (patient partnership, clinical practice, access to care, and information systems), which were identified through mapping to the current care processes. Once this new model of care was in place, they implemented relevant measures of care quality and began continually assessing progress and then adjusting the plan as needed, thereby demonstrating use of the Model for Improvement.



Finally Davis (2005:7) suggests that integrated care pathways have a “positive effect on patient conditions”. One of the areas in which they can make a difference is in the smooth implementation of current guidelines such as NICE guidelines and health communities’ individual clinical governance guidelines. They can also assist in the audit of services. For service users though, the real value lies in what Davis (op cit) refers to as the need for integrated care pathways to be multidisciplinary. Whilst Davis’ report focuses on the professional membership of the multidisciplinary team, this project has moved this idea on to include the beliefs and values of services users when services are being planned, commissioned and delivered.

## Phase One of the Project

The goal of phase one of this study was to identify relevant information such as access and uptake of antidepressant medication, prevalence and incidence of depression in Cheshire and Merseyside, days lost in employment due to depression and suicide rates in Cheshire and Merseyside and service user’s experience of accessing services for depression. The study also sought evidence of the application of the relevant National Institute for Care Excellence guidelines for depression across the primary and secondary health services for depression. A comprehensive data collection exercise, collecting national, local, and grey data for the time period of 2011 - 2014 was undertaken to gather this information. The purpose of this was to provide a baseline from which to develop an integrated depression care pathway.



## Findings:

### Antidepressant Prescribing in Cheshire and Merseyside - (Appendix 2)

The cost of prescribing antidepressants patients in 94 GP practices in Liverpool CCG in 2014 was £3,000,000. This amount was identified as an increased figure on previous years and the increase in prescribing volume was attributed to an increase in need/disease prevalence.

On Wirral, in the time period January to December 2014 the total number of prescriptions administered for antidepressants was 444,967 (data source ePACT. net). The cost of this was £1,628,134. It is not clear from the information provided whether all prescriptions were filled and used. However information obtained from NHS England, Medicines Optimisation Dashboard (<http://www.england.nhs.uk/2015/05/22/mo-dashboard/>) for 2013 - 2014 (Appendix 2) would seem to suggest that uptake of antidepressant use in the Cheshire and Merseyside areas for this time period was significant.

We do need to be cognisant of several important factors, specifically a lack of evidence relating to how long each individual took the prescribed antidepressant medication for and also to be wary assuming that this provides accurate evidence of how many people are experiencing depression in the identified areas. Given that the NICE Guidelines for depression (2009) advocate a stepwise approach to managing common mental health disorders. If GP's are adhering to these guidelines then the prescribing of anti-depressants will not be their first choice of intervention, they will look at other options such as referral to IAPT services. These guidelines recommend offering, or referring people for, the least intrusive and most effective intervention first. Therefore, non drug interventions (such as cognitive behavioural therapy [CBT]) should be the mainstay of treatment for many people with depression or Generalised Anxiety Disorder GAD, with drugs generally reserved for more severe illness or when symptoms have failed to respond to non drug interventions.

### Suicide Rates by Postcode and Prevalence and Incidence of Suicide in Cheshire and Merseyside.

The evidence for the information provided (*Appendices 3 and 4*) was obtained from - <http://www.phoutcomes.info>

The following information needs to be set in the context that the published data is for all suicides in the identified areas and it does not identify why people ended their life.

This report identifies that across Cheshire and Merseyside the rate of suicide for men has increased in the period 2001-2013, increasing from 14.8 to 15.2 per 100,000 head of population. For the same time period the incidence of suicide by women had decreased, reducing from 4.9 to 3.6 per 100,000 head of population. When both gender results are combined, the figures show a slight reduction to 9.7 to 9.2 per 100,000 head of population.

The 2014 National Confidential Inquiry Into Suicide and Homicide by People with Mental Illness Annual Report suggests that this figure may be slightly higher, i.e. by using the 2010-2012 values the report suggests that the rates of suicide in Cheshire, Warrington and Wirral was 8.9 per 100,000 head of population and for Merseyside, 10.1 per 100,000 head of population. When these are combined it suggests a crude rate for Cheshire and Merseyside of 9.5 per 100,000 head of population, the national average for England was 9.4 per 100,000.

The accessed information identifies that with the exception of Cheshire East and Merseyside, rates of suicide of both men and women in this locality are higher than the national average but interestingly the Cheshire East area shows higher rates of suicide by women than the national average.

The 2014 report identified that initially for the period 2002-2012 suicide rates in England began to fall. In the period 2007-2009 there was a significant increase which the report attributes to

financial pressures leading to unemployment and debt alongside an increasing population. From 2009 to 2012 after an initial reduction in the suicide rates, the statistics have remained largely static for both genders across England.

## Days Lost in Employment in Cheshire and Merseyside

Data was obtained for the national picture relating to days lost in employment due to depression. This provided a good overview the impact that depression can have on the economy of Great Britain. Specific data for Cheshire and Merseyside was not available and would have aided the local focus considerably. It would be useful if measures were put in place to address this issue. Two sources of information were used.

- Data provided by the Office for National statistics website <http://www.ons.gov.uk> has identified the following National Picture :-
- 131 million days of sickness absence from the workplace occurred in 2013. Of these according to the ONS 15.2 million were due to stress and anxiety and 8% of sickness absences in 2013 were due to this.
- A report by the Health and Safety Executive (2014) identified that between 2013/14, 38% of mental health problems identified as causes of stress in the workplace were due to anxiety/depression and 11.3 million working days in Great Britain were lost to work related stress. From this information it is possible to suggest that 38% of these were due to anxiety/depression and it is likely that this is reflected in the Cheshire and Merseyside area.

It would appear that sickness absences nationally due to anxiety and depression are increasing.

## Identification of Baseline data for Primary Care Service Provision in Cheshire and Wirral for Depression (IAPT)

The project brief required that the above aim needed to be met through the use of two methodologies -

- a) The provision of evidence of the application of the relevant NICE guidelines for depression in adults and children and young people transitioning from child to adult services for depression across primary and secondary care,

and

- b) The elicitation of service users views about services for depression using the Patient satisfaction questionnaires –using data collected from Primary care Services service evaluations (see Appendix 1).
- a) **This information was gained from the distribution of questionnaires (see appendix 7) to the following groups:**
  - i) Primary care services and mental health commissioners (all IAPT services and commissioners)
  - ii) GP's (all GP's)
  - iii) Secondary Care services (Mersey Care Trust and 5BPS Trust)
  - iv) Services for children and young people transitioning to adult services (1 service: RLCHT)

Using the relevant NICE guidelines the questionnaires were designed to provide evidence of the application of NICE guidelines across primary and secondary cares services. Questionnaires were sent to the following service providers

- Services to children and young people who are transitioning from child to adult



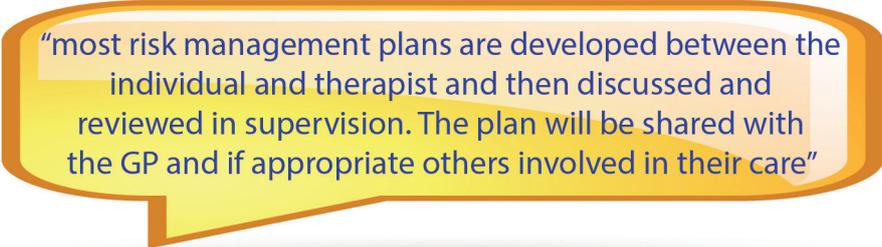
services - using the NICE guidelines for Depression in children and young people: Identification and management in primary, community and secondary care (March 2015)

- Primary care services including GPs, secondary care services and Mental health Commissioners-using NICE Quality Standards for Depression in Adults (2011) and the Department of Health – Best Practice in Managing Risk (2007)

All questionnaires reflected the Six Dimensions Of Care adapted by Coffey.

## Results from Questionnaires sent to service providers

The returned questionnaires from service providers and commissioners identified some interesting but not surprising information (see appendix 9). The majority of services (75% and above) were meeting the required NICE Quality Standard for Depression in Adults (2009), NICE Pathway (2015) and 100% of services who returned the questionnaire identified compliance with the Department of Health's Best Practice in managing Risk (2007). One of the returned questionnaires identified that:-



"most risk management plans are developed between the individual and therapist and then discussed and reviewed in supervision. The plan will be shared with the GP and if appropriate others involved in their care"

The local service providing services for young people transitioning to adult mental health services also self-assessed themselves as being fully compliant with the 2015 NICE Guidelines for Depression in Children and Young People: Identification and management in primary, community and secondary care (March, 2015).

