Croydon Joint Strategic Needs Assessment 2012/13

Key Topic 1: Depression in Adults
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The data in this chapter was the most recent published data as at 30 November 2012. Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the source shown under figures or listed in the appendices for the chapter for the latest information

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1 Acknowledgements

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Contributors to this chapter include members of the **JSNA steering group**, members of the **JSNA implementation group** (see *Appendix 1* for membership) and the organisations that they represent, **respondents to the online survey**, and the many people who attended the **consultative meeting** and the **stakeholder meetings** (Mental Health Forum and Depression Alliance).

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2 Executive Summary

Introduction

- This chapter forms part of the overall 2012/13 Joint Strategic Needs Assessment (JSNA), which focuses on mental health.
- This chapter focuses on adult depression. It should be read in conjunction with other chapters in the 2012/13 JSNA, particularly the *Overview Chapter*, which focuses on prevention of mental health problems such as depression. The aim of the depression chapter is to provide an overview of current and future need, to identify gaps and assets in service provision and identify priorities for future development.
- The most effective way of dealing with depression is to prevent it happening in the first place. High levels of well-being prevent depression, help those with depression to recover quickly and reduce relapse. This chapter on depression firmly supports a shift of focus to prevention, taking a population approach to improving well-being and increasing population resilience. It refers to the JSNA 2012/13 Overview chapter in describing prevention, promotion and well-being services.
- The chapter findings were informed by consultation with stakeholders. An online survey was made available, and a number of consultative events were held with service users, carers, providers and other stakeholders.

Background

- Depression is a common mental health disorder where people experience symptoms that include low mood, loss of interest, pleasure and /or energy. It often comes with symptoms of anxiety.
- Episodes last for 6 to 8 months and some people have many episodes in their life although they are often undetected. Depression is usually managed within primary care.
- Depression is the leading cause of disability for both males and females. The impact of depression extends beyond the individual concerned to family, friends, employers and society at large.
- Those most prone to depression include those with long term physical health problems, those with medically unexplained symptoms, those on low incomes, carers, asylum seekers, substance misusers, and women; the burden of depression is 50% higher for females than males.
- Depression comes at huge financial cost to society, not only in terms of cost to the health service but to society as a whole in terms of lost employment.
- In Croydon, an estimated three quarters (77%) of the estimated costs of £61 million associated with depression are in lost employment.

Need - How common is depression in Croydon?

- Not everyone with symptoms of depression has a diagnosis of depression. GPs vary considerably in their ability to recognise depressive illnesses.
- At any one time in Croydon, around 34,000 adults (nearly 12%) have symptoms of either depression or mixed anxiety or depression. Changes in the population mean that by 2021, we would expect numbers to increase by 5%.
- Postnatal depression (PND) is also expected to increase due to changes in the birth rate. PND affects approximately 13% of women and is expected to increase by 28% (from 717 to 918 women) by 2021.Postnatal depression will be explored in the chapter on Emotional Health and Well-being of Children and Young People
- In Croydon there are around 9,000 adults who were diagnosed with depression in the last five years, almost 3% of the population. This percentage varies widely across Croydon's GP practices.
- In Croydon, the prevalence of diagnosed depression is lower in every ethnic group than in those noted to be white British. For Black and Asian men and women and for Chinese/other women, prevalence rates are less than half the prevalence for white British. However, given what we know about who suffers from depression, we would not expect to see this: there is little evidence of variation in depression between white, black and south Asian men and in women there is some evidence of *higher* rates of common mental health disorders in South Asian women. A key finding of this report is therefore that people with depression in BME groups appear to be less likely to be diagnosed with depression in Croydon than their white British counterparts.
- Local data are also presented to show that when people from BME backgrounds are diagnosed with depression, their condition is more severe.
- ***The chapter recommends that as a priority, commissioners, primary care providers and BME groups work together to address the comparatively low diagnosis rate in BME populations and the resulting inequality in access, as well as taking action to tackle stigma and discrimination within services and in the community, particularly in BME groups.***
- People with a **long term condition (LTC)** are two to three times more likely to have depression. Similarly, people with depression are more likely to have an LTC. There are complex reasons for this link. The crucial point is that people with both long-term conditions and mental health problems have much higher treatment cost and worse outcomes. They find it more difficult to manage their own physical condition, are more likely to have unhealthy behaviours such as smoking, are more likely to miss medical appointments, and may find it more difficult to communicate effectively with health care staff and others providing support. In Croydon, there is evidence of under diagnosis of depression for

some people with LTCs. There is some evidence that treating depression in people with LTCs is highly cost effective.

- ***It is recommended that stakeholders writing strategies and developing existing and new services for the care of people with an LTC or depression, understand and take account of the need for integrated physical and mental health services.***
- ***It is also recommended that commissioners of physical and mental health services should consider taking steps to increase the identification of depression in people with LTCs.***

Services for people with depression

- In terms of treating depression, evidence supports a 'stepped care' approach, whereby the least intrusive intervention (i.e. 'watchful waiting', advice, self-help support) is offered at lower levels of need, with more intense interventions (such as medication or counselling for mild to moderate depression or crisis intervention for severe) being offered if need changes or if symptoms do not respond adequately. Whatever their level of need, people with depression benefit from activities that increase well-being.
- A strong theme identified in the consultation was the need to strengthen non-medical, holistic approaches in supporting people with depression.
- The chapter describes the services available at each level in Croydon by NHS, local authority, voluntary sector and private sector providers.
- The chapter goes on to make recommendations for the future at each stage of the stepped care approach.

Step 1: Identification, advice and referral: watchful waiting

- High quality primary mental health care is central to effective support for people with depression because a diagnosis of depression is typically made by GPs and most people with depression will be managed solely within primary care.
- Local data shows that there is much variation in the quality of primary care in Croydon. For example, depression diagnosis rates vary. Some but not all practices are screening the majority of patients with long term conditions like diabetes for depression, or reassessing the severity of depression 5-12 weeks after diagnosis.
- ***It is recommended that work is undertaken to strengthen mental health support in primary care and reduce unwarranted variation in primary care, with Croydon learning from high quality practices and providing support to underperforming practices to improve diagnosis rates of depression, screening of depression and appropriate re-assessment of severity of depression rates.***

- The chapter highlights the need for local commissioners to ensure that resilience, recovery, prevention and promotion services and activities, many of which are provided by the voluntary sector, are available to people with depression and that there is closer working between primary care and these services.
- ***It is recommended that Croydon promotes well-being services and self-care strategies more strongly to people with depression through closer working between primary care and community services.***
- Service users reported that they had not always been told about support services that they later found of value and providers had experienced difficulties in adding their services to the information available to GPs.
- ***It is recommended that Croydon should consider improving the range, accessibility and relevance of information about services and self-help resources and raising awareness of these resources in primary care***.
- Caring can be challenging and carers are at increased risk of depression. Carers with depression may need extra support in accessing services because of the limitations imposed on them through their caring responsibilities.
- ***It is also recommended that commissioners and carers' representatives consider how to ensure the needs of carers are considered in developing services that support people with depression*.**

Steps 2-3: Mild to moderate and moderate to severe depression

Low intensity well-being interventions

- Social isolation is one of the key challenges facing people with depression. Stakeholders value, very highly, activities and services that help people with depression to adopt healthier lifestyles, get more involved in social activities, support each other and manage their own support. Croydon provides a wide range of low intensity well-being services via different routes (face to face, internet and books).
- ***It is recommended that schemes that promote peer support, self-care, access to lifestyle and well-being services are further supported and promoted to GPs in Croydon, and that commissioner and providers across the different sectors consider ways of increasing capacity in community based services that improve well-being and improve access for more vulnerable groups.***

Prescribing

- Antidepressant prescribing in Croydon is low - 13th lowest of 152 PCT areas in England and 35% lower than the national average.
- This may mean that Croydon GPs are good at "watchful waiting", or that GPs are under prescribing antidepressants as well as under diagnosing

depression. Local data show that the likelihood of being prescribed antidepressants in Croydon reduces with age.

- ***It is recommended that commissioners, pharmacy advisors and primary care providers explore the reasons behind this variation by age and ensure that anti-depressant prescribing is clinically appropriate at all ages.***
- Prescribing of dosulepin, an antidepressant which can have harmful side effects, is higher in Croydon than in London and England
- ***It is also recommended that practices with high rates of dosulepin prescribing review their patients' medication with the aim of reducing dosulepin use.***

Psychological therapies

- Costs of psychological therapy are low and recovery rates are high: half will recover, with a much diminished risk of relapse. Psychological programmes can pay for themselves through reduced disability benefits and extra tax receipts and they also reduce health care costs for those with long term physical health conditions. Talking therapies are provided by a number of agencies including the voluntary sector and statutory sector, both of which provide vital support.
- The Croydon Improving Access to Psychological Therapies (IAPT) service is treating a smaller proportion of its population than almost any other London borough. In addition, it has fewer staff and longer waiting lists than the other boroughs in London that have IAPT services provided by SLAM. In Croydon, the level of employment support is small and the IAPT service has one employment advisor.
- ***It is recommended that as a priority, Croydon reduces the waiting times for IAPT services and increases its capacity to deliver psychological therapies.***
- ***It is further recommended that Croydon take steps to improve access to IAPT services by BME groups and older people.***
- It is estimated that 1% of the GP population suffers from severe medically unexplained symptoms (MUS) which would equate to 2,700 people in Croydon aged over 18. People with MUS use a lot of healthcare resources and are at very high risk of having depression.
- ***It is recommended that Croydon takes a whole systems approach to identifying patients with MUS at an early stage, provides psychological therapies, and draws on current best practice, starting with improved identification and coding in primary care.***

Step 4: Complex need

- People accessing step 4 secondary care services have more complex needs. They may not be responding to treatment, their depression may be persistent or they may be a risk to themselves or others.
- Croydon Integrated Psychological Therapies Service (CIPTS) offers a range of therapies to people with more complex needs.
- Consultation suggested that the service is highly valued. However, waiting times are excessively long, averaging at over a year for two of the three therapies, with some people waiting for over two years.
- ***It is recommended that, as a priority, Croydon reduces waiting times for people with complex needs who have depression and explore the reasons behind and improve the inequality of access for Asian and mixed ethnicity groups.***
- Access to some services for example those that promote social inclusion is restricted to people who are on CPA (Care Programme Approach) or people with high levels of need under FACS (Fair Access to Care Services).
- ***It is recommended that Croydon considers reviewing this eligibility criterion.***
- Mood anxiety and personality disorder (MAP) teams provide additional support to people with severe depression.
- As with CIPTS, people of Black and Asian ethnic origin are less likely to be on the MAP community team caseload than white populations.
- ***It is recommended that Croydon explores and addresses the reasons behind this inequality of access for Black and Asian groups.***

Experiences of service users and carers

- Views of services users and carers were collected as part of the stakeholder consultation and inform the whole chapter. Good patient experience is central to delivering a high quality service. Issues about care and patient experience are raised more often than issues around clinical treatment by services users.
- ***It is recommended that commissioners work with SLAM, the voluntary sector, service users and carers to collect service user experiences routinely and ensure service users and carers are engaged in the development of services*.**

Next Steps

- The JSNA chapter is a key part of the process of improving mental health outcomes for Croydon's population. Identifying ways of taking forward the recommendations is a vital next step. However, in undertaking the need assessment, lack of data was one of the barriers to fully understanding need and gaps in service provision.
- Many of the recommendations are best implemented through partnerships and multi-agency working.

- ***It is recommended that commissioners work with providers to improve the collection and dissemination of data around experience, outcomes and activity as well as access by higher risk and vulnerable groups.***
- ***It is recommended that a mental health strategy be produced based on the findings of this chapter, the other mental health JSNA chapters and evidence of what works. Croydon should ensure that an action plan is published, looking at short, medium and long term SMART (specific, measurable, achievable, relevant and timely) targets with clear timescales and owners.***

3 Summary of recommendations

Many of the recommendations in this JSNA chapter cover similar themes or describe issues that cut across different services and settings. The 33 recommendations in the chapter were grouped into 12 themes. Some recommendations relate to more than one theme.

- **Theme 1: WELL-BEING:** Promote and develop well-being services, improve access to well-being services and promote self-care strategies**.**
- **Theme 2: PRIMARY CARE:** Develop primary mental health care services, reduce unwarranted variation and promote collaboration between primary and community services.
- **Theme 3: BME GROUPS**: Improve diagnosis rates and reduce inequalities in access to secondary care services in BME groups.
- **Theme 4: PHYSICAL AND MENTAL HEALTH:** Integrate physical and mental health, increase identification and management of depression in people with physical health problems and those with medically unexplained symptoms.
- **Theme 5: DATA:** Improve the collection and availability of information especially about outcomes.
- **Theme 6: PRESCRIBING:** Explore the prescribing of antidepressants and develop appropriately.
- **Theme 7: PSYCHOLOGICAL THERAPIES:** Increase the capacity of and reduce waiting times for psychological therapies.
- **Theme 8: SERVICE USER AND CARER EXPERIENCE:** Improve engagement and learning from service user and carer experiences in particular around service developments.
- **Theme 9: SERVICE INTERFACES:** Improve the interface between some services.
- **Theme 10: INFORMATION:** Improve available information about services.
- **Theme 11: BENEFITS and HOUSING:** Strengthen advice on welfare benefits and housing.
- **Theme 12: STRATEGY AND ACTION:** Develop a strategic vision and action plan.

If you are viewing this document electronically, ctrl + click on the recommendation's page number to take you to the relevant section in the main text.

Theme 1: WELL-BEING: Promote and develop well-being services, improve access to well-being services and promote self-care strategies.

Recommendation 4

That commissioners, voluntary sector and primary care providers promote well-being services and self-management strategies to people with depression. Furthermore, that commissioners explore and support closer

working between primary care and community services through mechanisms such as social prescribing.

Recommendation 10

That the Exercise Referral Scheme and its commissioners review the recommendations made in the 2007 report and consider addressing those that have not been implemented.

Recommendation 11

That commissioners continue to support services, such as buddying and befriending schemes, that help people with depression to access services and engage in activities that promote well-being.

Recommendation 12

That providers and commissioners of the Books on Prescription scheme consider how they might evaluate its effectiveness, especially in light of the proposed refresh and re-launch of the service.

Recommendation 13

That commissioners and providers consider increasing availability of low intensity services, and services that improve access to low intensity services.

Theme 2: PRIMARY CARE: Develop primary mental health care services, reduce unwarranted variation and promote collaboration between primary and community services

Recommendation 5

That commissioners and providers of primary care services seek to reduce unwarranted primary care variation in screening and diagnosing depression, and in re-assessment of severity of depression.

Recommendation 6

That commissioners and providers of primary care services strengthen primary mental health care service capability and capacity through workforce training and support, taking account of best guidance and practice.

Theme 3: BME GROUPS: Improve diagnosis rates and reduce inequalities in access to secondary care services in BME groups

Recommendation 1

That as a priority, commissioners, primary care providers and BME groups address the comparatively low diagnosis rates of depression in BME populations.

Recommendation 8

That commissioners strengthen links with providers, communities, particularly BME communities, and other agencies to tackle stigma and discrimination within services, the community and the general public, through awareness raising, workforce training and evidence based campaigns.

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Recommendation 18
That commissioners, the IAPT service and voluntary sector groups consider exploring reasons behind lower access to IAPT services by BME groups and older age groups and take steps to improve access for these populations.

Recommendation 23
That commissioners, primary care and the CIPTS service explore the reasons behind lower access to CIPTS by Asian and mixed ethnicity groups, and take steps to improve access for these populations.

Recommendation 24
That commissioners work with the CIPTS service to explore how best to improve access by young asylum seekers, and people in crisis.

Recommendation 26
That commissioners, primary care and MAP teams explore the reasons behind lower access to MAP CAG teams by Black and Asian groups, and consider what tips might improve access for these populations.

Theme 4: PHYSICAL AND MENTAL HEALTH: Integrate physical and mental health, increase identification and management of depression in people with physical health problems and those with medically unexplained symptoms

Recommendation 2
That stakeholders writing strategies and developing existing and new services concerned with the care of people with LTCs or depression, understand and take account of the need for integrated mental and physical healthcare.

Recommendation 3
That commissioners of physical and mental health services and primary care providers should consider ways to increase the identification of depression in people with long term conditions.

Recommendation 21
That commissioners consider adopting a whole systems approach to identifying patients with medically unexplained symptoms (MUS) at an early stage, and offer psychological therapies to these patients, starting with improved identification and coding in primary care.

Theme 5: DATA: Improve the collection and availability of information especially about outcomes

Recommendation 16
That commissioners consider ensuring that outcome measures are collected by all services delivering psychological therapies across the voluntary sector.

Recommendation 19
That commissioners and providers consider how best to ensure that, with the introduction of the new IAPT information system, the service is able to report in detail on access by the priority groups identified by the government.

Recommendation 20

That commissioners, the IAPT service and primary care explore reasons why ethnicity is poorly recorded at the point of referral.

Recommendation 31

That commissioners work with providers to improve the collection and dissemination of data around experience, outcomes and activity, as well as access by higher risk and vulnerable groups.

Theme 6: PRESCRIBING: Explore the prescribing of antidepressants and develop appropriately

Recommendation 14

Commissioners, pharmacy advisors and primary care providers should consider exploring the reasons behind the lower prescribing of antidepressants to older age groups and encourage anti-depressant prescribing that is clinically appropriate at all ages.

Recommendation 15

Practices with high rates of dosulepin prescribing should be supported to review their patients' medication with the aim of reducing dosulepin use in line with NICE guidelines.

Theme 7: PSYCHOLOGICAL THERAPIES: Increase the capacity of and reduce waiting times for psychological therapies

Recommendation 17

As a priority, commissioners need to reduce waiting time for IAPT services and increase its capacity so that IAPT can meet the Department of Health 2014/15 target of reaching 15% of people in need.

Recommendation 22

As a priority, commissioners need to reduce waiting times to talking therapies for people with complex needs who have depression.

Theme 8: SERVICE USER AND CARER EXPERIENCE: Improve engagement and learning from service user and carer experiences in particular around service developments

Recommendation 29

That commissioners and SLAM consider providing Croydon-specific information when developing the PEDIC (Patient Experience Data Information Centre) system.

Recommendation 30

That commissioners and providers, together with service users and carers strengthen the gathering of service user and carer experiences and the engagement of service users and carers in the development of services.

Recommendation 9

That commissioners, providers and carer representatives consider how to ensure that the needs of carers are considered in developing services that support people with depression.

Theme 9: SERVICE INTERFACES: Improve the interface between some services

Recommendation 25

That commissioners consider reviewing the CPA / FACS criteria whereby only people on CPA or who are FACS eligible can be referred to some services such as social inclusion services.

Recommendation 27

That commissioners, working with the MAP CAG teams and primary care, explore ways to improve the primary / secondary care interface.

Theme 10: INFORMATION: Improve information about services

Recommendation 7

That commissioners, providers and community groups consider improving the range, accessibility and relevance of information provided about services and self-help resources and raise awareness of these resources in primary care.