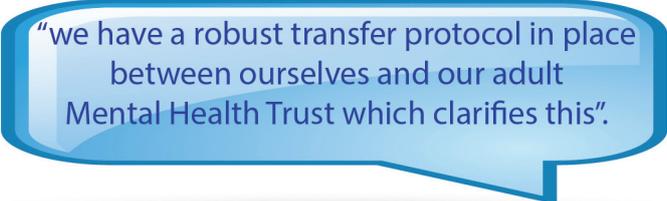
The service commented that it was also :-



"being dependent on specific cases"

However we were unable to ascertain children and young people and their carers views on this due no response to emails sent to a number of services for children and young people with mental health problems lack of access.

Where services identified that they were not currently meeting the NICE Quality Standard for Depression in Adults, the reasons given varied from different timescales being used for reassessment of the prescribing of antidepressant medication to patient compliance with scheduled follow up appointments (Statement 2 - People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.). For statement 4 (People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance) the reasons given for non-compliance ranged from :-



"we have a robust transfer protocol in place between ourselves and our adult Mental Health Trust which clarifies this".

to:



"clinicians doing counselling/cbt instead specialist services usually due to long waiting times for"

– typically, this was for both IAPT and secondary care.

The same reason, that is long waiting times was the most frequently cited reason for non-compliance with statements 5 (*People with moderate or severe depression, and no existing chronic physical health problem, receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy*) and 6 (*People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment*) but some services also identified that it



"was decided on a case by case"

for statement 6. The response from services to statement 7 (*People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed*) varied from clear protocols used that differed slightly from guidelines in relation to time frames to, deciding on a case to case basis. There was a clear message again from this in that these decisions were often influenced by access to psychological therapies. The reason provided for non-compliance with statement 10 (*People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions*) was that



"secondary care services are very poorly provided"

A key finding of this phase of the study is that there are still significant time delays in accessing therapy services for depression and that the application of clinical protocols for the prescribing of antidepressant medication and patient uptake of therapy services is being influenced by this.

**b) Service users views about services for depression using the Patient satisfaction questionnaires using data collected from Primary care Services service evaluations (see Appendix 1).**

The response to the questionnaires has been themed using the Six Dimensions of Care. This information will be explored in more detail in the discussion of findings section of the report.

Data from patient satisfaction questionnaires provided by Primary Care Services was analysed using the Six Dimensions of Care and presented in this format (see Appendix 1), from which themes were identified.

This was a relatively straight forward process as most of the issues raised by service users in

the questionnaires matched the six dimensions very clearly. It is important to note that both questionnaires provided evidence of excellent/good practice and where services users had received care/support/interventions that they felt were beneficial, they provided excellent and positive feedback.

The two tables provide information as to what service users would like from mental health services for depression. This information was used in the design of the integrated depression care pathway.

## Results from patient satisfaction questionnaire

Two services from the Cheshire and Merseyside area completed service user satisfaction questionnaires. Details from the analysis of these using the Six Dimensions of Care can be found in Appendix 1. Service 1 is an IAPT service and service 2 a local neighbourhood community support group.

There were common themes identified in both satisfaction questionnaires, for example:-

- Waiting times too long – referral and access
- Access difficult – physical location, times of services etc.
- Access difficult – referral process cumbersome and not individualised, ie service users believed that criteria for access to services was too limiting
- Communication between services problematic – this was highlighted particularly for young people transitioning from child and adolescent services to adult services but also for in service issues such as staff leaving, “*having to tell my story over and over again*” along with other communication problems.
- The need for more services and smaller groups- to include more creativity in service provision eg. reading groups, cookery courses, sewing, music
- Greater publicising of services – eg. in public areas
- The need for training of people providing services - particularly in interpersonal skills and signposting
- The predominance of what is perceived as ‘*short term*’ interventions

In one service, feedback identified that the majority of service users believed that they had been treated in a professional manner and the practitioner kept their promise, ie writing to other professionals/agencies.

## Phase Two of the Project

### Aim:

To identify what service users want from services for depression and how this can be provided for within a meaningful and accurate model of service delivery. Any developed pathway will incorporate current best practice as identified by the NICE standards.

As Coffey (2007) highlighted - ***“I strive to improve the behavioral health and wellbeing of our community through excellence in the science and art of health care and healing.*”**

***My personal vision is to work with each patient to achieve the best possible health care, always respecting the person’s wants and needs and always providing that person the quality of care and comfort I want for my family and myself.”***

The project team believe that an effective and valued integrated care pathway for depression has to start with this premise.



## Ethical Considerations

The NICE clinical guidelines for depression in adults (2011) state that treatment and care should take into account patient's needs and preferences and that people with depression should have the opportunity to make informed decisions about their care and treatment in partnership with their practitioners. The Cheshire and Merseyside Mental Health Network has adopted the model proposed by Coffey: Pursuing Perfect Depression Care: a model for eliminating suicide and transforming mental health care (2007). This model identifies six dimensions of perfect care and was devised by the Institute of Medicine (Crossing the Quality Chasm: A New Health System for the 21st Century, 2001). The creation of an integrated care pathway for the treatment, management and recovery from depression will provide a structured care methodology which will formalise patterns of care processes, as per Davis' Integrated Care Pathways: a guide to good practice (2005). The purpose of this study was to synthesise the information gathered from (past) service users, service providers and published/ service evaluations to produce an integrated care pathway that puts patients at the centre of care and meets both patient and service needs.

This was achieved by:

- i) Working with groups of service users in the completion of questionnaires (see Appendix 7) with facilitators following written consent being obtained from both the participants and the 'gatekeepers', ie support service managers. The questionnaire completed by service users was anonymous questionnaire and they were all destroyed once the data had been transcribed. In addition to the gathering of data via questionnaire in focus group sessions, the conversations generated by the completion of these were recorded and themes identified. All audio recordings were erased following transcription. The 3 members of the study group identified attended the focus groups and co-facilitated the sessions. All 3 members have the relevant experience and knowledge to support people in distress and for each group with which we worked, a list of local and appropriate support services was compiled by the 3 group facilitators. In addition all questionnaire group work occurred in the support services location so service users had immediate access to both written information and the support service staff.
- ii) Distribution of questionnaires to all services in the Cheshire and Merseyside region who commission or deliver mental health services. This included GP's, MH commissioners, Secondary Care Services and IAPT services (Please see appendix 6 for the questionnaires distributed). Services were informed that all data collected would be treated in confidence and accompanying emails were destroyed (only means of identification) once the data had been recorded.

Ethical approval was gained from the LJMU ethics committee.

## Methodology

In their professional life, practitioners do not exclusively use one source of knowledge. They draw on many sources which they blend into their clinical practice and research should be no different (Greenhalgh & Wieringa, 2011; Wilson et al, 2012). To meet the project aims, the project team recognised that different methodologies have to be applied including both 'top-down and bottom-up methods'. Aim one would be met by using a top-down approach; aims two and three required a more innovative bottom-up approach (Weber, 2011).

Historically, health and social care research has been based on using 'top-down' research methods; the difficulty with this approach is that the service user does not always have the opportunity to contribute in a meaningful way (Greenhalgh & Wieringa, 2011; Johnson et al, 2007). To ensure that the research was collaborative and user-led, a participatory methodology needed was used with a focus on developing sustainable outcomes (Greenhalgh & Wieringa, 2011; Bergvall-Kåreborn et al, 2009a; Bergvall-Kåreborn et al 2009b).

To provide a methodological structure to the project which in essence ensures meaningful and collaborative engagement, the project team used a 'living lab' approach. The living lab provides a pragmatic research environment where people living with depression have the opportunity to co-design and co-create the an integrated depression care pathway (Woods, et al, 2013, Bergvall-Kåreborn & Ståhlbröst 2010: 191) that was sought.

Using a living lab approach confers responsibility to ensure that engagement with people who are experiencing depression is collaborative and sensitive in style and delivery especially when working with a group of individuals who could be vulnerable (Woods et al., 2013). Taking this into consideration, the work of the project and the governance of its work not only interfaces with the relevant ethical frameworks, but it is also underpinned by the following principles (Bergvall-Kåreborn et al, 2009a):

- Continuity
- Openness
- Realism
- Empowerment of users
- Spontaneity

The project's living lab approach underpinned by these principles, collaboratively engages all partners with a specific focus on utilising the knowledge and expertise of people living with depression (Bergvall-Kåreborn et al, 2009b) (see Appendix 5). The living lab approach was initially developed within the area of communication technology but it is now used more widely within the health and social care context (Bergvall-Kåreborn et al, 2009b; Etzkowitz, H. & Leydesdorff, 1997). It has the characteristics of action research, emphasising a collaborative process which is user-centric (Reason & Bradbury, 2001b; Reason, 2003).

The aim was to widen the listening process using questionnaires and focus groups to collect as many narratives as possible.

Group work to complete service users questionnaire (see Appendix 7 - document G), used a mixed methodology: a quantitative method of the completion of a standardised questionnaire was undertaken by participants attending a focus group but the questionnaire for service users was



completed with some supporting qualitative work, namely facilitators helping service users to complete questionnaires and during this process acknowledging and recording any other relevant information. The value and advantage of using groups in qualitative research and in health and social sciences has been identified by Vant Rient et al (2001), Litosselli (2003) and Kitzinger (1995).

Karen Rea, Gloria Payne and John Roberts attended the groups to support the completion of the questionnaires and to provide support if the service user became distressed or required further information. All meetings occurred in support services buildings and were arranged for when the nominated gatekeeper for each service was available. Service users had access to information regarding support should they require it from the service and also from the three facilitators of the sessions. For each specialist group, the group facilitators provided a list of support services relevant to the group, the geographical area and the mental health problem of depression.

The group facilitators recognised that it was not their role to try and address any negative experiences of services, rather being there to manage any distress and signpost the service user to the appropriate option. The role of the questionnaire was clearly identified to all service users who agreed to complete the questionnaire, the goal being to produce an integrated pathway of care (ie. that meets service user's needs) that commissioners and providers of services can use when they are commissioning or designing depression services.

The support groups all had a nominated gatekeeper who advertised the purpose of the meeting and who was also available during the meeting in case they were required. The gatekeepers were all provided with the following information prior to the identification of service users:

- Gatekeeper form
- Participant information sheet that was given to service user participants at initial contact
- Participant consent form
- Service user questionnaire so that they could make an informed decision about participation and service user involvement.

Participants were recruited to the study via posters in GP practice/local community centres/information from voluntary and charitable service group leaders/members of study group. For group work, participants completed the service user's questionnaire. The project team identified one group (up to 10 participants) for each major service setting/target group with a maximum of 12 groups (see Appendix 7). All participants attending the group in order to complete the questionnaire were currently or had previously experienced depression or had/were caring for someone suffering from depression.

Gatekeepers to the proposed participants were voluntary and third sector agencies. They were primarily the service manager/leader. They publicised the focus groups but service user's attendance at these was voluntary. The majority of the gatekeepers attended the group work sessions and their input was both helpful and supportive.

Personal data was obtained from focus group participants but all information was treated as confidential and the report only contains fully anonymised data and information. Electronic data was securely stored on a password protected computer and written data was secured in a locked drawer in a locked room. Only the principal investigator had access to the original transcription data and all the data was handled and disposed of in accordance with Data protection Act DPA (1998) and university protocols.

Following this work, Karen, Gloria and John met with the steering group to identify the format and structure of the proposed model (Bergvall-Kåreborn & Ståhlbröst, 2010). The final stage was a cross-checking process with the steering group to ensure that the planned model was appropriate, helpful, attractive and reflected what service users and carers wanted; it also ensures commissioner and provider buy-in (McKeown et al. 2006; Woods et al. 2013, Hanley et al. 2004, Evans and Jones, 2004).



## Results from the Service User Questionnaire

A questionnaire was completed by service users accessing a broad range of primary care service providers across Cheshire and Merseyside for people experiencing depression. Service users were also invited to attend focus group sessions where the key areas of the questionnaire were explored with the participants. Please see *Appendix 9* for a breakdown of the results for the service user completed questionnaire. When asked for ideas regarding pictorial representations of current service provision, the picture provided below captures very well current beliefs and perceptions.



The picture kindly provided by a service user, identifies the service user and carers views that often services are successful in helping them but the road to this is often convoluted and overly complex.

The findings from the questionnaires and focus group work highlight that there is still significant work to be done to meet the Coffey Perfect Care for Depression model.

From the questionnaires and focus group work, it has been identified that the experience of feeling physically safe whilst accessing services was equally split between feeling very safe/safe and feeling very unsafe/unsafe with the highest percentage identifying that they felt unsafe. Reasons given for these beliefs ranged from:



and feeling that support services should be:



– ie usually the GP surgery,

to:

"feeling very uncomfortable having to tell my story over and over"

Other reasons cited included:

"feeling very unsafe whilst on medication so stopping taking it"

the need for:

"faster, quicker assessments"

and:

"better psychiatrists"

When it came to accessing emotional safety, slightly more than half of the participants stated that they felt either very unsafe/in danger or unsafe when accessing services. No reasons for this were provided.

The findings related to the effectiveness of services during the assessment and treatment of depression, identify that the participants overall believed that services were slightly less effective meeting their needs during the assessment and treatment provision. There were some very positive comments provided particularly in relation to assessment. For example

"they always seem to meet my needs and do everything that I ask of them"

but overall participants felt that more needed to be done. Some of the comments made include

"Make it more of a helpful service within the Doctors. for first line help rather than an appointment weeks away".

Participants also commented that they wanted

"not to be ignored and to listen to what people say more"

Some participants identified that

“medication should be a last resort.  
Want treatment tailored to self”

Some participants identified the need for faster and more straightforward access to treatment and that doctors in particular needed to be trained in interpersonal skills, particularly empathy. One participant also identified that the age of the practitioner was important to them, the person they saw was

“a very young girl, wasn’t helpful,  
went away feeling worse”

The practice of collaborative working also raised some interesting results. Over one third of the respondents identified that they had found collaborative working to be either very effective or effective in meeting their needs. However a quarter of respondents identified that they found this neither ineffective or effective and when this was explored in the focus groups, the consensus opinion appeared to be that they did not think that they could score this as they had not experienced collaborative working. Positive feedback highlighted that when they had experienced collaborative working this had been very beneficial and they felt valued and included in the decision making process. This does appear to be practitioner/service specific however as not all services/practitioners made the service user feel like this. Third sector services generally fared better in this area.

The respondent’s perceptions about their experience of patient centred care was more positive with over fifty percent of respondents recording that they had been provided with enough information and felt listened to. Reasons given included

“giving me  
more options”

“I was given a choice on my treatment  
– it was explained very well to me”

“my doctor was  
very helpful and caring”

Suggested ways of improving this included

“stop using  
government  
'strap' lines”

“More counselling sessions”

“put more  
information out”

“need to know what support  
there is for parents/carers”

This was not however mirrored in the respondent's experiences of being presented with choices regarding their treatment. Only just over a third responded that they had been given choice..

More of the participants were satisfied with the time taken to refer them into services than were dissatisfied. Just over half of the participants identified that they were satisfied with the waiting time to be assessed but only a third of the participants reported being very satisfied/satisfied with the time it took to provide treatment. Most of the comments provided regarding this related to waiting lists and delay in access to services.

Similarly, there appeared to be greater dissatisfaction with how long the participants had to wait to be discharged from service (just over fifty percent) in comparison with levels of satisfaction.

Interestingly however, this needs to be set alongside the very strongly held view by a number of participants that there should be greater input from the service user regarding how they are discharged. Most participants who voiced an opinion, stated that rather than the practitioner/ professional /service deciding when and how the service user should be discharged, this decision should be collaborative and phased with identified opportunities to revisit the service post discharge as a support mechanism.

Participant's views regarding the organization of their care were fairly equally distributed. Participants often cited the need for 1:1 working and not having a time limit on the number of sessions provided. They also commented that there needed to be more information provided about other opportunities/ therapy.