Theme 11: BENEFITS and HOUSING: Strengthen advice on welfare benefits and housing

Recommendation 28

That commissioners work with the voluntary sector and statutory services to support and strengthen the provision of advice about welfare benefits and housing.

Theme 12: STRATEGY AND ACTION: Develop a strategic vision and action plan

Recommendation 32

As a priority, that the mental health partnership considers developing a mental health strategy based on the recommendations of the JSNA chapters and other relevant mental health work. Such a strategy should include an action plan and identify short, medium and long term SMART (specific, measurable, achievable, relevant and timely) targets with clear timescales and owners.

Please note: acronyms used in the chapter are listed in *Appendix 2*.

4 Introduction

4.1 Aim

Croydon's 2012/13 mental health JSNA is made up of **five separate chapters**, each of which are or will be made available on the Croydon Observatory website. An **Overview chapter** describes the big picture of health and well-being in Croydon and considers the impact of demographic change on population mental health in Croydon. The other chapters are:

- **Depression** in adults
- **Schizophrenia** in adults
- **Emotional health and well-being of children and young people aged 0 to 18 years**

The **aim of the depression chapter** is to provide an overview of current and future need, to identify gaps and assets in service provision and identify priorities for future development. The focus is on adults from age 19 upwards.

The JSNA is a **crucial tool for commissioners** and other decision makers in Croydon

These four chapters should also be viewed in conjunction with the updated **Key Dataset for Croydon** which describes Croydon's position relative to London and England for over 200 indicators relating to health and well-being.

4.2 Links with other chapters

High levels of well-being prevent depression, help those with depression to recover quickly and reduce relapse. The **Overview Chapter** examines the factors that promote the population's mental health and well-being and the conditions that increase population resilience. The depression chapter refers to the overview chapter in describing prevention, promotion and well-being services and support.

People with serious mental illnesses such as **schizophrenia**, psychosis and personality disorder are more likely to suffer from depression. Where possible, aspects of the needs assessment for the two chapters on adult mental health (depression and schizophrenia) were carried out jointly since many of the stakeholders, services and issues are similar and linked.

Good **emotional health and well-being in children and young people** reduces the risk of depression in adulthood. The foundations for lifelong good mental well-being

are laid down in childhood. Emotional disorders in childhood are associated with an increased risk of depression and anxiety as an adult. It is estimated that up to half of lifetime mental health problems (excluding dementia) start by the age of 14.[1] Poor maternal mental health is associated with a fivefold increased risk of mental health disorders in the child.[2]

Addressing the findings and recommendations of the other chapters will help prevent depression and improve support for people with depression.

4.3 Methodology

The development of the JSNA was overseen by an **implementation group** consisting of representatives from commissioning (NHS, council, Clinical Commissioning Group), provision (primary care, secondary care, council, NHS and voluntary sector) and service user groups. Key concerns identified at the outset by the JSNA implementation group were:

- Perceived isolation in older adults and poorer access for older people, BME groups and men.
- Need for a more holistic approach in the prevention and management of depression.
- Need for better access to talking therapies.
- Need for better care for people with long term physical health conditions and depression.

The implementation group used a range of appropriate methods to answer key questions:

Key Questions	**Method**
What is depression? Why is it important? Who is most at risk?	Brief review
Where should our efforts be focused? What are the policy drivers? What works?	Brief review of national policy and guidelines
In Croydon, how many people have depression? How many will have it in the future? How many people with depression have a diagnosis?	Analysis of population (epidemiological) data combined with estimates of prevalence.

[1]Kessler, RC, Chiu WT, Demir O, Merikangas KR, Walters E (2005) Lifetime prevalence Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication *Archives of General Psychiatry,* 62 (6) p593-602; Erratum 62 (7) p798

[2]Meltzer H, Gatward R, Goodman R, Ford T (2003) Mental health of children and adolescents in Great Britain *International Review of Psychiatry* 15 (1-2): 185-7

What services do we provide? Is access to them fair? How do they compare to other areas? What are the gaps?	Data on service provision, activity and outcome from providers and commissioners, national datasets. This section of the chapter is structured around a framework based on NICE guidance.[3]
What do people think of the services we provide? What are we doing well? What could we do better?	Consultation with stakeholders including: • Online survey • Consultative event • Mental Health Forum event • Depression alliance event • One to one meetings.

The findings from the consultation are included throughout the chapter and given in full in *Appendix 3.*

[3]NICE (2012) Care for adults with depression – NICE pathway

5 Background

5.1 What is depression?

Depression is a common mental health disorder where people experience **symptoms** that include low mood, loss of interest and pleasure and/or loss of energy. Depression often comes with symptoms of **anxiety**. Depression can be categorized as **mild, moderate or severe** depending on the number, severity and persistence of symptoms, and their impact on function. Some people have symptoms that do not meet the criteria for diagnosis. Nonetheless they can be distressing and disabling, if persistent.

The first episode of depression occurs, on average, in the **mid-20s**, although depression can occur in childhood or adolescence. The average length of an episode of depression is 6-8 months. Over half of people with a single episode will go on to have at least one further recurrence, particularly if the first episode occurred in childhood/adolescence or in old age.[4] Complete relief of symptoms after an episode is associated with a lower likelihood of relapse. More than 80% of patients with depression are managed and treated in primary care.

Depression is often undetected. One of the reasons why GPs may miss making a diagnosis is somatisation whereby people present with physical symptoms rather than a low mood and where symptoms of depression are overlooked in people who already have a long term physical health problem.[5]

5.2 Impact of depression

Depression is the **leading cause of disability** for both males and females.[6]The impact on a person's social and economic well-being, physical health and mortality is substantial. It also places a large burden on family and friends. It

- reduces the ability to work effectively
- increases dependence on welfare benefits
- increases risk of developing physical health problems
- increases the pain, distress and disability associated with physical health problems
- reduces the ability to communicate and sustain relationships
- increases the risk of mortality even at low levels of distress.[7]

[4]National Institute for Health and Clinical Excellence (2009) *Depression in adults: the treatment and management of depression in adults.* CG90. London: NICE

[5]Timonen M, Liukkonen T.(2008) Management of depression in adults. BMJ. Feb 23;336(7641):435-9

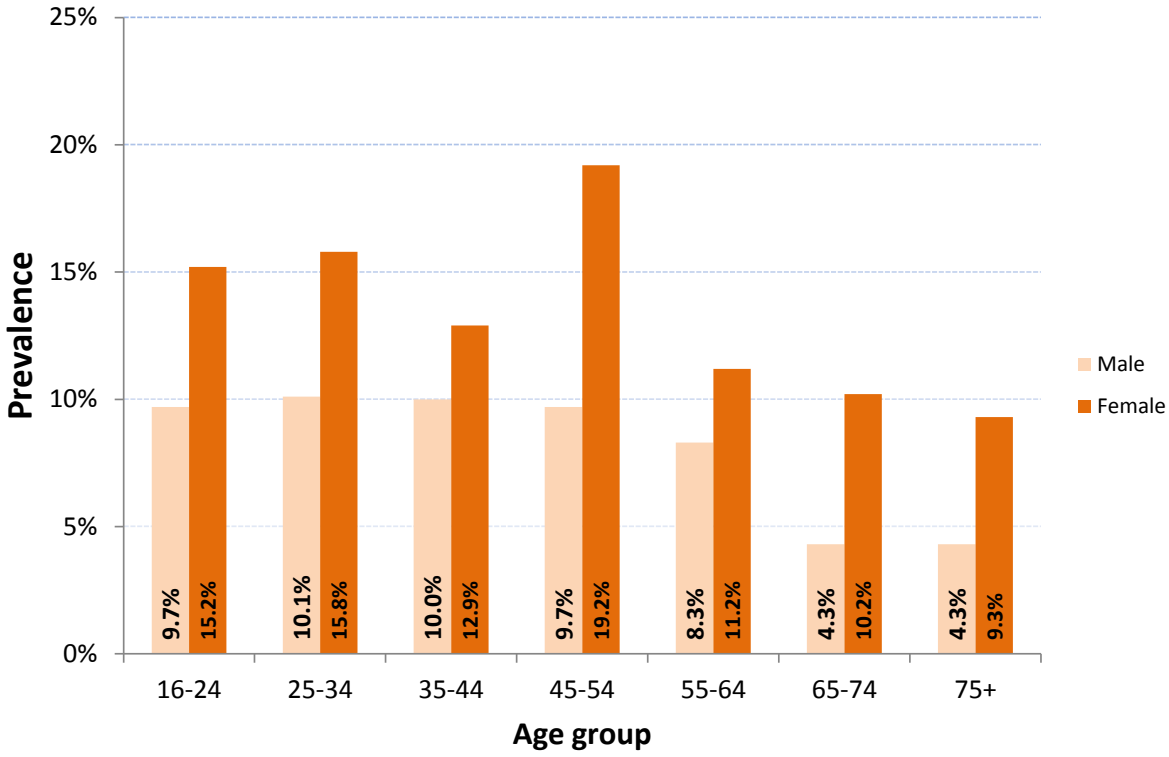
[6] World Federation for Mental Health (2012) *Depression: A global crisis* WFMH

[7] Russ TC, Stamatakis E, Hamer M, et al. (2012) Association between psychological distress and mortality: individual participant pooled analysis of 10 prospective cohort studies. *BMJ* 345 e4933

5.3 People at higher risk of depression

Nationally, **women** are more likely to have symptoms of depression or mixed anxiety and depression than men; the burden of depression is 50% higher for females than males.[8]People aged **45 to 54** are at higher risk than other ages (**Figure 1**). The proportion with depression is slightly lower at older age groups.

Figure 1 National prevalence of mixed anxiety and depression by age and sex



Source: NHS Information Centre (2007) Adult Psychiatric Morbidity Survey in England, 2007
NOTE: prevalence of depressive episodes together with mixed anxiety and depressive disorders

Some people with long term physical health conditions such as diabetes, chronic obstructive pulmonary disease and cardiovascular disease are more likely to suffer from depression. People with chronic pain and medically unexplained symptoms are particularly likely to become depressed. Other groups at higher risk of depression include those:[9,10,11]

- with medically unexplained symptoms
- with a history of depression
- living in households with low-income.

[8]World Federation for Mental Health (2012)*Depression: A global crisis* WFMH
[9]NHS Information Centre (2009*) Adult psychiatric morbidity survey in England: results of a household survey 2007*. London: Health and Social Care Information Centre
[10] HM Government (2010) Confident communities, brighter futures. A framework for developing well-being
[11] National Institute for Health and Clinical Excellence (2011) *Common mental health disorders CG123*. London: NICE http://publications.nice.org.uk/common-mental-health-disorders-cg123

- who have had adverse childhood experiences
- women who are South Asians
- who are carers
- who are lesbian, gay, bisexual or transgender
- who are asylum seekers
- with other mental health problems
- with substance misuse problems
- whose parents, especially mothers, had mental health problems
- survivors of sexual abuse.[12]

The *Overview* Chapter provides more information about some of these groups in Croydon, their increased risk of mental illness, and how their numbers are predicted to change over the next few years.

5.4 Costs of depression

It is estimated that the total cost of services for depression in England in 2012 was just over £2 billion. However, taking account of costs due to lost employment, this increases to nearly £9 billion. In total, an estimated three quarters (77%) of the financial costs associated with depression are in lost employment. Service costs include prescribed drugs, inpatient care, other NHS services, supported accommodation and social services. By 2026, these figures are projected to be £3 billion and £12.2 billion, respectively.[13]

Extrapolating these national figures on depression costs to the Croydon area, based purely on population size, it is estimated that the total cost of services for depression in Croydon in 2012 was £14 million. Taking account of costs associated with lost employment increased this total to £61million. By 2026, these figures are projected to be £20 million and £83 million, respectively.

Based on programme budgeting data, in 2010/11 NHS Croydon invested an estimated **£67.6m on mental health problems** (**Table 1**) not including primary care costs. This equates to £206 per person, down 5% from the previous year of £70m in 2009/10.[14]A limitation of the programme budgeting data is that spend on depression cannot be readily identified in the subcategories. It is likely that spend on depression is included in the "other" category. There is work underway at a national level to make these categories more meaningful.

[12] DH (2011) Commissioning Services for women and children who experience violence or abuse - a guide for health commissioners

[13]McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S.. (2008) *Paying the price: the cost of mental health care in England to 2026*. London: King's Fund. http://www.nliah.com/portal/microsites/Uploads/Resources/RMjbg3Jjc.pdf

[14]*SPOT tool and Department of Health Programme Budgeting PCT Benchmark Tool 2010/11*

Table 1: Mental Health programme budgeting data 2010/11

Programme Budgeting categories	Spend (£millions) in 2010/11
5a Substance Misuse	5.6
5b Organic Mental Disorders	10.0
5c Psychotic Disorders	15.7
5d Child and Adolescent MH Disorders	4.6
5x mental health disorders (other)	31.7
Total for Mental Health (category 5)	**67.6**

Source: Department of Health, Programme Budgeting Data

6 National policy and guidance

This section outlines the main policy documents that set out national objectives and key guidance about how care should be provided.

6.1 National Policy

Department of Health (2011) No health without mental health[15]

This cross-government, all-age strategy for mental health in England set out six objectives for improving mental health and well-being:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

In 2012, an implementation framework was published to help make these objectives a reality[16]together with briefings that set out the steps that local authorities and NHS commissioning groups can take to improve mental health care, treatment and support.[17]The implementation framework maps the six objectives of the strategy with indicators from the three Outcomes Frameworks (for the **NHS,[18] Public Health[19]**and **Adult Social Care[20]).**

Department of Health (2011) *Talking therapies: A four-year plan of action*.[21]

This describes the vision for the IAPT (improving access to psychological therapies) programme. The government aims to complete roll out of this programme by 2014/15. Four priority groups are identified:

- people aged over 65
- children and young people

[15]Department of Health (2011) *No health without mental health* London: Department of Healthhttp://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_123984

[16] Department of Health (2012) *No health without mental health: Implementation framework*http://www.dh.gov.uk/health/2012/07/mentalhealthframework/

[17]http://www.centreformentalhealth.org.uk/publications/NHWMH_guides_for_local_services.aspx

[18] Department of Health (2010) NHS Outcomes Framework

[19] Department of Health (2012) Healthy lives, healthy people: Improving outcomes and supporting transparency. Public Health Outcomes Framework

[20] Department of Health (2011) Adult Social Care Outcomes Framework.

[21] Department of Health (2011) *Talking therapies: A four-year plan of action*London: Department of Health.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123985.pdf

- people with long-term physical conditions or medically unexplained symptoms
- people with severe mental illness.

The Operating Framework for the NHS in England 2012/13

The framework identifies outcomes measures or proxies for 2012/13 under the domains of the NHS Outcomes Framework. *For Domain 2: Enhancing quality of life for people with long term conditions*, the operating framework notes that a particular focus is needed on improving access to psychological therapies for:

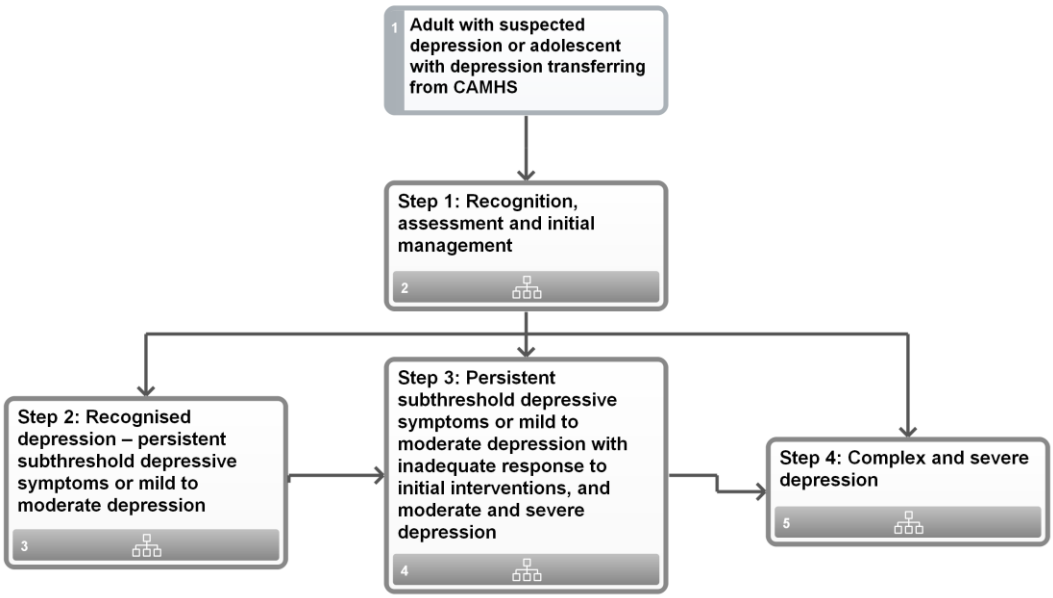
- black and minority ethnic groups
- older people
- people with severe mental illness
- people with long term health problems.

These policy documents inform local priorities and indicate where resources should be targeted.

6.2 National Guidance

In 2012, NICE published a depression pathway (**Figure 2**). It recommends a stepped care approach, whereby an individual is offered the least intrusive intervention for their need. If they do not improve enough, or if their symptoms get worse, they may be offered more intense interventions. NICE has also published a wealth of associated guidance and commissioning tools listed in *Appendix 4*.

Figure 2: Care for adults with depression pathway*



Source: NICE Pathway (2012) Care for adults with depression
**CAMHS is the acronym for Child and Adolescent Mental Health Services*

7 Need in Croydon

Not everyone with symptoms of depression has a diagnosis. In considering need, this section looks not only at how many people are estimated to have symptoms of depression, now and in the future, but also at how many people are diagnosed with depression. It describes patterns of diagnosed depression by age, sex, ethnicity and deprivation and explores the higher rates of depression in people with long term physical health problems.

7.1 How common are symptoms of depression in Croydon?

Depression/mixed anxiety and depression are the most common mental health disorders. In Croydon, at any one time, it is estimated that over one in 10 (11.6%) adults (33,664) have symptoms of either depression or mixed anxiety or depression (Table 2). The bulk of these (9.2%, 26,715 adults) suffer from mixed anxiety and depression, where the person experiences symptoms of both anxiety and depression but these are below the diagnosis threshold for either disorder. An additional 2.4% (6,949 adults) have symptoms that reach diagnosis threshold for depression alone.