It was encouraging to see that most of the participants identified that in regards to equality of access and service delivery, services were generally doing well. There were far more positive comments made than negative and these included :-

- *“being offered help and support at times that suit me”*
- *“clean and tidy & different nationalities working there”*
- *“disability good access”*
- *“as far as I know we are treated equally”*

The only negative comment made was –

- *“people are being given appointments which are a journey away in old decrepit building where disabled access is awful”*

## Discussion of Findings

The discussion of the findings of the focus groups and questionnaires and the review of other care pathway models eg. Coffey (2007), and Lanarkshire NHS (2010) were used to formulate a model for the Pathway.

A number of common themes emerged from the three data gathering methodologies, service user work, service questionnaires and patient satisfaction feedback.

- The length of time service users have to wait to access services for depression still appears to be a significant issue despite service delivery models such as IAPT being created with the explicit goal of reducing waiting times (Department of Health 2008a and Department of Health 2008b). Some Primary care services have responded to this by providing support and interventions within their service (Step1) but this was by no means commonplace so there remains considerable variation in service provision across Cheshire and Merseyside.
- The results of the focus group work and the completion of the questionnaire all



indicate that where service users and their carers have had positive and helpful experiences of the service for depression, this is perceived as valuable and useful.



My Doctor was very helpful and caring

A key element that is mentioned in almost 100% of the questionnaires and transcripts from the focus groups is the requirement of a feeling of respect which is identified by Bhanji (2013) as the due regard for the feelings, wishes, or rights of others. Whether participants were referring to current access to services or past experiences what appeared to be important service users and carers was being respected by service providers as equal partners in decisions about their care.. Much has been written about the need for dignity and respect in the provision of high quality mental health and social care across the broad spectrum of service provision (Warner, 2011, Department of Health, 2011), which is confirmed by the views and wishes of the participants of this study. The participant's experience of being respected was highly variable both from an individual's experience of multiple access to and uptake of services for depression and across the number of participants.

- The individual needs of people with disabilities, need for interpreter/ translation services etc... in accessing services was generally believed to be good, although a cautionary note needs to be included here in that the service users who participated in this study were from a predominantly white ethnic background.



Disability - Good access

- Where staff were deemed to have been well trained, particularly in interpersonal skills (most participants were referring to doctors as the staff group) the care that the service user received was sensitive, supportive and helpful.
- A significant number of participants identified that they had been helped with their depression and anxiety.
- The input of hard to reach groups was very limited despite a number of strategies for publishing the focus groups used. There continues to be a need to provide services that are perceived as non-stigmatising, easily accessible in more 'informal' and community based locations and which foster a policy of respecting the wishes and values of the service user and carer.

## Limitations of study

Access to participants in either focus groups or the completion of questionnaires was via a broad range of local support groups in Cheshire and Merseyside. Whilst a rich and informative degree of information was provided it needs to be acknowledged that all the participants were attending the support group for additional help/support or because support had not been available. Reasons given for this were predominantly that of services accessed or available not being perceived as meeting the service users and carers needs. The project team were unable to gain access to people who had used services that they believed had helped them to the extent that they felt was needed.

Access to young people and their carers moving from child and adolescent mental health services to adult services also proved problematic and a finding of the study identified that this transition phase is of concern to this group of people. This should be addressed when creating and commissioning services to provide effective transitions.

Participants in the focus group work and who completed the questionnaires were exclusively from a white, British ethnic background. This was unintentional and the project team was unable to influence this. Therefore it has to be recognised that whilst all the participants' input was valuable, some information/perceptions provided by the participants may not necessarily reflect the wider population of Cheshire and Merseyside. For example, the results arising from the question relating to meeting diverse needs suggests that the service provision regarding this is more than satisfactory, may well be less than accurate.

Access to data regarding days lost in employment due to depression for Cheshire and Merseyside was not available and data re antidepressant prescribing was available from only 2 services in Cheshire and Merseyside. It is suggested that these 2 areas are addressed through future work if possible.

### **Dissemination of the Results of this Study will be through:**

- Web sites of support groups/services
- Cheshire and Merseyside Strategic Clinical Networks website
- Launch event of the Cheshire and Merseyside Integrated Depression Care Pathway to be held on 11th November 2015



## Proposed Model

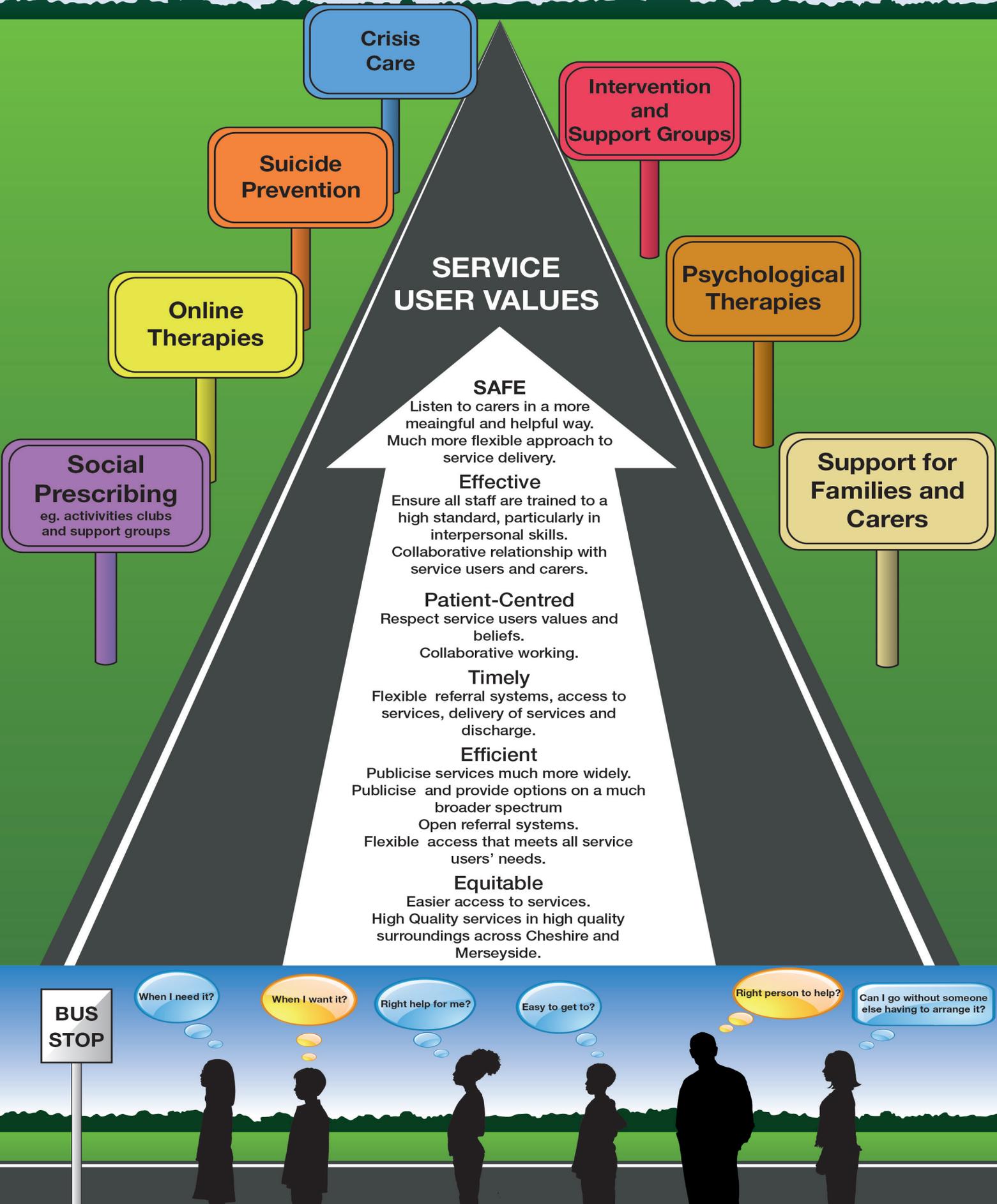
The proposed model is based on what services users want from services for depression. These expectations are formulated into a set of principles which underpin this model. The principles are:

- **Meets the needs of the service user with depression** - in a timely, collaborative and effective manner
- **Early identification** – this should include the opportunity for self referral/open referral systems and quick access to services
- **Primary care** - Access to services – **Secondary care** - service users and carers want clearer and more straightforward access to both primary care services – eg. self referral but in addition there is a need to more effective links and referral systems between primary and secondary care services
- **Service delivery**- services need to continually evolve to meet individual need – eg. use of technology, follow up services, location etc... the relationships between service user/carer should be based on mutual respect for the knowledge and experiences of all who are involved
- **(Zero Suicide)** - creating services that are effective in assessing and responding to crisis quickly and effectively that includes the service user and carer as an equal partner
- **Use of media**- services should continue to evolve in service delivery in ways which optimise the use of the growing range of media options eg. computerised interventions, use of Apps etc.
- **Coffey's adapted principles** – Safe, effective, patient centred, timely, efficient and equitable
- **Safe Discharge** – Wellness/recovery -the journey to recovery/ wellness is different for everyone. The creation of a model is helpful in planning services but there needs to be flexibility in any model to reflect those differences. The individuals needs when planning for discharge should take account of difference and tailor future support to meet their needs

## The Integrated Care Pathway for Depression Model

This model represents what service users and carers asked for in the study we undertook. Set within this model are the services that Cheshire and Merseyside currently provide (identified in the signposts within the model). When accessing these, the service user and carers should be able to access services they believe would help in the manner identified in the questions posed in the model. Once they have accessed the service then their expectations about the delivery of this should be met through the service delivering help and support based on the service users values identified in the arrow on the road. To facilitate the service users journey to wellness/ recovery access to appropriate support should meet the service user and carers needs in a fluid and flexible manner as this road may be winding or necessitate stopping off and rejoining services as and when required.

# Integrated Depression Care Pathway



# Recommendations

## - Key themes for improving services that have been identified from the data:

The findings from the questionnaires and focus group work highlight that there is still significant work to be done to meet the Coffey Perfect Care for Depression model and the identified values of the service users who engaged with this work. The continuing input from service users and carers is integral to the implementation of the recommendations identified below:-

- Reduce waiting times for referral to services, accessing services and then discharge. These were all pointed out as problematic with some area differences identified (**Safe and timely**).
- Develop systems which encourage easier and more open access to services. This was a recurring issue for participants. Open referral systems were frequently requested from focus group members and from the literature there is still a need to provide services for hard to reach groups (**Efficient**).
- Involving carers more meaningfully; that is, respecting their viewpoint and knowledge. One group of carers identified that when their son/daughter/partner etc... was unwell and unable to make sensible decisions, they had felt ignored. There was a discussion around this with the suggestion that the person experiencing mental health problems could consent to allowing decisions to be made for them by the identified carer in advance (**Safe and patient centred**).
- Increased access to psychological therapies – medication should be a last resort (**Timely and equitable**).
- Ensure that professionals are well trained and are able to engender optimism in a collaborative relationship (**Effective, efficient and patient centred**). This should include communication skills training, training around supporting people with literacy problems and cultural influences.
- Provide services that foster collaborative relationships which value feelings and opinions of service users in a meaningful way (**Patient centred**), in other words, to create a 'safe place' which service users are happy to access.
- Publicise services and options much more widely through libraries, pubs, community centres, homeless shelters and betting shops (**Efficient**).
- Improve and ensure the availability of robust systems for the collection of mental health metrics and increase the local knowledge base around prevalence and incidence of depression and associated issues: an example of these are in relation to antidepressant prescribing, employment and suicide.

## What Next?

- 1) It is recommended that the model is incorporated into commissioning specifications and used for audit of services for depression.
- 2) It is recommended that an economic impact assessment of implementation of the pathway be undertaken
- 3) It is recommended that the pathway is implemented
- 4) It is recommended that strategies to increase the means by which online resources are accessed. This can be either complementary to face to face intervention or as an option which may contribute to meeting the needs of hard to reach groups.

### Information for Commissioners

The findings from dialogue with Service users, families and other stakeholders tell us that the road map, based upon 10 rules for perfect care identified by Ed Coffey, for new pathway model should be underpinned by:

- **Care = relationships** - The relationship between the service users and practitioner/ professional/ service should be based on mutual respect and value.
- **Care is customised** - Service provision should be tailored to meet individual need rather than a 'model' or 'protocol' being generically applied
- **Care is patient centred** - Service users wishes and values should be respected and incorporated into plans for care
- **Share knowledge** - transparency in service delivery – across services and with services users
- **Manage by fact** - leave judgments and opinions outside the service room door!
- **Make safety a system priority** - from efficient referrals systems to managing distress in a timely and effective manner
- **Embrace transparency** - honesty about service delivery and options is essential to service users
- **Anticipate patient needs** - care models useful as long as they can be flexible!
- **Continually reduce waste** - services should be organised and efficient. Flexibility can also assist in this – ie having a valued out of hours service may attract more people than sticking to 9-5!
- **Professionals co-operate** - from referrals systems to the management of information and the meeting of service users needs.

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# Appendices



## Appendix 1 - Patient Satisfaction Questionnaires Results

Service 1 – 9 questions asked of a number of service users and service providers	Content from questionnaire
<i>Safe</i>	<p>Feeling safe to 'come out', helping people to recognise their positives to prevent deterioration/self destruction, levels of crime in neighbourhood/more secure housing, not respecting confidentiality, insensitive staff, dismissing symptoms ("pull yourself together")</p> <p>Working in partnership</p> <p>You have to be really bad, nearly suicidal before counselling is offered</p>
<i>Effective</i>	<p>Advertise on radio, TV, paper, through GP( GP screens etc..) , posters etc...libraries etc...</p> <p>Identify what is available and how to access it</p> <p>Train professionals to signpost</p> <p>User friendly services</p> <p>Telling your story over and over again – need continuity of services</p> <p>'map of medicine' –individual routes, training of GP's and GPs knowing patients, longer time slots for patients</p> <p>Reading groups</p> <p>Effective Primary Care services</p> <p>Normalise stress/anxiety/depression</p>
<i>Timely</i>	<p>Waiting times were too long, points system, no easy access to practitioners/support</p>
<i>Patient Centred</i>	<p>Breakdown media stereotype by training – no labelling, learn form others how they cope, treat isolation</p>
<i>Efficient</i>	<p>Courses ( eg cooking, sewing, music)</p> <p>Well being centre, counsellors in GP surgeries, advice centres, staff being able to signpost, More GP's, provide more information on recreational drugs and alcohol and their effects on stress and anxiety, advice centres, community referral, use of local support services ( numerous mentioned- all very positively)</p>
<i>Equitable</i>	<p>Hierarchical systems cause problems, not working in partnership, only providing strictly medical interventions, smaller groups although make sure these are effective rather than insular, help to get out of house/access services , services are not coordinated</p>

Service 2- 35 questions were answered by service users, carers, third sector organisations and support staff	Content from questionnaire
<b>Safe</b>	Transition from child to adult services was identified by a number of services users as problematic. Follow up when moving from one service, being supported through referral process ( this seems to have been a key issue) , ensuring care plan contains all relevant information and are provided, more information about their discharge, make sure additional needs are taken into account
<b>Effective</b>	Need to have staff trained in play therapy, better range of services needs to be provided rather than focus being on short term strategies. More information via posters in other agencies/public areas, advisors need to have freedom to be innovative, not be restricted by over prescriptive rules, information on third sector support
<b>Timely</b>	Shorter waiting times, more therapists are needed, more sessions
<b>Patient Centred</b>	Majority of service users felt that they were treated in a professional way ( 2 did not) keep promises ie to write to other professionals/agencies
<b>Efficient</b>	Discharge process for non-attendance/ appropriateness for service needs addressing. Someone always picked up the phone when I called. Provide a greater range of services, improve communication between staff, better continuation of care ( eg if a staff member leaves )
<b>Equitable</b>	Geographical access was good , not able to take baby into session, waiting times/list too long