Table 2: Need in Croydon[22]

Condition	Prevalence*	Number in 2012	% projected change 2012 to 2021
Mixed anxiety and depressive disorder	9.2%	26,715	5.0%
Generalised anxiety disorder	4.4%	12,811	5.2%
Depressive episode	2.4%	6,949	4.3%
All phobias	1.5%	4,289	5.0%
Obsessive compulsive disorder	1.2%	3,398	3.5%
Panic disorder	1.1%	3,207	5.4%
Any common mental health disorder	**16.4%**	**47,824**	**5.0%**

Source: Croydon prevalence rates and projections based on estimates from the Adult Psychiatric Morbidity Survey 2007

**prevalence is the percentage of people with depression*

7.2 People with symptoms of depression in the future

Nationally, it is estimated that prevalence rates for all mental disorders within all age groups are likely to remain broadly stable.[23] Nationally, the proportion of people

[22] *Croydon 2012/13 MH overview chapter*

suffering from a common mental health disorder changed little between 2000 and 2007.[24]

In Croydon, due to changes in the population structure, we expect there to be a gradual increase in the number of people with common mental health disorders including depression. By 2021, this will give a 5% increase.[25] Projected numbers by year are given in **Table 3**. Projections were calculated by applying prevalence rates by age and sex from the Adult Psychiatric Morbidity Survey 2007 to Croydon's population. Population projections for Croydon by age and sex were created based on the assumption that Croydon's population will continue to grow between 2011 and 2021 at a similar rate to the population growth between the 2001 Census and 2011 Census.

However this may be an underestimate. The *Overview Chapter* found that between 2004 and 2010, levels of deprivation increased in Croydon more than in any other borough in the south of London; these factors will increase the numbers of people with depression. Worsening socio-economic circumstances can increase the risk of depression.[26] Moreover, the impact of the welfare reforms has yet to be fully felt, and levels of homelessness in Croydon are increasing.

The *Overview Chapter* recommends that when 2011 Census data and updated deprivation indices are fully published, further analysis is undertaken to estimate more accurately the future prevalence of mental health conditions.

Table 3: Projected need in Croydon 2012 to 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Mixed anxiety and depressive disorder (diagnosed+undiagnosed)	26,715	26,923	27,121	27,304	27,478	27,586	27,698	27,817	27,940	28,059
Generalised anxiety disorder (diagnosed+undiagnosed)	12,811	12,903	12,994	13,083	13,172	13,228	13,284	13,345	13,409	13,471
Depression at a point in time (diagnosed+undiagnosed)	6,949	6,995	7,041	7,084	7,126	7,148	7,171	7,195	7,223	7,250
Phobias (diagnosed+undiagnosed)	4,289	4,315	4,343	4,373	4,401	4,420	4,440	4,461	4,483	4,504
Obsessive compulsive disorder (diagnosed+undiagnosed)	3,398	3,420	3,440	3,457	3,470	3,475	3,483	3,494	3,505	3,516
Panic disorder (diagnosed+undiagnosed)	3,207	3,229	3,252	3,275	3,297	3,311	3,328	3,345	3,363	3,380
Any common mental disorder (diagnosed+undiagnosed)	47,824	48,178	48,522	48,848	49,159	49,354	49,560	49,779	50,009	50,230

Source: 2012/13 overview chapter

[23] McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S.. (2008) *Paying the price – The cost of mental health care in England to 2026*. London: King's Fund http://www.kingsfund.org.uk/publications/paying-price

[24] NHS Information Centre (2009) *Adult psychiatric morbidity survey : results of a household survey 2007*London: Health and Social Care Information Centre

[25] See 2012/13 mental health overview chapter for details

[26] Lorant V. et al (2007) Depression and socio-economic risk factors: 7-year longitudinal population study The British Journal of Psychiatry (2007) 190: 293-298

7.3 Postnatal depression

It is estimated that in 2012, there were 717 women in Croydon who had postnatal depression (PND), and that taking account of predicted changes in birth rate, this will increase by 28% to 918 women by 2021.[27]PND affects approximately 13% of women[28] and we know that PND has a substantial impact not only on the mother, her partner and her family, but also on the longer term emotional and cognitive development of the baby.[29]Further consideration of postnatal depression can be found in the chapter on the *Emotional Health and Well-being of Children and Young People*. The estimates of depression shown in **Table 3** include women with PND.

7.4 How common is diagnosed depression in Croydon?

Based on Croydon GP records, there are almost 9,000 adults (8,359) currently living in Croydon who were given a diagnosis of either new or relapsed depression in the last five years (Read codes listed in *Appendix 5*). Two thirds of these are female. Overall age and sex standardised depression prevalence for adults in Croydon is almost 3% (2.94%). Between 2007/08 and 20010/11 there were on average almost 1,700 (1,693) cases of either new or relapsing depression recorded by GPs every year.

It is not possible to calculate the overall proportion of people in Croydon with symptoms of depression that have been diagnosed because the two estimates use different timeframes. Over **one week** there are an estimated 6,949 people with symptoms of depression (**Table 2**) in Croydon, whereas the GP database records approximately 1,700 adults diagnosed with depression **over a whole year**.

The age, sex standardised depression prevalence in Croydon varies almost 40 fold by GP practice from 0.3% to 11.5% (**Figure 3**). Although some of this variation may be explained by differences in practice populations, the large size suggests that variation in the ability of GPs to recognise depression also plays a part. There is evidence, nationally, that GPs vary considerably in the ability to identify depression.[30]

Nationally, it is estimated that half of people with depression will consult with their GP and half of those will be diagnosed.[31] Some people do not realise that they have depression and others may choose not to seek help for a variety of reasons, including fear of stigmatization. Symptoms of depression vary by age. Older adults tend to show more physical (somatic) symptoms and are less likely to complain of

[27] Overview chapter 2012/13. http://www.croydon.gov.uk/democracy/dande/minutes/healthwell-being/051212a

[28] O'Hara MW, Swain AM (1996) Rates and risk of postpartum depression--a meta-analysis. *International Review of Psychiatry*, 8 (1) 37-54

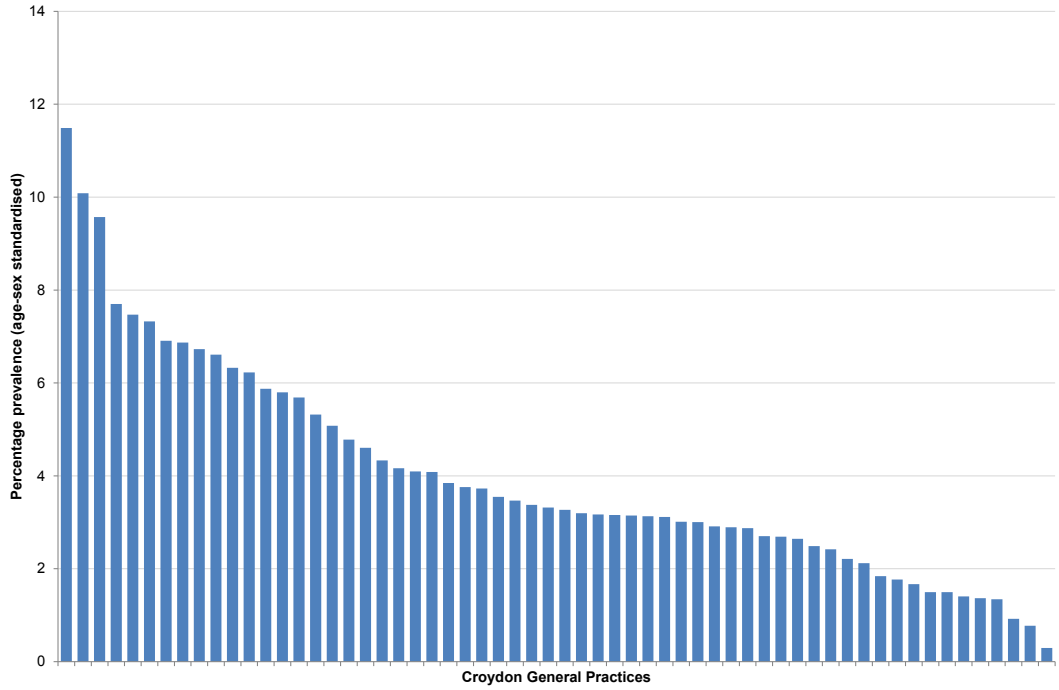
[29] Shakespeare J (2001) National Screening Committee. Evaluation of screening for postnatal depression against NSC handbook criteria.

[30] NICE (2009) Depression

[31] National Institute for Health and Clinical Excellence (2009*) Depression in adults; the treatment and management of depression in adults. CG90* London: NICE

low mood. Many people with depression may consult their GP with pain, lack of energy, insomnia and reduced appetite. Depression in patients who present with physical problems is most likely to be missed.[32]

Figure 3: GP recorded prevalence of depression, Croydon general practices as at 31st March 2012



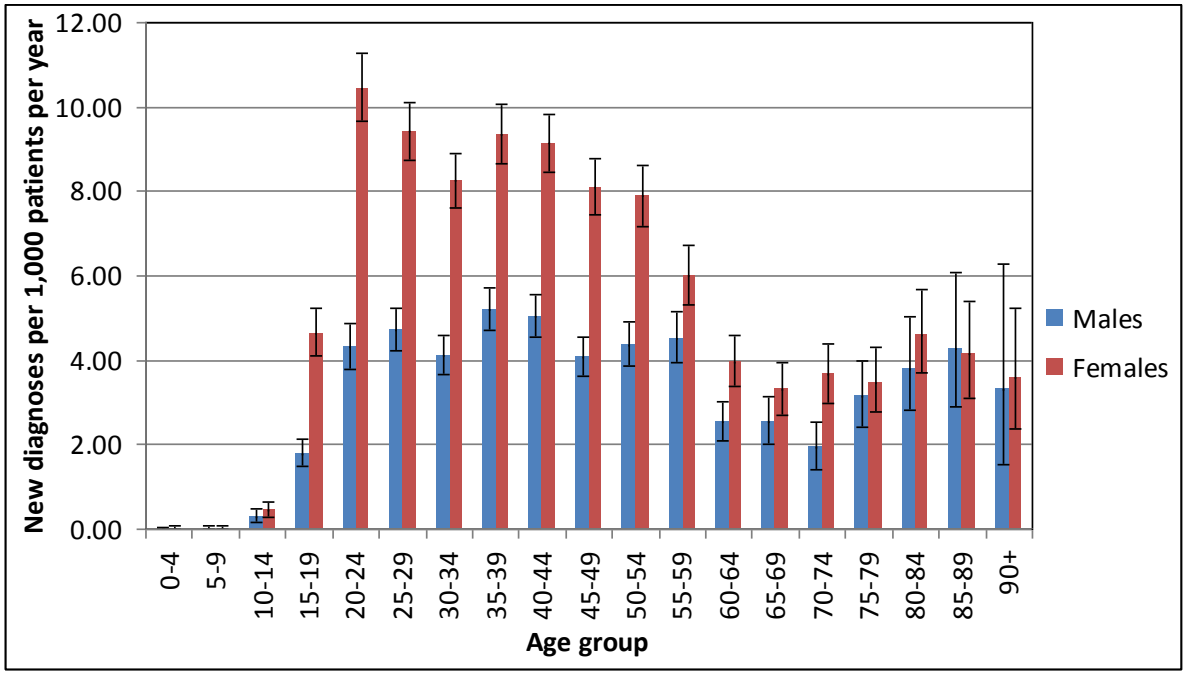
Source: Data from Croydon General Practices, 2011/12

7.5 Diagnosed depression in Croydon by age and sex

In Croydon women are more likely to be diagnosed with depression than men (**Figure 4**). This broadly fits with the national pattern of depression symptoms by age and sex (see **Figure 1**). However there are some differences. At younger ages, diagnosed depression is very much more common in women than men. At older ages there is little difference. In summary, there is some evidence of under diagnosis of depression in older women.

[32]Timonen M, Liukkonen T.(2008) Management of depression in adults. BMJ. Feb 23;336(7641):435-9

Figure 4: GP recorded prevalence of depression by age and sex, Croydon general practices as at 31st March 2012



Source: Data from Croydon General Practices, March 2012

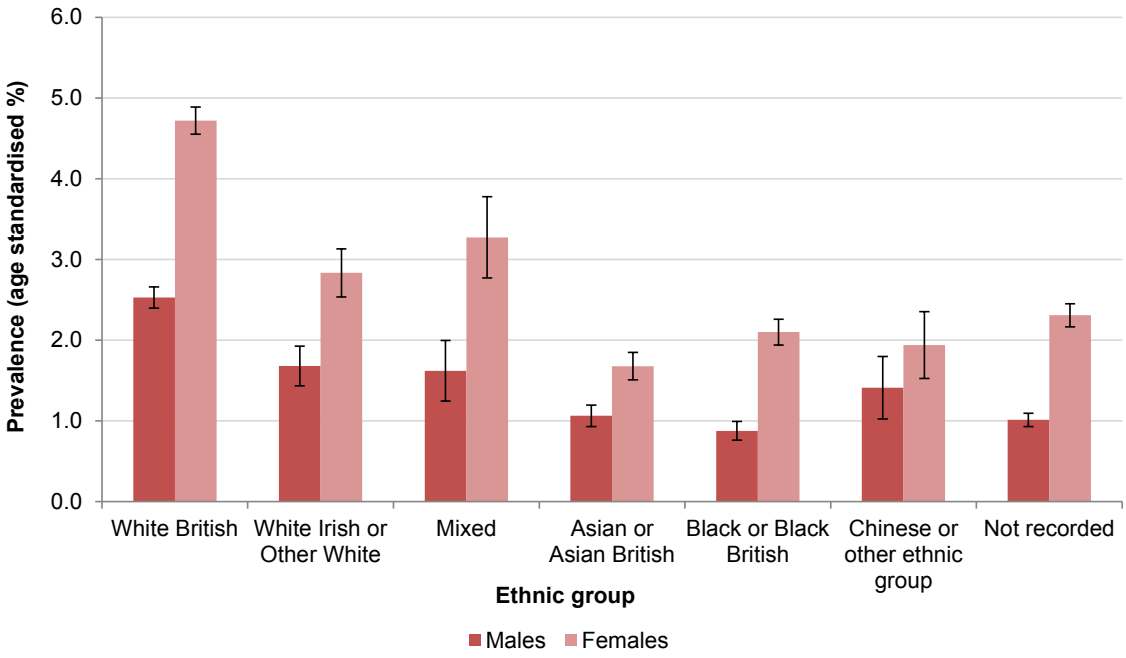
7.6 Diagnosed depression by ethnicity

Nationally, there are only small variations in the prevalence of depression in different ethnic groups with similar rates of depression, seen in white, black men and women, and south Asian men.[33] Among women, rates of depression are higher in South Asians.[34] However **Figure 5** shows that, in Croydon, diagnosed depression rates are lower in every ethnic group other than in the White British group. For both Black and Asian men and women and for Chinese/other women, diagnosed depression rates are less than half the rate for White British.

This Croydon finding is concerning and points to an inequality in access. Although self-referral provides an alternative route into some services, diagnosis by GP is the primary gateway to services and medication.

[33]Sproston K, Nazroo J (2002). E*thnic minority psychiatric illness rates in the community – quantitative report*. London: National Statistics.
[34]NHS Information Centre (2009*) Adult psychiatric morbidity survey in England: results of a household survey 2007*. London: Health and Social Care Information Centre

Figure 5: Prevalence of diagnosed depression by ethnic group, Croydon 2007 to 2012



Source: Croydon general practices, March 2012. Note: Prevalence is as recorded in the last 5 years

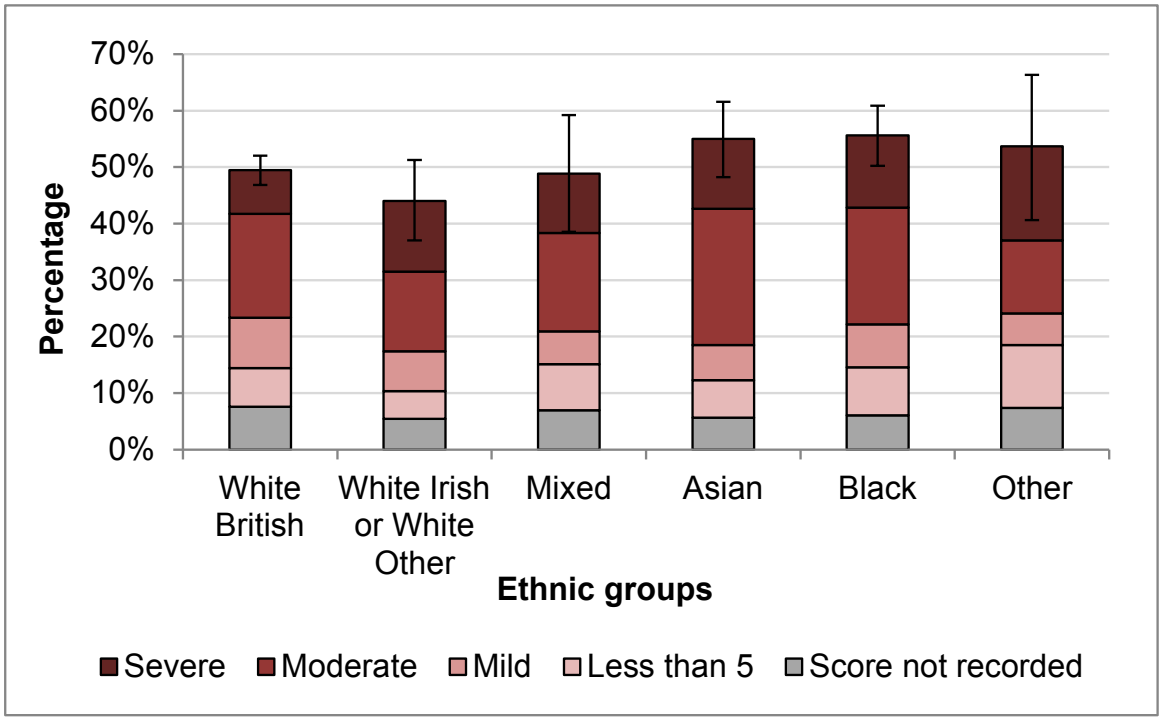
Severity of diagnosed depression by ethnic group

PHQ-9 (Patient Health Questionnaire) is a tool for measuring depression severity. Whilst the severity recorded by the GP takes into account more than just the PHQ-9 score, the tool gives a good indication of severity within the diagnosed population.[35]Analysis of the GP database shows that of the 2,820 people diagnosed with depression between Oct 2009 and Sept 2011, 51% (1448 people) had at least one PHQ-9 score recorded in the six months following diagnosis.

Figure 6 shows the proportion with mild, moderate and severe PHQ-9 scores in people diagnosed with depression. Overall there were 1,010 people where the PHQ-9 score was mild, moderate or severe[36] based on their first PHQ-9 score after diagnosis. The figure shows that diagnosed depression is more severe in people from BME groups than in those from white British populations. The percentage of white British that had a mild score (25%) was greater than for all individual BME groups and for BME groups (including white Irish) combined (18%). The percentage of white British that had a severe score (22%) was less than in individual BME groups and was statistically significantly lower than in BME groups (including white Irish) combined (32%).

[35] http://www.patient.co.uk/doctor/Patient-Health-Questionnaire-(PHQ-9).htm
[36] PHQ9 scores: Mild = 5-9, Moderate = 10-19, Severe = >=20

Figure 6: Proportion of patients with a first GP diagnosis of depression between Oct 2009-Sept 2011, who have a PHQ-9 score recorded within following 6 months, by ethnicity and severity



Source: Data from Croydon general practices, March 2012

NOTE: Confidence Intervals apply to the entire ethnic group

In summary

People from BME backgrounds in Croydon are less likely to be diagnosed with depression than their white British counterparts.