## Appendix 2 - Anti-depressant Prescribing Across Cheshire and Merseyside

NHS Eastern Cheshire CC...	NHS Halton CCG	NHS Knowsley CCG	NHS Liverpool CCG	NHS South Cheshire CCG	NHS South Sefton CCG	NHS Southport And Formb...	NHS St Helens CCG	NHS Vale Royal CCG	NHS Warrington CCG	NHS West Cheshire CCG	NHS Wirral CCG	Indicator	Period
5.5	6.0	5.2	6.6	6.7	6.8	4.5	7.5	6.1	6.3	5.2	6.7	Depression: QOF prevalence (18+)	2012/13
0.8	1.1	0.8	1.3	1.3	1.1	0.6	1.1	1.1	1.3	0.6	1.3	Depression: QOF incidence (18+)	2012/13
10.8	17.4	19.5	19.3	11.5	16.3	11.4	16.8	14.1	12.5	12.6	15.4	Depression and anxiety prevalence (GP survey)	2012/13
0.77	0.78	0.86	1.21	0.78	1.14	0.99	0.97	0.72	0.82	0.83	0.95	Mental health problem: QOF prevalence (all ages)	2012/13
4.5	7.2	6.3	6.7	4.5	5.9	4.7	6.3	5.4	4.5	5.6	6.4	% reporting a long-term mental health problem	2012/13

(From Public Health England. Community Mental Health profiles)

## Anti-Depressant Prescribing Across Cheshire and Merseyside

Number of local ccgs who provided information =12	Total average daily quantities (ADQ) usage for selected antidepressants (BNF 4.3 sub-set)
Knowsley CCG	1,646,180
Liverpool CCG	4,950,015
St Helens CCG	2,075,589
Wirral CCG	3,432,629
Eastern Cheshire CCG	1,675,942
West Cheshire	2,080,512
Warrington	1,845,659
Vale Royal	964,155
Southport and Formby	990,866
South Sefton	1,464,389
South Cheshire	1,431,094
Halton	1,291,247

WirralBITeam (NHS WIRRAL CCG )

## Appendix 3 - Incidence and Prevalence of Suicide in Cheshire and Merseyside Region for 2012/13

SCN Cheshire and Merseyside				
Depression: QOF prevalence (18+)	2012/13	-	5.8	-
Depression: QOF incidence (18+)	2012/13	-	1.0	1.1*
Depression and anxiety prevalence (GP survey)	2012/13	-	12.0	15.2*
Mental health problem: QOF prevalence (all ages)	2012/13	-	0.84	0.94*
% reporting a long-term mental health problem	2012/13	-	4.5	-

## Appendix 4 - Suicide Rates by Postcode

Breaking these down into the different areas in Cheshire and Merseyside we can see the following

### Suicide rate (Persons) 2011 - 13

Directly standardised rate - per 100,000

Area	Count	Value
England	13,758	8.8
Cheshire and Merseyside	657	9.2
Cheshire East	87	7.9
Cheshire West and Chester	88	8.9
Halton	36	9.6
Knowsley	47	11.1
Liverpool	127	9.5
Sefton	81	9.7
St. Helens	62	11.9
Warrington	55	9.2
Wirral	74	8.0

Source: Public Health England (based on ONS source data)

## [Suicide rate \(Male\)2011 - 13](#)

Directly standardised rate - per 100,000

Area	Count	Value
England	10,596	13.8
Cheshire and Merseyside	525	15.2
Cheshire East	62	11.9
Cheshire West and Chester	69	14.3
Halton	28	15.4
Knowsley	39	20.2
Liverpool	105	15.9
Sefton	63	16.2
St. Helens	56	21.9
Warrington	44	14.6
Wirral	59	13.3

*Source: Public Health England (based on ONS source data)*

Again with the exception of Cheshire East and Wirral areas the number so suicide by men is higher than the national average with two areas –Knowsley and St Helens having significantly worse suicide rates –refer to research/stats on social deprivation and employment and depression here

[Suicide rate \(Female\)](#) 2011 - 13

Directly standardised rate - per 100,000

Area	Count	Value
England	3,162	4.0
Cheshire and Merseyside	132	3.6
Cheshire East	25	4.5
Cheshire West and Chester	19	*
Halton	8	*
Knowsley	8	*
Liverpool	22	*
Sefton	18	*
St. Helens	6	*
Warrington	11	*
Wirral	15	*

Source: Public Health England (based on ONS source data)

## Appendix 5 – Methodology Information

Procedure or Intervention	Participants	Number of participants	No. of procedures per participant	Avg. Time to complete
<p>questionnaires re NICE guidelines for services to complete</p> <p>-see attached documents – A-D</p> <ul style="list-style-type: none"> <li>ALSO INCLUDED – information letter which will be attached to questionnaire – identified as document E and F</li> </ul>	<p>In the Cheshire and Merseyside area- IAPT services - Primary Care, GPs, Mental Health Commissioners, Secondary Care Services, transition from child to adult services</p>	<p>All Cheshire and Merseyside Mental health services will be approached</p>	<p>1</p>	<p>4 weeks</p> <p>End of July 2015</p>
<p>Group work to complete questionnaire</p> <p>Information sheet/ Questionnaire identified as Document F</p>	<p>Service user ( SU) Representatives from the following groups ( who have all experienced/ are currently experiencing depression) –</p> <p>Adults</p> <p>Older adults</p> <p>Individuals who are homeless</p> <p>Military veterans</p> <p>Pregnant women</p> <p>Lesbian, gay, Bisexual and Transgender representation</p> <p>Individuals with a learning disability</p> <p>Representatives of Black and Asian minorities</p> <p>Individuals who are unemployed</p> <p>Carer groups</p> <p>Young People in transition from Child and Adolescent Services to adult</p> <p>Representatives from the Chinese Community</p>	<p>Representative sample of SU's from Cheshire and Merseyside Mental health services</p> <p>Up to 10 attendees at group meeting for each specialist support group</p>		



Cheshire and Merseyside  
Strategic Clinical Networks

**Questionnaire – Integrated Care for Depression Pathway – Patients/Service Users**

The aim of this questionnaire is to identify what we need to do to care for people who are experiencing depression. This will help us to improve services across Cheshire and Merseyside.

**All information gathered from this questionnaire will be anonymised and treated with confidentiality.**

**Completion and return of this questionnaire assumes the following –**

*“I have read the information sheet provided and I am happy to participate. I understand that by completing and returning this questionnaire I am consenting to be part of this research study and for my data to be used as described in the information sheet provided.”*

-----

- 1) a) On a scale of 1-5 (1 being very unsafe and 5 being very safe)  
How safe physically did you feel you when you accessed Mental Health services for your depression?

1 Very unsafe/ in danger	2 Unsafe /uncomfortable	3 Neither safe or unsafe	4 Fairly safe/ comfortable	5 Very safe

- b) How could this be improved?

- 2) a) On a scale of 1-5 (1 being very unsafe and 5 being very safe)  
How safe emotionally did you feel when you accessed Mental Health services for your depression?

1 Very unsafe/ in danger	2 Unsafe /uncomfortable	3 Neither safe or unsafe	4 Fairly safe/ comfortable	5 Very safe

- b) How could this be improved?

- 3) a) On a scale of 1-5(1 being very ineffective and 5 being very effective)  
How effective would you say the service was in meeting your needs during the assessment of your mental health problem?

1 Very ineffective	2 Ineffective	3 Neither ineffective of effective	4 Effective	5 Very effective

- b) how could services improve their effectiveness?

- 4) a) On a scale of 1-5(1 being very ineffective and 5 being very effective)  
How effective would you say the service was in meeting your needs during the treatment of your depression?

<b>1 Very ineffective</b>	<b>2 Ineffective</b>	<b>3 Neither ineffective of effective</b>	<b>4 Effective</b>	<b>5 Very effective</b>

- b) how could services be improved?

- 5) a) On a scale of 1-5(1 being very ineffective and 5 being very effective)  
How effective would you say the service was in meeting your needs through collaborative working (you and the service deciding what would be best/most helpful)

<b>1 Very ineffective</b>	<b>2 Ineffective</b>	<b>3 Neither ineffective of effective</b>	<b>4 Effective</b>	<b>5 Very effective</b>

b) how could services be improved?

6) Did you feel that the service was 'patient centred', e.g. were you always given enough information to make an informed decision, were your views and wishes taken into consideration and did you feel 'listened to' and respected

YES  NO

were you presented with choices?

YES  NO

if YES – in what way

if NO – why not

How could this be improved?

7) On a scale of 1-5 (1 being very dissatisfied and 5 being very satisfied)

How satisfied were/ are you with the time taken to

1 Very unsatisfied	2 Unsatisfied	3 Neither satisfied or dissatisfied	4 Satisfied	5 Very satisfied

i) Refer you

1 Very unsatisfied	2 Unsatisfied	3 Neither satisfied or dissatisfied	4 Satisfied	5 Very satisfied

ii) Waiting times

<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>

iii) Assess you

<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>

iv) Provide help/support/treatment

<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>

vi) Discharge you ( if appropriate)

b) Any additional comments you want to make please write below-

8) a) On a scale of 1-5 (1 being very dissatisfied and 5 being very satisfied)

How satisfied were you with how your care/treatment was

i) organised

1 Very unsatisfied	2 Unsatisfied	3 Neither satisfied or dissatisfied	4 Satisfied	5 Very satisfied

ii) delivered

1 Very unsatisfied	2 Unsatisfied	3 Neither satisfied or dissatisfied	4 Satisfied	5 Very satisfied

b) How can this be improved

9) In your opinion does the service/s that you have used/are currently using treat all people fairly and equitably? E.g. think of such issues for wheelchair users accessing the building or those whose first language is not English etc... You can use your own experiences as examples

YES

NO

If YES please give examples

If NO please give examples

If you have any concerns or complaints about your experience of services we would recommend that you contact your support service manager for advice.

Thank you for taking the time to complete this questionnaire.

**Karen Rea – Project Manager Liverpool John Moores University**  
**Gloria Payne- Cheshire and Merseyside Strategic Clinical Networks (SCN)**  
**John Roberts – Deputy chair of project group (Integrated Depression Care Pathway group)**  
**Pat Sneddon Cheshire and Merseyside SCN**  
**Elaine Owen – Cheshire and Merseyside SCN**



Cheshire and Merseyside  
Strategic Clinical Networks

## Questionnaire to General Practitioners

LJMU and Cheshire and Merseyside Strategic Clinical Networks are currently working on a joint project the purpose of which is the development of an Integrated Care Pathway for Depression for Cheshire and Merseyside.

This questionnaire has been developed using the NICE Quality standards for depression in adults (2011) and the Department of Health – Best Practice in Managing Risk (2007) and reflects the Six Dimensions of Perfect Care for Depression identified by Coffey (2007)

The deadline date for the return of this information is: Friday 31<sup>st</sup> July 2015.

Please return the completed questionnaire to [k.rea@ljmu.ac.uk](mailto:k.rea@ljmu.ac.uk)

All information provided will be treated in confidence and all data will be destroyed once it has been transcribed (anonymously) into the planned report.

Please tick the relevant YES/NO box for your service next to the standards identified below. We would also appreciate any comments that you may have with regards to meeting the standards identified below and have included a box for these comments.

NICE Quality Standard – Depression in adults	Yes	No	Comments
1) People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode			
2) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.			
3) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.			
4) People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific			

clinical criteria in accordance with NICE guidance			
5) People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.			
6) People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy.			
7) People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse			
8) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment			
9) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed			
10) People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse are referred for appropriate psychological interventions.			

## Questionnaire to primary care service providers and commissioners of mental health services for depression

LJMU and Cheshire and Merseyside Strategic Clinical Networks are currently working on a joint project the purpose of which is the development of an Integrated Care Pathway for Depression for Cheshire and Merseyside.

This questionnaire has been developed using the NICE Quality standards for depression in adults (2011) and the Department of Health – Best Practice in Managing Risk (2007) and reflects the Six Dimensions of Perfect Care for Depression identified by Coffey (2007)

The deadline date for the return of this information is Friday 31st July 2015

Please return the completed questionnaire to [k.rea@ljmu.ac.uk](mailto:k.rea@ljmu.ac.uk)

All information provided will be treated in confidence and all data will be destroyed once it has been transcribed (anonymously) into the planned report.

Please tick the relevant YES/NO box for your service next to the standards identified below. We would also appreciate any comments that you may have with regards to meeting the standards identified below and have included a box for these comments.

NICE Quality Standard – Depression in adults	Yes	No	Comments
1) People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode			
2) Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance.			
3) Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of intervention			

4) People with persistent sub threshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.			
5) People with moderate depression and a chronic physical health problem receive an appropriate high-intensity psychological intervention			
6) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.			
7) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.			
<b>Best Practice in Managing Risk. Department of Health</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
8) Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners in your service.			
9) Risk management is conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.			
10) Risk management is built on a recognition of the service user's strengths and should emphasise recovery.			
11) Risk management includes an organisational strategy as well as efforts by the individual practitioner.			
12) Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.			
13) Risk management takes into account that risk can be both general and specific, and that good management can reduce and prevent harm.			
14) Knowledge and understanding of mental health legislation is an important component of risk management.			
15) The risk management plan includes a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.			
16) Risk management is based on assessment using the structured clinical judgement approach.			
17) All staff involved in risk management are capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.			

18) Risk management is based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.			
20) Risk management plans are developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.			
21) All staff involved in risk management relevant training, which should be updated at least every three years.			



## **Questionnaire to secondary care service providers and mental health commissioners**

LJMU and Cheshire and Merseyside Strategic Clinical Networks are currently working on a joint project the purpose of which is the development of an Integrated Care Pathway for Depression for Cheshire and Merseyside.

This questionnaire has been developed using the NICE Quality standards for depression in adults (2011) and the Department of Health – Best Practice in Managing Risk (2007) and reflects the Six Dimensions of Perfect Care for Depression identified by Coffey (2007)

The deadline date for the return of this information is : Friday 31<sup>st</sup> July 2015.

Please return the completed questionnaire to [k.rea@ljmu.ac.uk](mailto:k.rea@ljmu.ac.uk)

All information provided will be treated in confidence and all data will be destroyed once it has been transcribed (anonymously) into the planned report.

Please tick the relevant YES/NO box for your service next to the standards identified below. We would also appreciate any comments that you may have with regards to meeting the standards identified below and have included a box for these comments.

<b>NICE Quality Standard – Depression in adults</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
1) People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode			
2) Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance.			
3) Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of intervention			
4) People with persistent subthreshold depressive symptoms or mild to moderate depression receive appropriate psychosocial interventions.			
5) People with moderate depression and a chronic			

physical health problem receive an appropriate psychological intervention			
6) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.			
7) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.			
8) People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.			
9) People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.			
10) People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions.			
<b>Best Practice in Managing Risk. Department of Health</b>			
8) Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners in your service.			
9) Risk management is conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.			
10) Risk management is built on a recognition of the service user's strengths and should emphasise recovery.			
11) Risk management includes an organisational strategy as well as efforts by the individual practitioner.			
12) Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.			
13) Risk management takes into account that risk can be both general and specific, and that good management can reduce and prevent harm.			
14) Knowledge and understanding of mental health legislation is an important component of risk management.			
15) The risk management plan includes a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.			



physical health problem receive an appropriate psychological intervention			
6) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.			
7) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.			
8) People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.			
9) People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.			
10) People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions.			
<b>Best Practice in Managing Risk. Department of Health</b>			
8) Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners in your service.			
9) Risk management is conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.			
10) Risk management is built on a recognition of the service user's strengths and should emphasise recovery.			
11) Risk management includes an organisational strategy as well as efforts by the individual practitioner.			
12) Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.			
13) Risk management takes into account that risk can be both general and specific, and that good management can reduce and prevent harm.			
14) Knowledge and understanding of mental health legislation is an important component of risk management.			
15) The risk management plan includes a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.			

16) Risk management is be based on assessment using the structured clinical judgement approach.			
17) All staff involved in risk management are capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.			
18) Risk management is based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.			
20) Risk management plans are developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.			
21) All staff involved in risk management relevant training, which should be updated at least every three years.			



## Questionnaire to service providers and commissioners of mental health services supporting Children & Young People transitioning to adult services.

LJMU and Cheshire and Merseyside Strategic Clinical Networks are currently working on a joint project the purpose of which is the development of an Integrated Care Pathway for Depression for Cheshire and Merseyside. The pathway will be developed using the Ed Coffey Perfect Care for Depression Pathway framework (2007).

**This questionnaire has been developed using the NICE guidelines for *Depression in children and young people: Identification and management in primary, community and secondary care* ( March 2015) and reflects the Six Dimensions of Perfect Care for Depression identified by Coffey( 2007)**

The deadline date for the return of this information is: Friday 31<sup>st</sup> July 2015.

Please return the completed questionnaire to [k.rea@ljmu.ac.uk](mailto:k.rea@ljmu.ac.uk)

All information provided will be treated in confidence and all data will be destroyed once it has been transcribed (anonymously) into the planned report.