For both Black and Asian men and women, and for Chinese/other women, diagnosed depression rates are less than half the rate for white British.

When depression is diagnosed in BME groups, their condition is more severe.

Croydon's black and minority ethnic community is growing and is expected to reach 60% by around 2021.[37]

Recommendation 1

As a priority, commissioners, primary care providers and BME groups explore, and address as appropriate the comparatively low diagnosis rates of depression in BME populations.

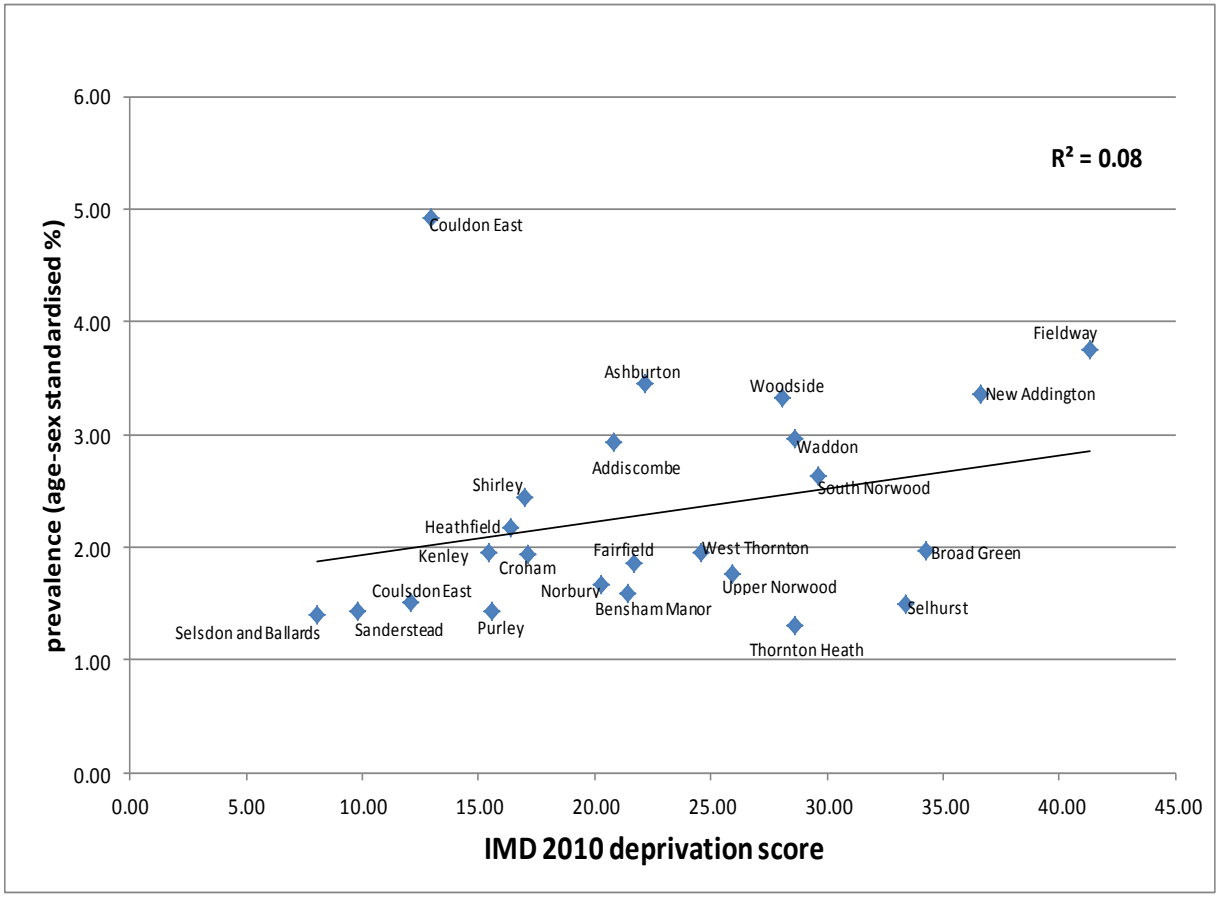
[37] JSNA overview chapter 2011/12

7.7 Diagnosed depression by deprivation and ward

Figure 7 shows the relationship between diagnosed depression and deprivation across Croydon. It suggests that only 8% of the variation in diagnosed depression in wards across Croydon can be explained by its association with deprivation.[38] Levels of diagnosed depression reflect not only the differences in symptoms of depression but also differences in GP diagnosis and recording of depression.

Overall, those living in the most deprived quintile are a third (36%) more likely to be diagnosed with depression than those living in the least deprived quintile. The association with deprivation is less strong for depression than for serious mental health conditions such as schizophrenia.[39]

Figure 7: Association between prevalence of GP recorded depression and deprivation by ward, Croydon, March 2012



Source: Data from Croydon general practices, March 2012

[38] R^2, the correlation coefficient was 0.08
[39] 2012/13 Overview chapter

7.8 Diagnosed depression and long term physical health conditions (LTCs)

This section describes the links between physical and mental health and the extent to which depression in people with long term conditions is diagnosed in Croydon. It is subdivided into

- Depression and long term conditions in England
- Depression and long term conditions in Croydon

7.8.1 Depression and Long term conditions in England

Nationally, people with long term physical health conditions (LTCs) such as diabetes, asthma, back pain, coronary heart disease are more likely to have depression. In addition, people with depression are more likely to have LTCs. For example, people with depression are between 50% and 100% more likely to develop coronary artery disease and ischaemic heart disease.[40]People with diabetes or a range of cardiovascular diseases are two to three times more likely to have depression.[41]

The health costs of treating someone with an LTC and depression is 45% higher than treating a person with an LTC only. There is evidence that when people with physical symptoms receive psychological therapy, the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of the psychological therapy.[42]Details of the evidence behind this is given in *Appendix 6*. One of the government priorities is to increase access to talking therapies for people with LTCs.[43]A recent report on the cost of healthcare for people with long term conditions and mental health problems summarised the statistics and key facts:[44]

- **LTCs are common**. Nationally, 30 per cent of the population have one or more long-term condition. LTCs are more common at older ages.
- **Between 12 and 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health and well-being**, equating to approximately £1 in every £8 spent on long-term conditions.
- **The reasons why mental and physical health are linked are complex.** Biological, psychosocial, environmental and behavioural factors are involved.
- **People with long term conditions and mental health problems have worse outcomes.** They are more likely to die early, experience more pain, have a lower

[40]Benton T, Staab J, Evans DL. (2007). Medical co-morbidity in depressive disorders.*Annals of Clinical Psychiatry* 19(4): 289-303
[41]Vamos EP, Mucsi I, Keszei A, Kopp MS, Novak M (2009). 'Comorbid depression is associated with increased healthcare utilization and lost productivity in persons with diabetes: a large nationally representative Hungarian population survey'. *Psychosomatic Medicine*, 71(5): 501–7.
[42] Centre for Economic Performance (2011) How mental health loses out in the NHS
[43] Department of Health (2011) *Talking therapies: A four-year plan of action*. London: Department of Health
[44] King's Fund; Centre for Mental Health (2012) *Long term conditions and mental health: The cost of co-morbidities*. London: King's Fund http://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

quality of life and reduced ability to manage physical symptoms effectively. For example, cardiovascular patients with depression experience 50 per cent more acute episodes per year and have higher mortality rates.[45] One study found that depression increases mortality rates after heart attack by 3.5 times. Another study found that patients with chronic heart failure are eight times more likely to die within 30 months if they have depression.[46]

- **Worse outcomes are linked to poorer self-management, poorer lifestyles and lower attendance for medical appointments.** People with LTCs and mental health problems find it more difficult to actively manage their own physical condition. They are more likely to have unhealthy behaviours such as smoking and more likely to miss medical appointments. Depression can reduce the ability to communicate effectively with health care staff and others providing support.

A recent report by the NHS confederation provides an overview of psychological interventions for people with long-term conditions in general, and specifically diabetes, chronic obstructive pulmonary disease and medically unexplained symptoms. It presents evidence of the potential to improve quality of life and quality of care, and to generate service efficiencies and cost savings. It also describes practical implementation examples, lists other useful resources and identifies where such approaches can support Quality, Innovation, Productivity and Prevention (QIPP) programmes.[47]

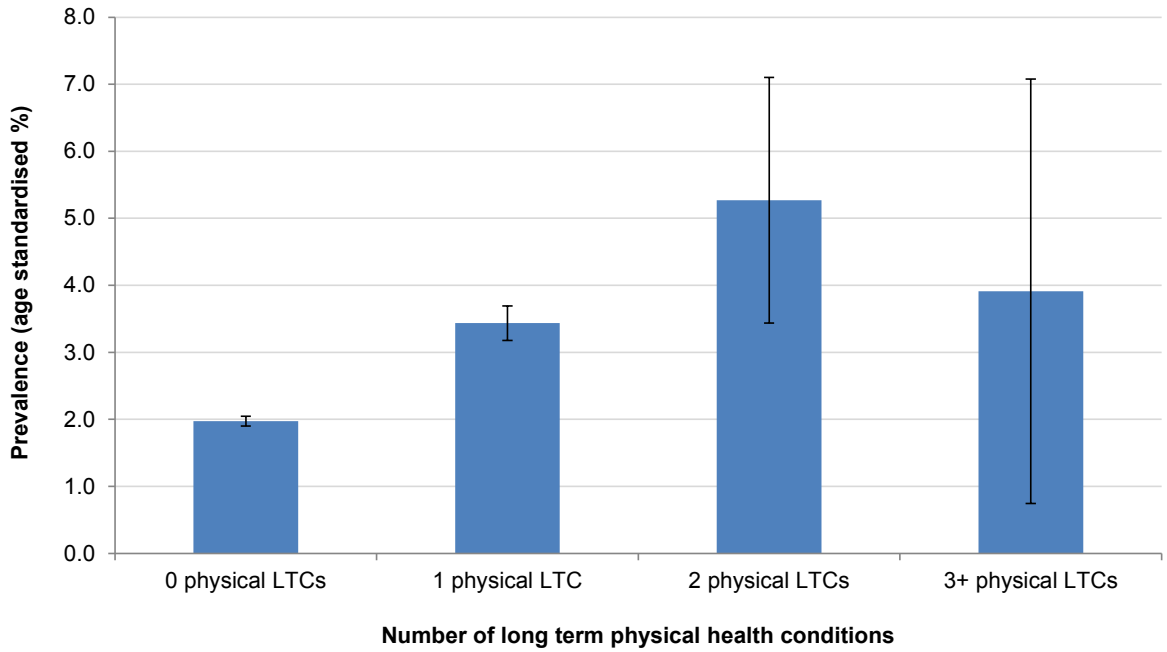
7.8.2 Depression and long term conditions in Croydon

As is the case nationally, people with depression in Croydon are more likely to have an LTC and people with LTCs are more likely to have depression. In Croydon, people with diagnosed depression are twice as likely to have COPD (chronic obstructive pulmonary disease) and asthma, 42% more likely to have CHD (coronary heart disease) and 39% more likely to have diabetes. [48]

Almost one in five people in Croydon (19.1%) have at least one LTC. Long term conditions are more common in older people[49] and those living in deprived areas. **Figure 8** shows that people with one LTC (12.5%) are 1.74 times more likely to have depression than those with no LTCs. People with two LTCs (4.4%) are 2.7 times more likely to have depression.

[45] Whoole MD, de Jonge P, Vittinghoff E, et al (2008). Depressive symptoms, health behaviors, and risk of cardiovascular events in patients with coronary heart disease'. *JAMA*, 300(20): 2379–88.
[46] King's Fund; Centre for Mental Health (2012) *Long term conditions and mental health: The cost of co-morbidities*. London: king's Fund
[47] NHS Confederation Mental health networks (2012) Investing in emotional and psychological well-being for patients with long-term conditions
[48] Croydon general practices, March 2012
[49] Croydon JSNA 2010/11 Living well in later life

Figure 8: Prevalence of depression by number of long term physical health conditions, Croydon, March 2012



Source: Data from Croydon General Practices, March 2012
Note: Prevalence is as recorded in the last 5 years

There is evidence that for some people in Croydon with an LTC and depression, their depression has not been diagnosed. Although the prevalence of diagnosed depression in people with specific LTCs is higher than in the general Croydon population, it is not as high as we would expect from looking at rates in the literature (**Table 4**). For example, compared to the general population, prevalence of diagnosed depression in people with diabetes in Croydon is 57% higher and in people with coronary heart disease, it is 6% higher. These figures (particularly the latter figure) are surprising and concerning because GPs are incentivised to screen for depression in these two groups and we know from national and international surveys that rates of depression are 200% to 300% times higher in those with diabetes and cardiovascular disease.[50]

One of the objectives of the NHS Commissioning Board (now NHS England) is to put mental health on a par with physical health.[51]The need for closer working between physical and mental health services has been highlighted within Croydon.

[50] King's Fund; Centre for Mental Health (2012) *Long term conditions and mental health: The cost of co-morbidities*. London: King's Fund
[51] Department of health (2012) mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015

Table 4: Prevalence in last five years of diagnosed depression in people in Croydon with selected long term conditions

Long term condition	Population diagnosed with condition (%)	Increased risk of diagnosed depression*	What does the evidence say
Hypertension	10.9%	67% higher	24% of patients with hypertension have depression[52]
Diabetes	4.4%	57% higher	Diabetes doubles the odds of depression. Major depression is present in 11% of people with diabetes[53]
Asthma	4%	97% higher	Depression is present in 45% of adults with asthma[54]
Coronary heart disease	2%	6% higher**	Depression in patients with ischaemic heart disease is two to three times greater than the general population[55]
Cancer	2%	59% higher	Conservative estimates suggests that between 23% and 26% of patients with cancer have depression[56], [57]
Epilepsy	0.5%	57% higher	People with epilepsy have with lifetime depression prevalence rates ranging between 30 and 35%[58]
Multiple sclerosis	0.1%	400% higher	Studies show a lifetime prevalence of approximately 50% and an annual prevalence of 20%[59]

Source: Data from Croydon general practices, March 2012

*compared to general Croydon population

**not statistically significant

[52]Gunn JM, Ayton DR, Densley K et al (2012). 'The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort'. *Social Psychiatry and Psychiatric Epidemiology*, 47 (3) pp175–84.

[53]Anderson RJ, Clouse RE, Freedland KE, Lustman PJ (2001) The prevalence of comorbid depression in adults with diabetes: a meta-analysis. *Diabetes Care* 24 (6) 1069-1078

[54]Mancuso CA, Peterson MGE, Charlson ME (2000) Effects of depressive symptoms on health-related quality of life in asthma patients . *Journal of General Internal Medicine* 15 (5) 301-310

[55]Wei Jiang, Glassman A, Krishnan R,. O'Connor CN,et al. (2005) Depression and ischemic heart disease: What have we learned so far and what must we do in the future? American Heart Journal 150 (1) 54-78

[56]Chapman DP, Perry GS, Strine TW (2005). 'The vital link between chronic disease and depressive disorders'. *Preventing Chronic Disease*, 2 (1) 1–10

[57]Gunn JM, Ayton DR, Densley K, et al (2012). 'The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort'. *Social Psychiatry and Psychiatric Epidemiology*, 47 (3)175–84.

[58] Kanner AM, Schachter SC, Barry JJ et al (2012) Depression and epilepsy: epidemiological and neurobiologic perspectives that may explain their high comorbid occurrence. *Epilepsy & Behavior*24 (2) 156-68

[59] Siegert RJ, Abernethy DA (2005) Depression in multiple sclerosis: a review. *Journal of Neurology, Neurosurgery and Psychiatry* 76 (4) 469-75

A Croydon **mental health review**[60] recommended that commissioners develop high quality care pathways with a strong focus on the physical health of those with mental health problems and the mental health of those with physical health problems. A number of strategies and service specifications recommend that mental and physical health problems are considered together:

- Croydon's **long term conditions strategy** recommends that "improved access to psychological therapies (IAPT) and Liaison Psychiatry services for the treatment of long-term conditions and medically unexplained symptoms" should be part of an integrated care pathway across physical and mental health care.[61]
- Croydon's **Adult Intermediate Tier Diabetes specification** has a clear requirement that the service should ensure people with diabetes are referred to an appropriate psychological support service where needed and staff have the skills and knowledge to provide psychological and emotional support within the diabetes service.[62]

In summary,

Mental and physical health are inextricably linked. The best outcomes are achieved when physical and mental health problems are considered together.

One in five people in Croydon have an long term conditions (LTCs). Many of them are older people. Depression is very much more common in people with LTCs.

There is evidence that costs of treating depression in those with LTCs would be more than recouped by savings in the treatment of the LTC. This is because treating depression in people with an LTC leads to lower use of health care services for their physical health condition, better health outcomes and improved self-management.

There is evidence that in Croydon, there is under diagnosis of depression in people with LTCs, particularly in people with coronary heart disease.

Recommendation 2

That stakeholders writing strategies and developing existing and new services concerned with the care of people with LTCs or depression, understand and take account of the need for integrated mental and physical healthcare.

Recommendation 3

That commissioners of physical and mental health services and primary care providers should consider ways to increase the identification of depression in people with long term conditions.

[60] NHS Croydon (2012) Croydon mental health PBMA review: final report and recommendations

[61] Croydon CCG (2012) Management of care for people with long term conditions

[62] Croydon Intermediate Tier Diabetes Service Specification, April 2013 – March 2016

8 Services for people with depression in Croydon

This section describes the support that is provided to people with depression in Croydon. It identifies assets and gaps in service provision and makes recommendations for future development. It describes the framework used to structure this section, estimates the number of people expected to be in each step of the framework based on national models and then describes services within each step. It has the following sections:

- Framework and exploration of well-being strand of framework
- Numbers expected to enter services
- Step1: identification, advice or referral, watchful waiting
- Step 2 and Step 3: mild to moderate and moderate to severe depression
- Step 4: more complex need

8.1 Framework of services

The framework used in this section of the chapter to describe services and support in Croydon (**Table 5**) is based on the stepped care approach in the depression pathway published by NICE.[63]It was adapted to include **Step 0** and a **well-being** strand, which runs alongside all of the steps. The well-being strand was included because NICE depression guidance has a clinical focus and a strong theme identified by all respondents in the stakeholder consultation was the need to strengthen the non-medical, holistic approach in the management of depression.

People in **Step 0** have depression but have not been identified or diagnosed with the condition.[64] This step was included because the majority of people with depression are in this category. For this group, housing, access to green spaces and the numerous other factors that influence the circumstances of their lives will have an impact on their depression.[65]

The main providers of services for people with depression are primary care, NHS and social care, SLAM and a range of voluntary sector organisations. Whilst the framework outlines some of the key providers and services within each section, fuller listings and descriptions are available e.g. Mind in Croydon's Mental Health directory[66] and the HearUs guide.[67]

[63]http://pathways.nice.org.uk/pathways/depression
[64]NICE (2012) CMG41: Commissioning stepped care for people with common mental health disorders
[65] Overview Chapter
[66]http://directory.mindincroydon.org.uk/Pages/Subjects.aspx
[67]http://www.hear-us.org/aboutus/TheGuide/The-Guide.html

Table 5: Framework of depression support services in Croydon

Well-being: Resilience, promotion, prevention, protection, recovery.	Physical activity, volunteering, creative arts, music, singing, gardening, cooking, smoking cessation, weight management, learning new skills, advice on welfare benefits, debt and housing, help with seeking employment , peer support groups, befriending	**Step 0**	**Not identified or not seeking treatment**
			good quality housing, good social networks, financial security, education, access to green spaces, transport, meaningful activity, employment, volunteering, community safety.
		Step 1	**Identification, advice or referral, watchful waiting**
			Screening of those with coronary heart disease / diabetes **Diagnosis** in those presenting with symptoms
		Step 2 and Step 3	**Mild to moderate and Moderate to severe low-intensity psychosocial interventions, low and high intensity psychological therapy, medication**
			Low intensity psychosocial interventions: Primary care advice on sleep, hygiene, diet; individual guided self-help; books on prescription; websites e.g. beating the blues, living life to the full, MoodGYM **Low intensity and high intensity psychological therapies:** IAPT (improving access to psychological therapies) **Counselling services:** e.g. MIND counselling; Off the record; CPF counselling;[68]Drop In, Care to Listen, RASASC[69], Woodside Bereavement and CRUSE[70] **Structured Group Physical Activity programme;** exercise referral scheme **Medication:** Anti-depressant treatment
		Step 4 and above	**More complex needs**
			Crisis resolution / home treatment **CMHT support** **Inpatient treatment: ECT** **Medication**: Anti-depressant and consider anti-psychotics **High intensity psychological interventions**: CIPTS/PTS (Croydon Integrated Psychological Therapies Service / Psychological Therapies Service)

Source: adapted from NICE depression guideline (2012)

[68] Croydon Pastoral Foundation counselling
[69]Rape And Sexual Abuse Support Centre
[70]CRUSE and Woodside are bereavement services, not aimed at people with clinical depression

8.2 Numbers expected to enter services

Table 6 shows the expected use of services by people with a common mental health disorder in each step of the framework. It is based on national models of service usage.[71] The table shows that we expect less than half of the 47,824 people aged 18 and over in Croydon in 2012 who have a common mental health disorder to be known to services. Of this estimated 19,128 adults, we expect approximately 2,779 to have depression and a further 10,683 to have mixed anxiety and depression, with the rest having other common mental health problems such as anxiety, obsessive compulsive disorder and others.

Table 6: Estimated proportion and numbers of people with common mental health problems and depression who are expected to enter each step in 2012

	Proportion expected[72]	Numbers expected to be known to services in each step		
		common mental health problem[73]	depression	mixed anxiety and depression
Step 0 (Not identified or not seeking treatment)	More than 60%	28,694	4,169	16,025
Step 1 (On GP register)	Up to 20%	9,565	1,390	5,342
Step 2 (Low-intensity psychological interventions)	9%	4,304	625	2,404
Step 3 (High-intensity psychological interventions)	6%	2,869	417	1,602
Step 4 and above (CIPTS MAP CAG teams)*	Less than 5%	2,391	347	1,335
Number accessing services		**19,129**	**2,779**	**10,683**
TOTAL		47,824	6,949	26,715

Source: NICE (2011): Commissioning stepped care for people with common mental health disorders. CMG41. London: NICE and the associated commissioning and benchmarking tool.
**CIPTS (Croydon Integrated Psychological Therapy Services) and MAP CAG (Mood, Anxiety and Personality Disorder Clinical Academic Group) are described later in the chapter*

[71] http://www.nice.org.uk/media/496/2C/CommonMentalHealthDisordersCABTool.xls
[72] **National Institute for Health and Clinical Excellence (2011): *Commissioning stepped care for people with common mental health disorders. CMG41*. London: NICE**
[73] http://www.nice.org.uk/media/496/2C/CommonMentalHealthDisordersCABTool.xls

Nationally, overall, it is estimated that approximately a quarter (24%) of adults with a common mental health disorder are receiving treatment (14% receiving medication, 5% counselling/ therapy and 5% both). For those with a mixed anxiety and depressive disorder, only 15% are estimated to be receiving treatment. For those with depression, estimates are over three times higher (50%).[74]

8.3 Well-being strand of framework

People with depression, at every step in the framework from **Step 0** through to **Step 4**, can benefit from undertaking activities that promote well-being. High levels of well-being can prevent relapses of depression, and can help people with depression recover and stay well. People with depression are more likely to have unhealthy lifestyles. They are more likely to smoke, have a poor diet, drink too much alcohol and lead sedentary lives. These lifestyles reduce well-being and are risk factors for physical illness. The depression chapter firmly supports a shift in focus of mental health commissioning to prevention, taking a population approach to improving well-being and increasing population resilience.

Many of the services and activities listed in the well-being strand of the framework are used or undertaken by everyone in Croydon on a regular basis, regardless of whether or not they suffer from depression or another mental health condition. However some people, especially those with mental health problems, need additional support to access and benefit from these services. People who suffer from depression are increasingly eager to play an active role in the management of their symptoms. Self-management strategies such as maintaining social interactions, and improving lifestyle factors through increasing physical activity, sensible drinking and eating a balanced diet can enhance quality of life and prevent relapse.

The consultation found that service users and carers wanted to be offered more community services when they suffered an episode of depression. GPs often advise and signpost people with depression to community services, so stronger collaboration between GPs and community and well-being services can be an effective way of promoting non-medical support. There is evidence, nationally, that GPs would prefer to offer services that promote healthier lifestyles, creative arts and crafts, etc as an alternative to antidepressants.[75]There are a number of approaches to strengthening links between primary care and community support. Social prescribing is one such mechanism[76] although the level of social prescribing in Croydon cannot be identified from routine data sources because there is no reliable electronic data. There are other approaches. The NHS confederation website describes a **collaborative primary care-led approach** to improving mental health

[74]NHS Information Centre (2009) A*dult psychiatric morbidity survey in England; results of a household survey 2007* London: Health and Social Care Information Centre
[75]CSIP North West Development Centre (2009) *Social prescribing for mental health: a guide to commissioning and delivery*
[76]CSIP North West Development Centre (2009) *Social prescribing for mental health: a guide to commissioning and delivery*

and well-being.[77]One of the recommendations identified by stakeholders in the consultation was the development of in-reach and outreach services where, for example, advice services based in GP surgeries facilitate referral between primary care and community services.

The voluntary sector is a key provider of community services and the stakeholder consultation identified the voluntary sector, and the community support it provides, as one of Croydon's strengths. Stakeholders described these services as "vital" and expressed concern about the impact of recent cuts to the voluntary sector on this support.

Some voluntary sector services are aimed at groups that can be more vulnerable such as BME groups and older people. They can play a key role in supporting these groups, in part because some of their users are wary of statutory services and feel more comfortable in a voluntary sector environment.

The *Overview Chapter* explores in detail the factors that affect mental well-being.[78]

Recommendation 4

That commissioners, voluntary sector and primary care providers promote well-being services and self-management strategies to people with depression. Furthermore, that commissioners explore and support closer working between primary care and community services through mechanisms such as social prescribing.

8.4 Step 1: Identification, advice or referral, watchful waiting

This section looks at the role of primary care in identifying and managing people with depression and variations in depression-related primary care quality indicators in Croydon. It has the following subsections:

- Primary care mental health services
- Variation in quality of primary care
- Information provided at first diagnosis
- Stigma
- Carers

8.4.1 Primary care mental health services

High quality primary mental health care is central to effective support for people with depression because a diagnosis of depression is typically made by GPs and most people with depression will be managed solely within primary care. The role of primary care has changed hugely in recent years. It delivers a growing range of activities, the size of practices and groups of practices have become larger and

[77] http://www.nhsconfed.org/Publications/reports/Pages/CaseStudyReportOnSandwell.aspx (accessed 17 December 2012

[78] Overview chapter 2012/13

multidisciplinary staff play a larger role. This evolving role provides both opportunities and challenges in developing a strong primary mental health care team that can deliver integrated care linked to the community and focussed on recovery. Recent guidance for commissioners of primary mental health services provides evidence based models of good primary care and identifies the benefits of having a strong primary mental health care service:[79]

- reduced use of secondary care
- better links between physical and mental health
- better management of people with complex problems
- provision of support closer to home in a non-stigmatizing environment.

The guidance describes in detail what a good service would look like: evidence based, patient-centred, based on need, age inclusive, capable, integrated, accessible, sufficient capacity, outcome-focused, recovery-focused, community-linked and preventative.

8.4.2 Variation in primary care quality

A very strong theme arising from the chapter consultation was the variability in the quality of GP support for people with depression in Croydon. Many respondents saw GPs as one of Croydon's very clear strengths but equally there was a strong feeling that quality was variable.

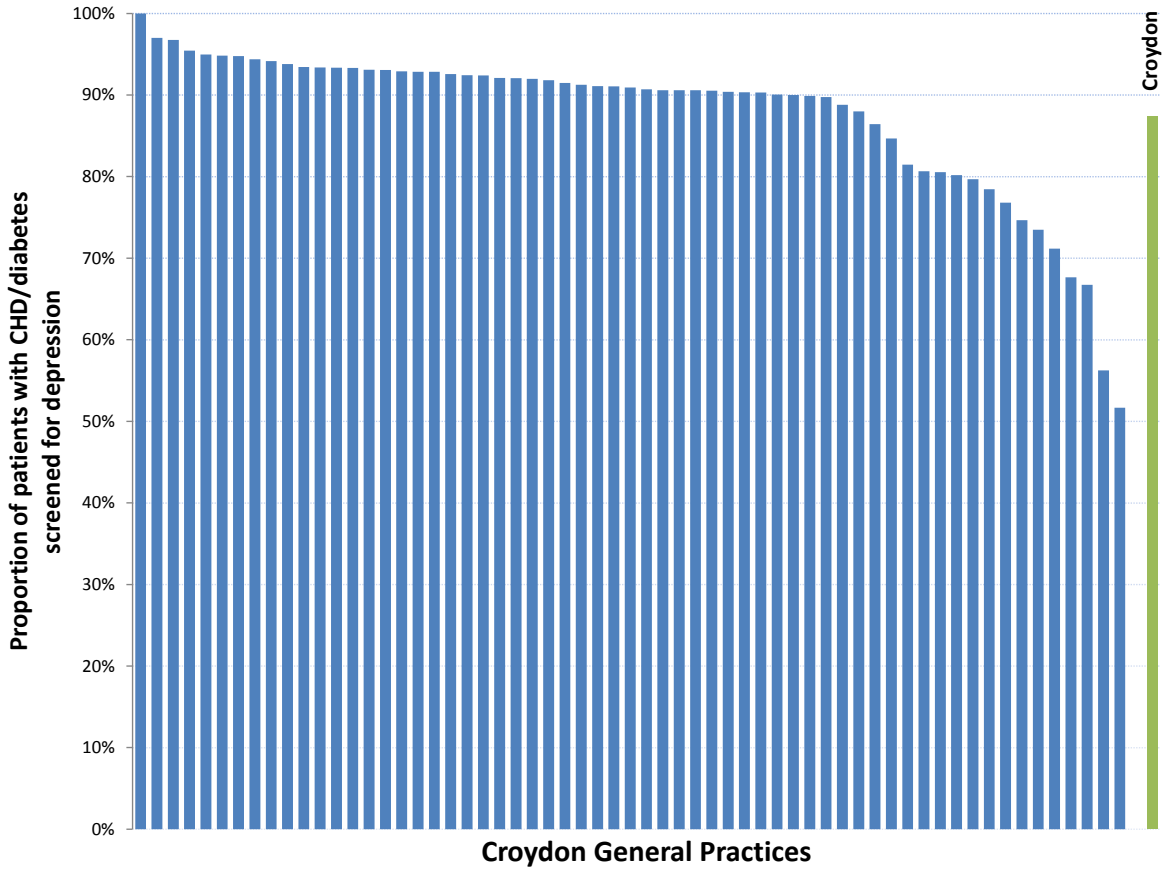
Satisfaction with primary care services, based on the 2012 GP patient survey, is statistically significantly worse in Croydon than in England [80] although these survey findings are not specific to mental health. There are currently no mental health local enhanced services, nor GPs with a special interest in mental health. Work has been undertaken locally to improve the primary care depression pathway. A local guideline for depression in adults based on guidance from NICE (the National Institute for Health and Care Excellence), and tailored to Croydon, was published in late 2011.

The perceived variation in primary care quality is supported by some local data that shows wide variation in screening for depression and early management of diagnosed depression as well diagnosed depression (see **Figure 3**). Nationally, GPs are incentivised to screen for depression in people with diabetes and CHD (coronary heart disease) because depression is more common in people with these conditions. **Figure 9** shows that in 50% of practices, over 90% of patients with diabetes and/or CHD are screened for depression. However, in almost a quarter of practices (23%) less than 80% of patients are being screened for depression.

[79] Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of primary mental health care services

[80] Croydon Key Dataset 2012/13

Figure 9: Screening for depression in people with diabetes and/or coronary heart disease, as at 31st March 2012



Source: Quality and Outcomes Framework 2011/12

Another marker of good quality on-going care is that patients with depression have the severity re-assessed four to 12 weeks after first assessment[81]

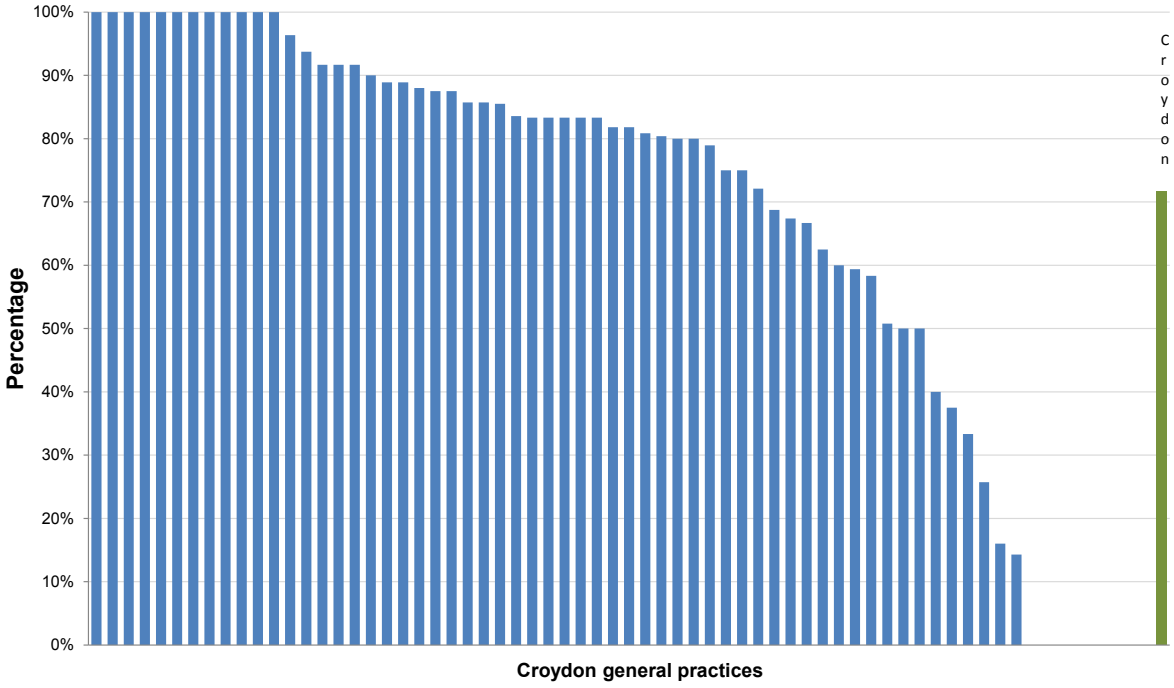
Figure 10 shows that this is achieved for 100% of patients in almost a fifth of practices (20%). However, for a handful of practices (four), less than half are re-assessed within these time frames.

This Croydon picture of wide variation between practices fits with what is known nationally. A recent inquiry by the King's Fund found wide variations in performance of primary care and recommended that more should be done to increase awareness of this amongst those working in general practice.[82] Annual practice profiles are produced by the Croydon Public Health Intelligence Team which compare individual GP practices with all other practices in the borough on a number of key indicators. These can and should be used to highlight variation in primary care locally.

[81] Quality and Outcomes framework guidance for CMG contract 2011/12
[82] King's Fund (2011) Improving the quality of care in general practice

Given the evidence of under diagnosis of depression in some ethnic groups and in people with LTCs, it is a priority that practices with lower performance are supported to improve.

Figure 10: Re-assessment of severity of depression 5-12 weeks after initial recording of assessment, as at 31st March 2012



Source: Quality and Outcomes Framework 2011/12

In summary

A strong primary mental health care service is central to supporting people with depression and there is guidance that describes the characteristics of a high quality effective service.

There is strong evidence of variation in primary care quality and practice within Croydon.

There is a need for commissioners and providers to identify and learn from practices where management of depression is recognised as being high quality and identify and support those where there is scope for improvement.

Recommendation 5
That commissioners and providers of primary care services seek to reduce unwarranted primary care variation in screening and diagnosing depression, and in re-assessment of severity of depression.

Recommendation 6
That commissioners and providers of primary care services strengthen primary mental health care service capability and capacity through workforce training and support, taking account of best guidance and practice.

8.4.3 Information provided at first diagnosis

When a patient is diagnosed by their GP with a new or relapsing episode of depression, they are usually provided with advice about managing their depression and information about services they may want to access. Some GPs will provide leaflets, for example from the patient.co.uk website.[83] The information varies in quality and completeness and there is no standard set of information that all GPs and patients can access. The chapter consultation identified the need for better information provision as a strong recommendation, particularly noting that GPs sometimes seemed unaware of what was available. Service users reported that they had not always been told about support services that they later found of value and providers reported difficulties in adding their services to the information available to GPs. Patients reported that even when information about a service was provided, it was sometimes difficult to find the motivation and confidence to make contact with services.

A recommendation arising from the consultation was the delivery of a one-stop shop with information about services. Whatever the level of need, people with mental health problems and people with low levels of well-being can benefit from self-help approaches. Croydon has produced a version of the five ways to well-being[84] that links each of the five steps to Croydon specific support. GPs reported that they did not have easy access to this.[85] A recommendation of the overview chapter is that this resource is updated and made more widely available.

The national mental health implementation strategy recommends that primary care providers know what specialist mental health and well-being support is available so that they can help people to access community-based support.[86]GPs can and should have a role in encouraging and supporting patients to contact services.

In summary

GPs have a key role in providing information and signposting to services

The stakeholder consultation reported a need for better provision of information about services and self-help approaches.

[83] http://www.patient.co.uk/health/Depression-A-Self-Help-Guide.htm
[84] http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-well-being.aspx
[85] Personal communication
[86] Department of Health (2012) *No health without mental health: A cross-government mental health strategy for people of all ages* . London: Department of Health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Recommendation 7

That commissioners, providers and community groups consider improving the range, accessibility and relevance of information provided about services and self-help resources and raise awareness of these resources in primary care.