Please tick the relevant YES/NO box for your service next to the standards identified below. We would also appreciate any comments that you may have with regards to meeting the standards identified below and have included a box for these comments.

NICE Quality Standard – Care of all children and young people with depression –Transfer to adult services	Yes	No	Comments
The CAMHS team currently providing treatment and care for a young person aged 17 who is recovering from a first episode of depression will normally continue to provide treatment until discharge is considered appropriate in accordance with this guideline, even when the person turns 18 years of age. [2005]			
The CAMHS team currently providing treatment and care for a young person aged 17–18 who either has ongoing symptoms from a first episode that are not resolving or has, or is recovering from, a second or subsequent episode of depression will			

normally arrange for a transfer to adult services, informed by the Care Programme Approach. [2005]			
A young person aged 17–18 with a history of recurrent depression who is being considered for discharge from CAMHS is provided with comprehensive information about the treatment of depression in adults (including the NICE 'Information for the public' version for adult depression) and information about local services and support groups suitable for young adults with depression. [2005]			
A young person aged 17–18 who has successfully recovered from a first episode of depression and is discharged from CAMHS will not normally be referred on to adult services, unless they are considered to be at high risk of relapse (for example, if they are living in multiple-risk circumstances). [2005]			

## Appendix 8 - Results of Returned Questionnaires Sent to Service Providers and Commissioners

NICE Quality Standard – Depression in adults	Meets relevant Nice Guidelines	Does not meet relevant Nice Guidelines
1) People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode	100%	
2) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.	95%	5%
3) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.	100%	
4) People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance	75%	5%
5) People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.	90%	10%
6) People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy.	80%	20%
7) People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse	85%	15%
8) People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment	100%	
9) People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed	100%	
10) People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse are referred for appropriate psychological interventions.	95%	5%



<b>Best Practice in Managing Risk. Department of Health</b>	<b>Meets relevant Nice Guidelines</b>	<b>Does not meet relevant Nice Guidelines</b>
8) Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners in your service.	100%	
9) Risk management is conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.	100%	
10) Risk management is built on a recognition of the service user's strengths and should emphasise recovery.	100%	
11) Risk management includes an organisational strategy as well as efforts by the individual practitioner.	100%	
12) Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.	100%	
13) Risk management takes into account that risk can be both general and specific, and that good management can reduce and prevent harm.	100%	
14) Knowledge and understanding of mental health legislation is an important component of risk management.	100%	
15) The risk management plan includes a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.	100%	
16) Risk management is based on assessment using the structured clinical judgement approach.	100%	
17) All staff involved in risk management are capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.	100%	
18) Risk management is based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.	100%	
20) Risk management plans are developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.	100%	
21) All staff involved in risk management relevant training, which should be updated at least every three years.	100%	

<b>NICE Quality Standard – Care of all children and young people with depression –Transfer to adult services</b>	<b>Meets relevant Nice Guidelines</b>	<b>Does not meet relevant Nice Guidelines</b>
The CAMHS team currently providing treatment and care for a young person aged 17 who is recovering from a first episode of depression will normally continue to provide treatment until discharge is considered appropriate in accordance with this guideline, even when the person turns 18 years of age. [2005]	100%	
The CAMHS team currently providing treatment and care for a young person aged 17–18 who either has ongoing symptoms from a first episode that are not resolving or has, or is recovering from, a second or subsequent episode of depression will normally arrange for a transfer to adult services, informed by the Care Programme Approach. [2005]	100%	

<p>A young person aged 17–18 with a history of recurrent depression who is being considered for discharge from CAMHS is provided with comprehensive information about the treatment of depression in adults (including the NICE 'Information for the public' version for adult depression) and information about local services and support groups suitable for young adults with depression. <b>[2005]</b></p>	<p>100%</p>	
<p>A young person aged 17–18 who has successfully recovered from a first episode of depression and is discharged from CAMHS will not normally be referred on to adult services, unless they are considered to be at high risk of relapse (for example, if they are living in multiple-risk circumstances). <b>[2005]</b></p>	<p>100%</p>	



## Appendix 9 - Table of Results of Questionnaires Completed by Service Users

1) On a scale of 1-5 (1 being very unsafe and 5 being very safe) How safe physically did you feel you when you accessed Mental Health services for your depression	<b>1 Very unsafe/ in danger</b>	<b>2 Unsafe /uncomfortable</b>	<b>3 Neither safe or unsafe</b>	<b>4 Fairly safe/ comfortable</b>	<b>5 Very safe</b>
	20%	28%	4%	24%	24%

2) On a scale of 1-5 (1 being very unsafe and 5 being very safe) How safe emotionally did you feel when you accessed Mental Health services for your depression?	<b>1 Very unsafe/ in danger</b>	<b>2 Unsafe /uncomfortable</b>	<b>3 Neither safe or unsafe</b>	<b>4 Fairly safe/ comfortable</b>	<b>5 Very safe</b>
	28%	28%	0%	28%	16%

3) On a scale of 1-5(1 being very ineffective and 5 being very effective) How effective would you say the service was in meeting your needs during the assessment of your mental health problem?	<b>1 Very ineffective</b>	<b>2 Ineffective</b>	<b>3 Neither ineffective or effective</b>	<b>4 Effective</b>	<b>5 Very effective</b>
	24%	16%	12%	28%	20%

4) On a scale of 1-5(1 being very ineffective and 5 being very effective) How effective would you say the service was in meeting your needs during the treatment of your depression?	<b>1 Very ineffective</b>	<b>2 Ineffective</b>	<b>3 Neither ineffective or effective</b>	<b>4 Effective</b>	<b>5 Very effective</b>
	28%	20%	8%	28%	16%

5) On a scale of 1-5(1 being very ineffective and 5 being very effective) How effective would you say the service was in meeting your needs through collaborative working (you and the service deciding what would be best/most helpful)	<b>1 Very ineffective</b>	<b>2 Ineffective</b>	<b>3 Neither ineffective or effective</b>	<b>4 Effective</b>	<b>5 Very effective</b>
	20%	20%	24%	16%	20%

6a) Did you feel that the service was 'patient centred', e.g. were you always given enough information to make an informed decision, were your views and wishes taken into consideration and did you feel 'listened to' and respected	Yes	No
	56%	44%

6b) were you presented with choices	Yes	No
	36%	64%

7) On a scale of 1-5 (5 being very dissatisfied and 1 being very satisfied) How satisfied were/ are you with the time taken to refer you	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>
	24%	20%	4%	28%	24%

7b) On a scale of 1-5 (5 being very dissatisfied and 1 being very satisfied) How satisfied were/ are you with waiting times	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>
	16%	32%	8%	24%	20%

7c) On a scale of 1-5 (5 being very dissatisfied and 1 being very satisfied)	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>



satisfied) How satisfied were/ are you with the time taken to assess you	24%	8%	24%	24%	28%
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7d) On a scale of 1-5 (5 being very dissatisfied and 5 being very satisfied) How satisfied were/ are you with the time taken to Provide help/support/treatment	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>
	28%	16%	20%	24%	12%

7e) On a scale of 1-5 (5 being very dissatisfied and 5 being very satisfied) How satisfied were/ are you with the time taken to discharge you	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>
	28%	24%	12%	24%	12%

8a) On a scale of 1-5 (1 being very dissatisfied and 5 being very satisfied) How satisfied were you with how your care/treatment was organised	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>
	20%	20%	16%	20%	24%

8b) On a scale of 1-5 (1 being very dissatisfied and 5 being very satisfied) How satisfied were you with how your care/treatment was delivered	<b>1 Very unsatisfied</b>	<b>2 Unsatisfied</b>	<b>3 Neither satisfied or dissatisfied</b>	<b>4 Satisfied</b>	<b>5 Very satisfied</b>
	20%	12%	28%	16%	24%

9) In your opinion does the service/s that you have used/are currently using treat all people fairly and equitably? E.g. think of such issues for wheelchair users accessing the building or those whose first language is not English etc... You can use your own experiences as examples	YES	NO
	76%	24%



# Integrated Depression Care Pathway

## Project Report

Karen Rea and Grahame Smith



Cheshire and Merseyside  
Strategic Clinical Networks

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dream plan achieve