8.4.4 Stigma

There are many reasons why a person with symptoms of depression may not receive a diagnosis. For some people, especially ethnic minorities, this can include cultural differences in seeking help. The chapter consultation identified fair access to services as a key recommendation and cited stigma and fear of discrimination as reasons why some people may not seek help as well as lack of language and culturally appropriate resources and services.

Stigma can affect whether or not a person with depression takes the initial step to seek help and can influence management and experience of the condition. Stigma and/or cultural beliefs about the nature of mental disorder can affect an individual and their likelihood of seeking help. Reducing stigma is one of the government's six mental health objectives.[87]Stigma can be addressed through campaigns, community champions, raising awareness, information in language and culturally appropriate formats, training and development for staff in recognising depression. Time to Change has developed a range of projects and initiatives that aim to end the stigma and discrimination that face people with mental health problems.[88]An evaluation of the programme between 2007-2011 shows some evidence of a reduction in average levels of discrimination.[89]

Recommendation 8

That commissioners strengthen links with providers, communities, particularly BME communities, and other agencies to tackle stigma and discrimination within services, the community and the general public, through awareness raising, workforce training and evidence based campaigns.

8.4.5 Carers

Family, friends and carers can play a vital role in supporting people experiencing both mental and physical health problems. However the role of caring can be challenging and carers are at increased risk of depression.[90]Given the burden of caring, carers may be less likely to seek help and once diagnosed, carers with

[87] Department of Health (2012) *No health without mental health: A cross-government mental health strategy for people of all ages*. London: Department of Health
[88] http://www.time-to-change.org.uk/
[89] Reducing stigma and discrimination: evaluation of England's Time to Change programme', *British Journal of Psychiatry*, April 2013, Volume 202, Issue s55 Edited by Claire Henderson and Graham Thornicroft
[90] Health and Social Care Information Centre (2010) *Personal social services. Survey of adult carers in England - 2009-10.*

depression may need extra support in accessing services because of the limitations imposed on them through their caring responsibilities. The need for better support for carers was identified as a strong theme in the survey consultation and in other stakeholder events.

Recommendation 9

That commissioners, providers and carer representatives consider how to ensure that the needs of carers are considered in developing services that support people with depression.

8.5 Step 2 and Step 3 – mild to moderate and moderate to severe depression

This section looks at some of the interventions offered to people with mild to moderate and moderate to severe depression. People in **Steps 2 and 3** of the framework will be managed in primary care and these two steps were combined because the information about services could not be disaggregated into the two steps. When diagnosed, following initial management, the **treatment** offered is typically some combination of antidepressants, psychological interventions and low intensity psychosocial interventions such as physical activity, or self-help resources based on the principles of cognitive behavioural therapy. The section has three sub-sections:

- Low intensity interventions
- Antidepressant medication
- Psychological therapies

Effective services at **Steps 2 and 3** will reduce the use of **Step 4** services.

It bears repeating that whatever the level of need within the steps, people will benefit from accessing well-being services.

8.5.1 Low intensity interventions

One of the strongest themes, identified by service users and carers in the consultation, was social isolation and difficulties in “getting out of the house”. One of the most commonly mentioned improvements suggested in the stakeholder consultation was to increase non-medical support. Service users reported a strong need for more help in getting involved in social activities, more peer support groups and befriending services. Some of the low intensity interventions described in NICE guidance can help promote healthy lifestyles, increase well-being and reduce isolation:

- individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised cognitive behavioural therapy (CCBT)
- a structured group physical activity programme

The services considered in this section are:

- Croydon's exercise referral scheme
- Active lifestyle buddying scheme, part of the Active Minds service
- Books on prescription
- Big White Wall

Exercise Referral Scheme

Physical activity is effective in the promotion of well-being and in the treatment of depression[91], and is recommended by NICE.[92,93]It has benefits at all ages and can reduce the risk of developing depression and mental illness. It can also reduce the risk of developing an LTC or some of the risk factors for LTCs such as obesity, cardiovascular disease, musculoskeletal conditions, diabetes and cancer,[94] which are, in turn, risk factors for depression. Croydon has a lower percentage of adults (16+) participating in recommended levels of physical activity (7.7%) than England (11.5%) and Croydon is in the bottom fifth of PCTs in the country.[95]

Croydon's exercise referral scheme (ERS) is part of the active lifestyles project. It is aimed at sedentary adults with a medical condition that is a low or medium risk factor for coronary heart disease (CHD). The most common reason for referral is obesity and referrals for obesity account for almost two fifths (37%) of those assessed in 2011/12.[96] Eleven per cent of people were referred for depression, although this is likely to be an underestimate as the service reports that individuals referred for physical health conditions such as obesity and back pain will often describe symptoms of depression during the assessment.

In 2011/12 the ERS received 1,685 referrals of which approximately 60% came from GPs (989 referrals between Sept 2011 and Sept 2012). There is wide variation in the number of referrals that practices make, with a 20 fold variation between the top five and bottom five referring practices.

The numbers of referrals are growing. There was a 14% increase between 2010/11 and 2011/12 and the service may have insufficient capacity to deal with this growing workload. Referrals in 2011/12 were twice the target level. However because of funding limits, the service did not expand to meet demand.

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[91]Rimer J, Dwan K, Lawlor DA, Greig CA, McMurdo M, Morley W, Mead GE. Exercise for depression. *Cochrane Database of Systematic Reviews* 2012, Issue 7

[92]National Institute of Health and Clinical Excellence. (2008) *Mental well-being and older people. PH16.* London: NICE

[93] National Institute of Health and Clinical Excellence (2008) *Promoting physical activity in the workplace*. PH 13. London:NICE

[94]Department of Health (2011) *Start active, stay active: A report on physical activity from the four home countries' Chief Medical Officers*. London: Department of Healthhttp://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128210.pdf

[95]North East Public Health Observatory (2012) Community Mental Health Profile

[96]Exercise Referral 2011/12 Year End report

Access to the ERS by BME groups and older ages

The service has good access by BME groups. In 2011/12, almost two thirds (62%) of clients were from non-white groups, almost 50% higher than the proportion of Croydon's adult population from non-white groups of 42%.[97] The high proportion of BME referrals may reflect differences in the prevalence of conditions leading to referral. There is little evidence of differences in rates of depression between ethnic groups – however there is some local evidence of variation in levels of obesity by ethnic group.[98]

Almost a quarter (24%) of referrals were in people aged 61 to 75. This demonstrates very good access by older people as only 12% of Croydon's population is aged over 65[99]. A 2007 report on the scheme showed self-reported improvements in physical and mental health in those who completed the scheme.[100] The physical health results were statistically significant. It also showed that 94% of people using the service were satisfied with their experience.

The report made a number of recommendations to further improve the service, including the need to improve communication between users, the ERS team and referrers. One of the barriers to accessing the scheme identified by services users was attending alone. The buddy scheme run by Mind in Croydon helps people with mental health problems to engage with the ERS and it has improved the uptake of this service.

Recommendation 10

That the Exercise Referral Scheme and its commissioners review the recommendations made in the 2007 report and consider exploring and addressing those that have not been implemented.

Active Minds

Mind in Croydon delivers a variety of projects through Active Minds, which focuses on reducing social isolation by enabling people to take part in leisure, sports and social activities.[101]Active Minds is for people with mental health problems and aims to prevent relapse and promote well-being.

The active lifestyle buddying scheme, part of the active minds service, aims to provide the extra support that some people with mental health problems need to use the Active Minds services, the ERS or mainstream lifestyle services. Although people

[97] Overview chapter 2011/12 http://www.croydonobservatory.org/docs/1083713/1246374
[98] Croydon JSNA (2009/10) Healthy weight healthy lives. http://www.croydonobservatory.org/docs/strategies/HWHL
[99] ONS Mid-2011 Population Estimates
[100] Bains R (2007) Croydon Exercise Referral Scheme report
[101] http://www.mindincroydon.org.uk/active-minds.asp

using the buddying service have a wide range of diagnoses, depression is the most common diagnosis.

The majority of people in the pilot schemes were helped to access either boxercise (a non-contact boxing scheme run by Mind in Croydon) or the exercise referral scheme. The scheme showed self-reported improvements in the mental and physical health of both the buddies and the services users.[102]

Recommendation 11

That commissioners continue to support services, such as buddying and befriending schemes, that help people with depression to access services and engage in activities that promote well-being.

Books on prescription

Self-help book schemes can ease pressure on primary care and those based on CBT principles are recommended by NICE.[103]Croydon's Books on Prescription (BoP) scheme aims to help borough residents with mild to moderate mental health issues by providing self-help books and leaflets. The ten resources are available across all of the borough's 13 libraries. When the scheme started, some books were issued via book prescriptions from GPs, many more were self-selected. In the last 18 months, the library reports that there have been no formal prescriptions.

Table 7 shows that approximately 600 to 800 books are issued per year and this level of activity has remained fairly stable since the scheme started in 2008. The higher number of issues in 2009/10 may be a reflection of the service's higher profile following its formal launch. The stock is now three to four years old and has not been updated with new editions or titles, although the IAPT service (who now deliver BoP) is working with the libraries to address this and re-launch the service.

Information is not currently collected to assess the effectiveness of the scheme either in easing pressure on primary care or improving the well-being of those who use it.

Table 7: Books on prescription issues

Time Period	Number of Issues
2008/09	635
2009/10	1033
2010/11	674

[102] Active Lifestyle Buddying Project (February 2011) Mind in Croydon
[103]Farrand, P. (2005). Development of a supported self-help book prescription scheme in primary care *Primary Care Mental Health*, 3: 61-66.

2011/12	762
April 2012 to Sept 2012 (six months)	355

Source: Croydon Central Library, 2012

Recommendation12

That the providers and commissioners of the Books on Prescription scheme consider how they might evaluate its effectiveness, especially in light of the proposed refresh and re-launch of the service.

Big White Wall.

The Big White Wall (BWW) Mental Well-being Online Service is an early intervention, online service for people experiencing psychological distress. It aims to improve mental well-being through peer engagement and support in an online community, with links to e-learning on mental health topics and networking with others.[104]

It has trained staff online at all times day and night who aim to ensure engagement with and the safety and anonymity of members.

A recent report on Croydon use of BWW from September 2010 to May 2011 found that it was used primarily by young women (75% female and 60% aged under 35),[105] a slightly different profile to national users who are older and more likely to be male.[106] Almost a third (29%) of Croydon users were from BME backgrounds, slightly less than the population prevalence of BME groups in Croydon of 42%. Over a third had seen a doctor for a common mental health condition in the last month and over 40% (2 in 5 people) had taken medication for a common mental health condition in the last month.

BWW is an innovative approach to providing mental health support; user satisfaction is high, with some evidence of improvements in mental health outcomes.[107]

In summary

There is an overlap between the low intensity services offered at Step 2/3 and the well-being services.

The range of low intensity services delivered via different routes (e.g. face to face books and internet) improves access through catering for different preferences.

Service users value, very highly, activities and services that reduce social isolation

[104] www.bigwhitewall.com
[105] Big White Wall (2011) Croydon closing report
[106] Big White Wall (2011) Brief profile for the most recent 1,500 members
[107] Big White Wall (2011) Croydon closing report

and offer non-medical support such as the low intensity services.

Commonly mentioned improvement suggested by stakeholder in the consultation was to increase non-medical support

Recommendation 13

That commissioners support and promote well-being and social inclusion services and services that promote self-management.

8.5.2 Antidepressant prescribing

Antidepressant medication is recommended in the treatment of some people with depression. In general, the more severe the depression, the greater the benefit of antidepressant medication. Where a person has benefited from antidepressants, it is recommended that they continue medication for at least 6 months after symptoms improve (remission).[108]

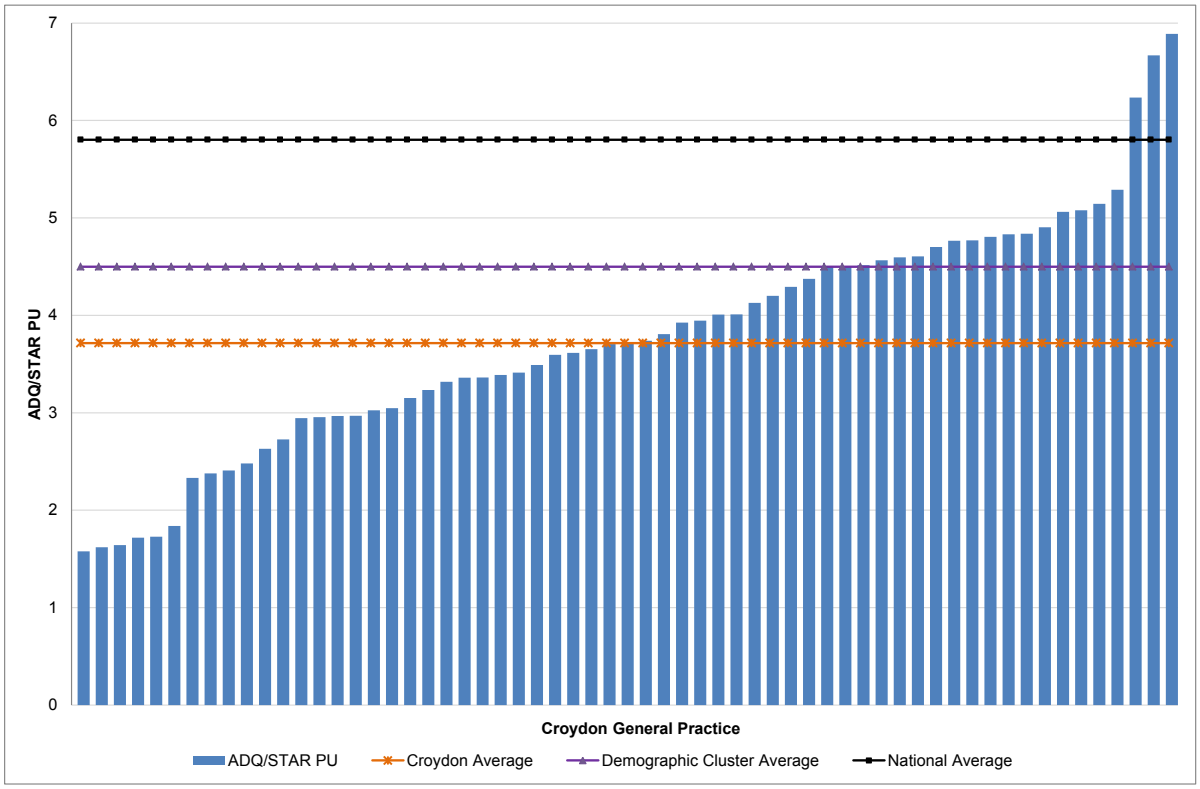
The majority of antidepressants are prescribed in primary care. In the 12 months from July 2011 to June 2012, Croydon spent £864,419 on antidepressant drugs, which accounted for 31% of the total mental health primary care prescribing budget.[109]Spending on antidepressants in 2011/12 was approximately 10% lower than spend in 2010/11 mainly because some drugs came off patent.[110]Local Croydon depression guidelines to support GP prescribing/management of depression were approved November 2011 by the Croydon Pharmacy Committee and launched in December 2011.

Figure 11 shows that antidepressant prescribing in primary care in Croydon is relatively low. Levels are similar to the average for London, but 17% lower than the average of Croydon's demographic cluster[111] and 35% lower than the national average. In 2010/11, of 152 PCT areas in England, antidepressant prescribing in Croydon was the 13th lowest by volume.

To fully understand this requires further exploration. It may mean that Croydon GPs are good at "watchful waiting" (Step 1) whereby they are offering advice on sleep, diet and so on, monitoring their patients and offering community support as alternatives to antidepressants. It may mean that GPs are under diagnosing depression and/or under prescribing antidepressants.

[108] NICE (2009) Depression in Adults CG90
[109] EPACT, 2011/12
[110] When a drug is off patent, cheaper, generic drugs can be offered
[111] Demographic cluster is areas where the population is similar to Croydon in terms of its prescribing: Redbridge, Barnet, Harrow, Hounslow, Hillingdon, Portsmouth City, Medway, South East Essex, Peterborough, Milton Keynes

Figure 11: Primary care antidepressants ADQ/STAR PU Croydon PCT*: 2011/12



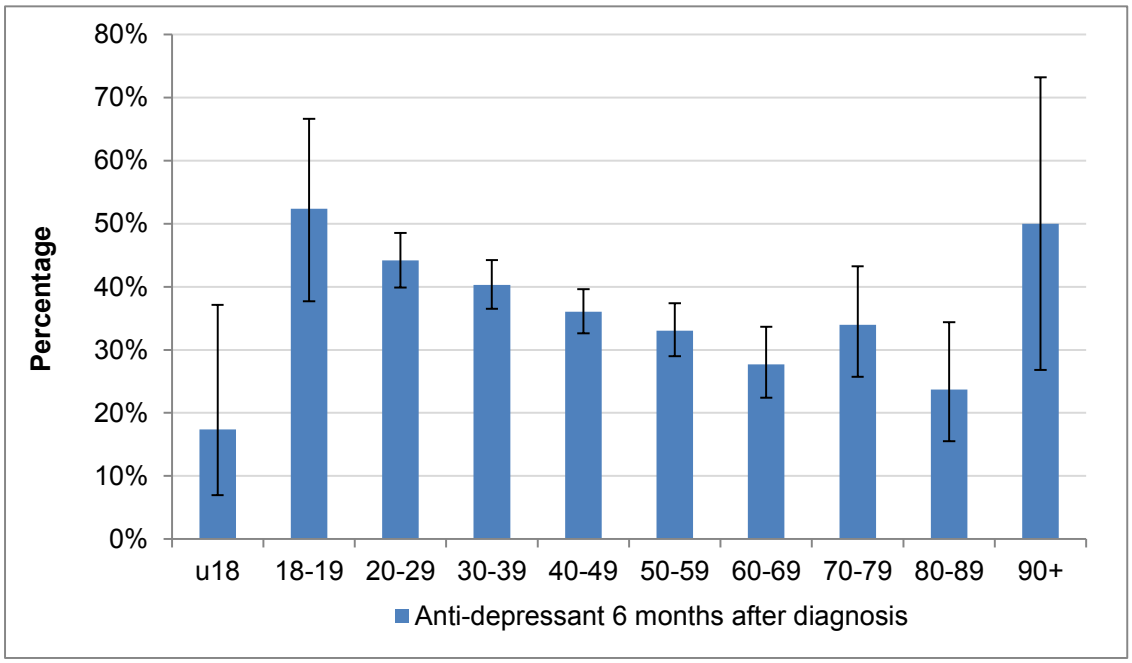
Source: Information Services Portal, NHS Prescription Services
**ADQ/STAR PUs (Average Daily Quantity per Specific Therapeutic group Age-sex Related Prescribing Units) is a method of taking account of the differences in size and age sex structure between Croydon and other areas*

Antidepressant prescribing by age

The Croydon GP database shows that of the 2,820 people given a diagnosis of depression in the two year period Oct 2009 to Sept 2011, a third (37%, 1,042 people) were prescribed anti-depressants in the six months following the diagnosis (see *Appendix 5* for details of read codes and antidepressant codes used). This percentage varies by age. **Figure 12** shows that the older a person, the less likely they are to be prescribed antidepressants in the six months following a diagnosis of depression. Almost half (44%) of people aged 40-49 who are diagnosed with depression in Croydon are prescribed an antidepressant in the following six months. This percentage decreases steadily to only a quarter (28%) of people aged 60 to 69. This trend may be, in part, because older people have more illnesses and prescribing will take account of possible medication interactions.

Analysis of the Croydon GP database showed that neither gender nor ethnicity were associated with the likelihood of being prescribed antidepressants.

Figure 12: Proportion of patients, by age, prescribed anti-depressants within 6 months of a diagnosis of depression.



Source: Data from Croydon General Practices, October 2009 to March 2012

Recommendation 14

Commissioners, pharmacy advisors and primary care providers should consider exploring the reasons behind the lower prescribing of antidepressants at older age groups and encourage anti-depressant prescribing that is clinically appropriate at all ages.

Quality in antidepressant prescribing

Two markers of quality in antidepressant prescribing are the proportion of antidepressants that are “first choice” and the proportion that are dosulepin.

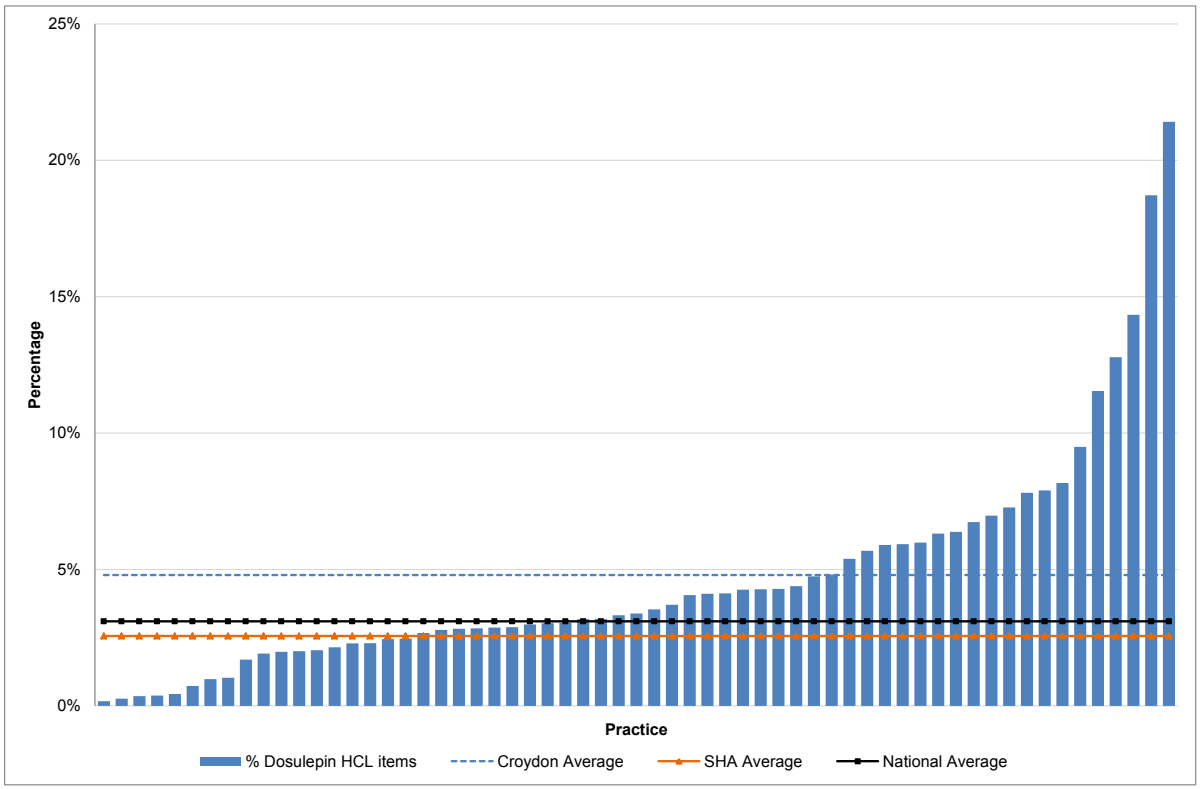
The proportion of antidepressants that are first choice is collected as a national prescribing indicator. It is generally accepted that the first line antidepressant should be an SSRI (selective serotonin re-uptake inhibitor). NICE has recently recommended Sertraline as a first choice agent in terms of efficacy, tolerability, and acquisition costs (cost effectiveness). The national indicator for “first choice” also includes Citalopram and Fluoxetine both of which are also SSRIs. Prescribing of “first choice” antidepressants is also encouraged through Script switch messages which appear at the point of prescribing an antidepressant on the GP clinical system.

A high proportion of antidepressants that are dosulepin may be a marker of poor adherence to quality standards. NICE guidelines and local depression guidelines recommend that dosulepin is NOT prescribed because of cardiac side effects and toxicity in overdose, although historically it has been widely used.

In Croydon in 2011/12, 64% of antidepressants prescribed were first choice agents. This figure is similar to both national and demographic cluster averages as well as the London average. However, within Croydon, there is wide variation for individual general practices from 32% to over 80%.[112]

Prescribing of dosulepin is higher in Croydon than London or England. **Figure 13** shows that in Croydon, dosulepin accounted for 4.8% of antidepressant prescribing, almost double (1.9 times higher) the figure for London (2.6%) and 1.5 times higher than the national average (3.1%). The average is high because for five Croydon practices dosulepin makes up over 10% of all antidepressants prescribed. This prescribing may reflect historical practices or prescribing for indications other than depression.

Figure 13: Percentage dosulepin items of total antidepressants. Croydon July 2011 to June 2012



Source: epact, accessed Sept 2012

Recommendation 15

Practices with high rates of dosulepin prescribing should be supported to review their patients' medication with the aim of reducing dosulepin use in line with NICE guidelines.

[112] Croydon prescribing team - EPACT

8.5.3 Psychological Therapies

In recent years, the government has made it a priority to increase access to psychological therapies. Costs of psychological therapy are low and recovery rates are high. Half of those with depression and who take up an offer of appropriate therapy will recover, with a much diminished risk of relapse.[113]Psychological programmes can pay for themselves through reduced disability benefits and extra tax receipts and they reduce health care costs for those with long term physical health conditions. Good and timely psychological support can reduce the need for secondary care services.

This section is further subdivided into

- Voluntary sector talking therapies
- IAPT services
- Psychological therapies in people with medically unexplained symptoms

Table 8 shows the psychological therapies commissioned by NHS Croydon/Croydon Council for those in Steps 2 and 3.[114] The table shows that there were approximately 1,200 completed treatments in 2011/12, of which half were delivered by IAPT services and half by voluntary sector organisations. Not everyone who received treatment was suffering from depression. Levels of funding vary hugely and this will obviously impact on the numbers of people seen within a service.

8.5.3.1 Voluntary sector talking therapies

Talking therapies provided by the voluntary sector are a vital part of the support provided to people with depression. Some people feel more comfortable in a voluntary sector environment and many people who could benefit from therapy do not meet the criteria for IAPT services. Voluntary sector services can offer therapies over a longer period of time. Many are closely linked with other support and well-being services such as debt advice or peer support groups. A theme emerging from the chapter consultation was the high quality of services delivered by the voluntary sector. There is some evidence of good take up of voluntary sector counselling services by BME groups in Croydon.[115]

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[113]London School of Economics and Political Science. Centre for Economic Performance. (2012)*How mental health loses out in the NHS*. London: LSE.

[114]Table does not include

- talking therapies provided in, but not commissioned by Croydon.
- CIPTS (Croydon Integrated Psychological Therapies Service) which is aimed at people with more complex needs (step 4) and is described on page 3???.
- CRUSE and Woodside Bereavement Service which offers talking therapies for people who are dealing with bereavement and is not intended to help people with depression
- therapies offered privately, for which we do not have information.

[115]Pacitti R et al (2011) Making the first steps to counselling services *Mental Health Today* Sep-Oct: 28-33

A recent review of many of the voluntary sector providers[116] listed in **Table 8** found that:

- providers report dealing with increasingly complex cases - the perception is that clients with depression and anxiety disorders increasingly present with moderate to severe presentations
- not all providers are using recognised clinical outcomes measures
- for some services, there were lower proportions of people from ethnic minorities in therapy than assessed. Data that was given did not fully explain the differences in ethnic makeup of those in assessment and those in therapy; however this issue should be explored further. Poor access by BME groups was raised as a potential issue at the start of the JSNA process.

Recommendation 16

That commissioners consider ensuring that outcome measures are collected by all services delivering psychological therapies across the voluntary sector.

8.5.3.2 IAPT therapies

Improving Access to Psychological Therapies (IAPT) is a national programme to develop new, evidence based psychological therapies services across England for the effective treatment of depression and/or anxiety. Upon completion of the programme in 2014/15, the Department of Health target is that IAPT services should have the ability to provide support to 15% of those in the borough who are estimated to have a common mental health disorder, with 50% recovery rates. Five groups are a priority for expansion:[117,118]

- people aged over 65
- children and young people
- people with long-term physical conditions or medically unexplained symptoms
- people with severe mental illness
- people from BME groups.

In Croydon, people can be referred to IAPT or self-refer. The IAPT service is currently provided by SLAM. SLAM also delivers IAPT services in Lambeth, Southwark and Lewisham. Although these boroughs are not demographically similar to Croydon, some comparisons are made with these three boroughs in this section because more detailed data is available for them.

[116] NHS Croydon (2012) Review of adult mental health services provided by voluntary and community sector providers,
[117] Department of Health (2011) *Talking therapies: A four-year plan of act*ion. London: Department of Health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123985.pdf
[118] NHS operating framework 2012/13

Table 8: Talking therapy services for depression commissioned by the adult mental health Commissioning and Partnership Team [119]

	Mind in Croydon Counselling	Croydon Drop In – Support for Young People*	Off the Record Youth Counselling	CPF Counselling[120]	IAPT[121]
Age	18 +	11 – 25	14 to 25	18+	18+
Condition	depression and anxiety	depression and anxiety	depression and anxiety	depression and anxiety	depression and anxiety
Type of counselling	20 weeks individual, some group	Unlimited individual (6 weekly reviews) CBT, SFT and Hypnotherapy	12 or 6 weeks individual	mostly unlimited (3 year) therapy	NICE compliant 4 to 6 weeks or 14 to 20
2011/12 number of people treated	158	91 aged over 19	320	20	633**
post assessment waiting time 2011/12	68% waited 13 weeks or less.	70% seen in less than 8 weeks	89% waited three months or less	67% within 8 weeks	N/A
Outcomes	CORE -OM collected	Scaling and self-assessment outcome tool	CORE -OM	no recognised clinical outcome tool	Various

Source: Review of adult mental health services provided by voluntary and community sector providers, NHS Croydon (2012) and national IAPT returns
**not commissioned by the commissioning and partnership team*
***1306 entered treatment, 633 completed treatment*

[119] Croydon Council, NHS Croydon and the Croydon Clinical Commissioning Group.
[120] http://www.cpfcounselling.org.uk/ previously known as the Croydon Pastoral Foundation
[121] In 2011/12 there was a retendering of the IAPT service.SLAM delivered full IAPT services from early 2012

The chapter consultation found that quality of the Croydon IAPT service is seen as very high. Many people reported good experiences and praised the staff. In the fourth quarter of 2011/12, the recovery rate was 43% in both Croydon and across London. However, capacity is small and waiting lists are long. A recent report on the IAPT programme in London found that Croydon is currently one of the "most concerning IAPT areas in London" in part because the challenging financial situation that Croydon faces means that Croydon is unable to maintain current provision and unable to increase capacity.[122] Established in 2010, Croydon is a wave 3 site, which means it did not benefit from as much central resource as those services established in 2008 and 2009.

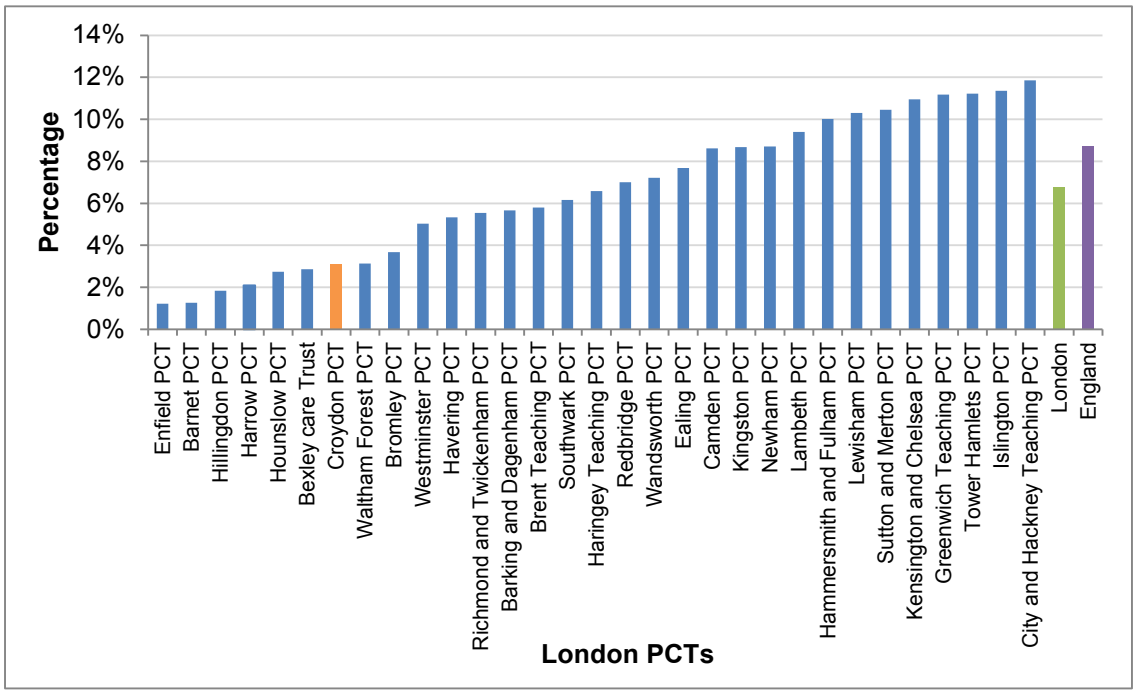
A number of Croydon stakeholders have identified lack of access to psychological therapies as a particular concern and this has been highlighted over a number of years.[123,124]A Croydon needs assessment for psychological therapies[125]carried out in 2008 recommended that the Croydon psychological therapy strategy should:

- Increase capacity of psychological therapy services.
- Explore reasons for lower rates of referral to psychological therapies and higher rates of anti-depressant prescribing in the over 65s.
- Improve access to services through self-referral.
- Link employment support services with psychological therapy services.

The Croydon service is treating a smaller proportion of its population than almost any other London borough. **Figure 14** shows that in 2011/12, only 3% of people with anxiety or depression entered treatment (1306 individuals). This proportion is half the London average (of 7%), a third of the England average (of 9%), and one fifth the Department of Health target for the end of 2014/15 (of 15%). Moreover, Croydon has a slightly lower proportion of people completing treatment (2 or more sessions) than London and England (Croydon 48%; London 59%; England 62%[126]). IAPT is currently contracted to meet 3.8% of need – the Department of Health target is that IAPT should meet 15% of need.

[122]London HealthProgrammes (April 2012) Improving Access to Psychological Therapies in London Clinical Assurance Report.
[123] Croydon NICE subgroup (2011) Baseline assessment for CG90 and CG91
[124] Croydon NICE subgroup (2012) Baseline assessment for CG123
[125] Henderson H (2008) Croydon Psychological Therapy Needs Assessment
[126] Numbers completing treatment are not a direct subset of those entering treatment

Figure 14: People who have entered IAPT treatment as a proportion of people with anxiety or depression, London PCTs (2011/12)



Source: The Health and Social Care Information centre

Waiting lists

Waiting times for IAPT services in Croydon are long. Waiting times from opt in (when the patient takes up a referral) to treatment for Croydon IAPT are approximately 5-6 months on average, with those who have particular needs and preferences sometimes having to wait longer. Waiting times fluctuate periodically, and variation can be considerable.

Waiting times in Southwark and Lewisham (two of the other boroughs where the IAPT service is provided by SLAM) are considerably shorter. Waiting times for Lewisham and Southwark IAPT services at end 2012 are approximately 8 weeks, on average, from referral to first appointment (Lewisham) or opt in (when patient takes up a referral) to first treatment (Southwark). However those with particular needs / preferences might have a longer wait before they can be seen. Again, waiting times fluctuate periodically and variation can be considerable.

Extremely long waiting times for therapies was the strongest challenge identified in the survey consultation and was mentioned universally in stakeholder meetings and events. There was a great deal of concern that some people worsen whilst waiting for treatment, and both suffer avoidable distress and make greater use of secondary care services.

The relatively small size of the service means that as well as longer waiting times, the service is offered in fewer locations, it is less flexible for people on the borders of eligibility, the service can offer fewer types of therapy and it has limited capacity to see people with conditions other than anxiety and depression.

Investment in psychological therapies

Currently Croydon invests £1.12 million in its IAPT service. Information was not available about how this investment compares with other areas nor how investment has changed over the last few years.

Nationally, investment in psychological therapies for the recovery of patients with depression and anxiety has increased significantly in recent years.[127]Over the last three years, there has been a larger percentage change in spend on psychological therapies (95%) than in any other services (accommodation at 18% increase is the second largest area).[128]

A recent report found that psychological therapies are highly cost effectiveness. It concluded that "the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of the psychological therapy." [129]

Staffing

The Croydon IAPT service has fewer staff than other London boroughs that are demographically similar. **Table 9** shows that Croydon has two thirds to one quarter of the staffing levels of boroughs that are demographically similar, and just less than one sixth of the workforce required by 2014/15.

Table 9: Actual and required workforce for IAPT / common mental health service

	Low intensity therapists	High Intensity therapists	Total therapists	Target population (15% of need)	therapists per 1,000 target population
Croydon	4	7	11	6337	1.7
Enfield	5	10	15	5289	2.8
Waltham Forest	7	10	17	4485	3.8
Greenwich	13	21	34	4619	7.4
WTE workforce needed in Croydon*					
Croydon workforce	20.2	40.4	60.6		

*Source: London Health Programmes (April 2012) Improving Access to Psychological Therapies in London and *Common mental health disorders: commissioning and benchmarking tool – NICE (2011) CMG41*

[127] Department of Health (2012) Investment in 2011/12 - National Survey of investment in adult mental health services, Mental health Strategies, report prepared for DH.
[128] See figures 12c of Department of Health (2012) Investment in 2011/12 - National Survey of investment in adult mental health services, Mental health Strategies, report prepared for DH
[129]London School of Economics and Political Science, Centre for Economic Performance.(2012) *How mental health loses out in the NHS*. London: LSE

IAPT and employment support

Some employment support is integrated within IAPT to help people gain or retain employment.[130]In Croydon, the level of employment support is small and the IAPT service has just one employment advisor. Overall 31 people moved off sick pay/benefits in Croydon 2011/12, representing 4.9% of people who entered treatment during the year, slightly lower than the equivalent figures for London (7.1%) and England (6.8%).

One of the potential benefits of the IAPT programme is to reduce the economic costs of untreated depression in terms of lost employment and welfare benefit claims. Providing good employment support should be a priority.

Referrals and diagnosis

Based on data provided by the Croydon IAPT service, over the seven months from February 2012 to August 2012, the IAPT service received 2275 new referrals and 791 people entered treatment. Four fifths (81%) of referrals were from GPs and just over a sixth (17%) were self-referrals. Half of the referrals were for depression; the remainder were for anxiety (about two fifths) or a mixture of anxiety and depression. A small minority had another diagnosis (average of 4%).

Access by BME groups

Ethnicity was not recorded for a large proportion of referrals (39%). This is largely because a significant proportion of clients do not take up their referral and for these people, ethnicity can only be gleaned from the GP referral form.

Where ethnicity was stated, 32% of referrals were from ethnic minorities, a figure that is lower than expected as approximately 42% of Croydon's population are from ethnic minority communities.[131]It is likely that some of the poor access is a consequence of low diagnosis rates in ethnic minority groups within primary care.

Access to psychological therapies by people from black and minority ethnic groups is one of the CCG (Clinical Commissioning Group) quality indicators recently published by NICE in the mental health Clinical Commissioning Group Outcome Indicator Set.[132]

Access by older people

Only 5% (42/791) of people who entered treatment were aged over 65. Although depression is slighter less common at older ages, 12% of Croydon's population is aged over 65[133] suggesting poorer access by older people. Age and ethnicity are

[130]London Health Programmes (April 2012) Improving Access to Psychological Therapies in London Clinical Assurance Report,
[131] JSNA Overview 2011/12. http://www.croydonobservatory.org/docs/1083713/1246374
[132] NICE (2012) Mental health COF http://www.nice.org.uk/aboutnice/cof/MentalHealth.jsp
[133] ONS Mid-2011 Population Estimates

protected characteristics under the Equality Act 2010 and public bodies have a duty to remove discrimination from their services.

Strategies to increase access by BME groups and older people, although certainly desirable, will also increase referrals overall, for which the service has very limited capacity. In addition, the use of interpreters, which can be essential, has cost implications.

At the time of writing this report, the service was using an information system that it had inherited from the previous providers and did not provide full analysis tools. Because of this, the IAPT service was not able to provide detailed breakdowns by age, sex, primary diagnosis, nor was it able to report the proportion of people that had long term conditions or comorbid serious mental illness, two of the government's four priority groups. The service reported that more information was recorded than could be extracted from the systems. A new information system was introduced in October 2012 that is intended to improve the information flow.

In summary

IAPT is seen as a high quality service. However it has relatively low capacity, long waiting times (approximately five to six months) and a relatively small employment support service.

It currently treats 3% of people with anxiety or depression, only one fifth of the Department of Health target for the end of 2014/15 of 15%.

To increase capacity would require investment. There is some evidence that extra investment would be more than recouped through savings in treatment of physical health conditions and reductions in employment related benefit payments

IAPT has poor access by BME groups and older people.

At the time of writing, the limited information system meant that detailed information was not available about access by age, sex, diagnosis, physical health conditions and by people with medically unexplained symptoms, which are the categories identified by the government as priority groups for expansion of services. The information system has been updated and this information should be available in the future

Recommendation 17

As a priority, commissioners need to reduce waiting time for IAPT services and increase its capacity so that IAPT can meet the Department of Health 2014/15 target of reaching 15% of people in need.

Recommendation18

That commissioners, the IAPT service and voluntary sector groups explore reasons

behind lower access to IAPT services by BME groups and older age groups and take steps to improve access for these populations.

Recommendation 19

That commissioners and providers consider how best to ensure that, with the introduction of the new IAPT information system, the service is able to report in detail on access by the priority groups identified by the government.

Recommendation 20

That commissioners, the IAPT service and primary care explore why ethnicity is poorly recorded at the point of referral.

Psychological therapies and people with medically unexplained symptoms

Medically unexplained symptoms (MUS) are physical symptoms that have no currently known physical pathological cause. It is estimated that 1% of the GP population suffers from severe MUS[134] which would equate to 2,700 people in Croydon aged over 18.

Identifying and managing people with MUS appropriately is important because people with MUS are high users of health care resources, sometimes with limited or no benefit and the more they are investigated and referred, the more difficult it becomes to help them. It is estimated that between 20% and 30% of consultations in primary care and 50% of contacts in secondary care are with people who are experiencing MUS and have no clear diagnosis.[135]MUS can result in unnecessary and costly referrals, diagnostic tests and operative procedures.

Up to 70% of people suffering with MUS will also suffer from depression and/or anxiety disorders. These mental health disorders are detectable and treatable, irrespective of the explanation for the physical symptoms. Psychological treatment can also reduce the use of healthcare. There is evidence that CBT is one of the most cost effective interventions for people with MUS and produces net cost savings within two years.[136]The government wants to increase access to talking therapies for people with MUS as a priority over the next two to three years.[137][138]

[134] Commissioning Support for London (2011) *Medically Unexplained Symptoms (MUS) Project implementation report* London: CSL
[135] IAPT (2008) *Medically unexplained symptoms positive practice guide*. NHS IAPT
[136]McDaid D, Park A-La, Parsonage M (2011) Making the economic case for tackling somatoform disorders. *Psychiatrische praxis*, 38 (S 01).
[137] Department of Health (2011) *Talking therapies: A four-year plan of action*. London: Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123759

An evaluation of pilot sites that are developing models for expanding access to talking therapies for people with MUS and LTCs is due in autumn 2013.[139] Best practice guidance has also been published [140] and a London pilot identified key priorities for development including the identification and coding of patients with MUS in primary care.[141]SLAM have set up a pilot project in Southwark and Lambeth to transform the care of patients with MUS and to develop primary / secondary care pathways. Croydon CCG should consider the findings of this pilot evaluation and whether there would be benefits for Croydon's population in commissioning a similar service.

Recommendation 21

That commissioners consider adopting a whole systems approach to identifying patients with medically unexplained symptoms (MUS) at an early stage, and offer psychological therapies to these patients, starting with improved identification and coding in primary care.

8.6 Step 4 – more complex need

Services for people with more complex need are delivered in secondary care. This section will describe briefly the secondary care services for people with depression and describe, in detail, two of the main services for adults of working age with depression. This section also outlines key issues raised by secondary care service users based on their experiences.

The section is subdivided into four sections:

- Secondary care services used by people with depression
- CIPTS (Croydon Integrated Psychological Therapies Service)
- MAP Community Teams
- Service user experience

8.6.1 Secondary care services used by people with depression

People accessing Step 4 secondary care services have more complex needs. They may not be responding to treatment, their depression may be persistent or they may be a risk to themselves or others.

[138] Department of health (2012) *No health without mental health: A cross-government mental health strategy for people of all age*s. London: Department of Health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

[139]www.iapt.nhs.uk/ltcmus/ltcmus/

[140] Commissioning Support for London (2010) *Medically Unexplained Symptoms – a whole systems approach*. London: CSL

[141]Commissioning Support for London (2011) *Medically Unexplained Symptoms (MUS). Project implementation report* London: CSL

People with a diagnosis of depression aged 18 to 65 who have contact with secondary care will be treated by the **Croydon MAP CAG (mood anxiety and personality disorder Clinical Academic Group)** teams.

Other secondary care services used by people with depression include:

- **OAMH CAG -** Older adults with depression who would benefit from secondary care interventions are managed within the OAMH CAG (older adults mental health clinical academic group).
- **Psychosis CAG.** People with depression in the Psychosis CAG receive psychological therapies delivered by staff within the psychosis CAG
- **Psychiatric Liaison service** People admitted to CUH (Croydon University Hospital) with psychiatric problems, including depression, are managed by the psychiatric liaison service provided by SLAM
- **Psychiatric inpatient admissions**– for people in crisis who are assessed as needing inpatient treatment
- **A&E –** accident and emergency used by people in crisis who have not found an alternative way of meeting their need

Information on some of these services is covered in the schizophrenia chapter. Data on depression-related inpatient admissions was not available at the time of writing.

The MAP CAG has three main services that deal with depression:

- **IAPT** (described in the previous section) - aimed at people in Steps 2 and 3
- **CIPTS** (Croydon Integrated Psychological Therapies Service) - based at Tamworth Road
- **MAP Community teams** - MAP East, based at Tamworth Road, and MAP West, based at the Purley Resource Centre.

In addition, MAP CAG is developing a **Reablement Service** in Croydon, funded as a one year pilot by the Reablement & Discharge Board within the Council. It will work alongside the MAP Community Teams to support patients who would otherwise be supported through care co-ordination, provided by the secondary mental health service. The service will deliver an intensive programme of brief health and social care interventions over a period of six to eight weeks. It is not covered in this chapter because at the time of writing, the reablement pilot had not started.

The **SUN project** is not covered in this chapter because it is aimed at people who have longstanding emotional and behavioural problems (personality disorder) rather than depression.

Primary diagnosis of people on CIPTS and MAP Community Team caseload

A snapshot of the CIPTS and MAP Community Team (MAP East and MAP West) caseloads is shown in **Table 10**. A quarter (22%) have missing or no diagnosis.[142]It may be that some people who do not have a diagnosis are waiting or have not yet seen a psychiatrist. Individuals may attend both CIPTS and MAP teams, therefore totals cannot be reached by summing figures for all services.

Of those with a diagnosis code, two in five (38%) have a primary diagnosis of depression. This is likely to be an underestimate since many others will have depression either as part of their presenting condition (e.g. bipolar affective disorder) or in addition to their presenting complaint (for example personality disorder with a comorbid diagnosis of depression). Bipolar affective disorder and emotionally unstable personality disorder account for two of the three most common single diagnosis codes, aside from depression (**Table 11**).

Table 10: Snapshot of caseload (active and waiting) for CIPTS, MAP East and Map West in October 2012

	People (active or waiting)	Number (%) with Primary diagnosis of depression[143]	Number (%) with blank or no diagnosis[144]
MAP East Team	906	252 (28%)	197 (22%)
MAP West Team	661	239 (36%)	97 (15%
CIPTS	527	164 (31%)	130 (25%)
ALL services	**1855**	**553 (30%)**	**407 (22%)**

Source: South London and Maudsley (2012) data extract

Table 11: most common single diagnosis codes for people in MAP CAG at October 2012

Primary Diagnosis code (ICD10 code)	number	% of total MAP CAG
Emotionally unstable personality disorder (F60.3)	132	7%
Bipolar affective disorder (F31)	84	5%
Post-traumatic stress disorder (F43.1)	79	4%

Source: South London and Maudsley (2012) data extract

8.6.2 Croydon Integrated Psychological Therapies Service (CIPTS)

The CIPTS service is aimed at people aged 18 to 65 with moderate to severe complex mental health problems that can be treatment-resistant or recurrent, or associated with complex personality disorder and interpersonal dysfunction. To be seen in CIPTS, treatment usually needs to have already been tried at primary care level and symptoms persisted. It offers five kinds of therapy:

- CBT (Cognitive Behavioural Therapy)
- CAT (Cognitive Analytic therapy)
- Psychodynamic therapy (either individual or group)

[142] ICD10 code Z71.1 person with feared complaint in whom no diagnosis is made orICD10 code F99 Mental disorder, not otherwise specified
[143] ICD10 codes of F32, F33, F34 or F41.2
[144] ICD10 code Blank or F99 or Z71.1

- EMDR (Eye Movement Desensitisation and Reprocessing therapy)
- NET (Narrative Exposure Therapy)

The CIPTS service was described as high quality and as being a strong asset by the survey consultation. The National Audit of Psychological Therapies baseline report for 2012 found that CIPTS performs very well and is in the top 25% of services for two standards: delivering appropriate, evidence based therapy (100% of CIPTS patients) and for delivering therapy either until recovery or as recommended by NICE (87% of CIPTS patients).[145]

Waiting times

Waiting times for CIPTS are extremely long. **Table 12** shows average waits of over a year for two of the three services (CBT and psychodynamic therapy). Some people waited over two years from referral to starting treatment.

Excessively long waiting times for therapies was the strongest challenge identified in the chapter consultation and was mentioned universally in stakeholder meetings and events.

Table 12: CIPTS waiting times (September 2012)

	Numbers waiting for therapy	Average waiting times from referral to start of treatment in weeks (years, months)	Max waiting times from referral to start of treatment in weeks (year, months)
CBT*	68	63 weeks (1 year, 2 months)	86 weeks (1 year, 8 months)
CAT	23	44 (over 10 months)	68 (1 year, 4 months)
Psycho-dynamic	76	81 (1 year, 6 months)	129 (2 years, 6 months)

**includes people waiting for EMDR and NET*
Source: Croydon Integrated Psychological Therapies Service waiting list report, October 2012

A waiting list initiative that funded four Band 7 posts gave additional support to CIPTS and brought down the numbers on the waiting list. Numbers of people on the waiting list have increased again since the waiting list initiative ended. The numbers of people on the waiting list increased from 108 in January 2011 to 167 in September 2012.

The National Audit of Psychological Therapies baseline report for 2012 found that CIPTS was in the bottom 25% of trusts for both of the waiting times standards

[145] National Audit of Psychological Therapies Additional Analysis for Secondary Care Services – Baseline Audit 2012

presented in the secondary care report. It found that 28% of patients were assessed within 13 weeks of referral and 6% began treatment within 18 weeks of referral.

It is of real concern that such a large number of people, many of whom have multiple diagnoses and personality problems, are waiting for such long periods of time for psychological therapies.

Access by BME groups

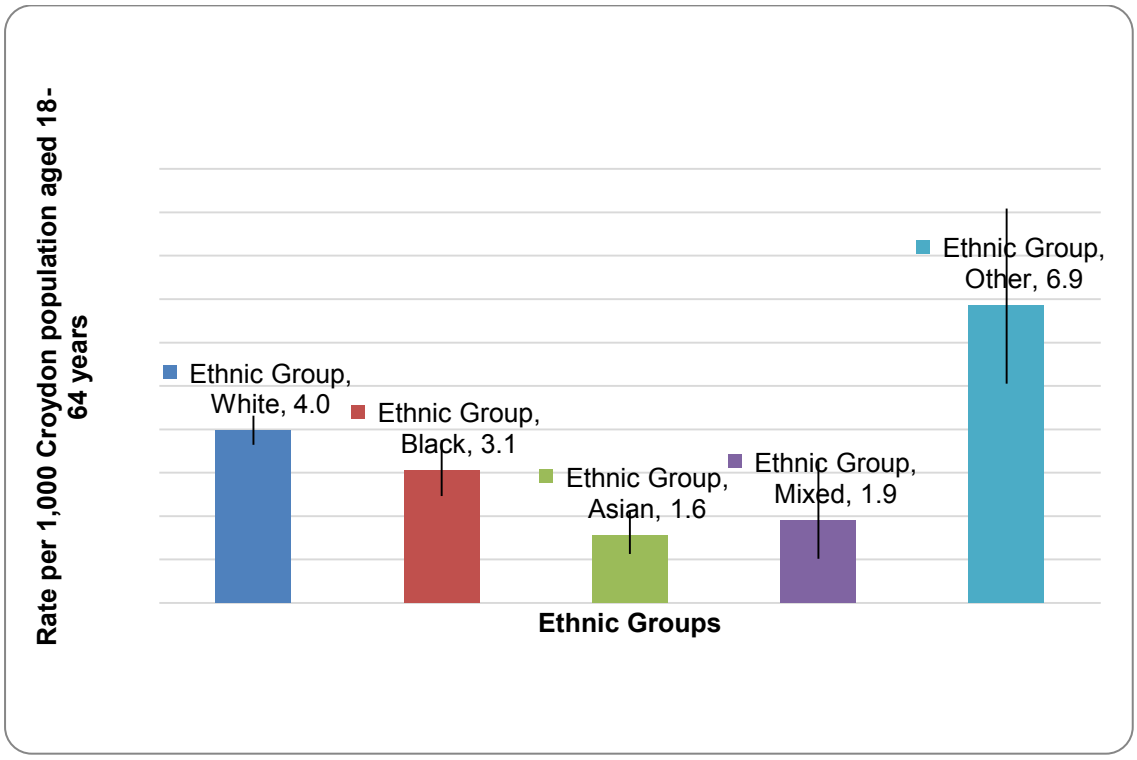
Figure 15 shows the variation in ethnicity for the 750 individuals who were either accepted on the CIPTS caseload as at the end of October 2012 or who had been discharged in the 18 month period of April 2011 to Oct 2012. It shows that people of Asian and mixed ethnic origin are less than half as likely to be on the CIPTS caseload than white populations. Twenty three percent of the Croydon population are Asian or of mixed ethnicity and this group is set to grow to 30% by 2021.[146]It also shows that people from "other" backgrounds are more likely to be on the CIPTS caseload. These findings are statistically significant although they may reflect a problem with data quality.

The CIPTS service reported a number of additional issues facing the service:

- It has been harder for CIPTS patients to access services in crisis, such as the Foxley Lane Women's service, due to the demands on the service. Foxley Lane Women's service provides an alternative to admission to the wards at the Bethlem Royal Hospital. It has historically been used to help CIPTS patients to manage risk and crises during therapy so that they can continue attending and making use of the therapy.
- Young asylum seekers aged over 18 years often do not speak English so cannot access services, such as those that reduce social isolation, unless an interpreter is available. This means they have a reduced support network and can be seen as a silent group with no voice.
- Due to historical low investment, Croydon has reduced access to other services provided by SLAM such as schema therapy for people with Borderline Personality Disorder.

[146] Overview Chapter

Figure 15: Variation in CIPTS caseload per 1,000 population by ethnicity, Croydon 2011/12



Source: South London and Maudsley (2012) data extract and 2009 ONS population estimates by ethnicity

Eligibility for social inclusion services

Although all of CIPTS patients have complex mental health problems, not all of the people using CIPTS services are on CPA(Care Programme Approach)[147].In October 2012 only about 1 in 10 (12%) of the 192 people on the waiting list were on CPA.

This is important as this restricts access to social inclusion services. Under current arrangements, an individual must either be on CPA or FACS (Fair Access to Care Services)[148] eligible at levels "substantial" or "critical" before they can be referred to social inclusion services such as employment support. This assessment is carried out by SLAM and therefore a pre-requisite is that the individual has been referred to secondary care.

Many stakeholders reported that needing to be on CPA or FACS eligible before they can access other support services in the community is a barrier to improving outcomes. It could be argued that the eligibility criteria encourage the idea of a "sickness service" where people have to demonstrate high levels of need before they can access support.

[147] CPA is a tool used by the secondary services to manage the most complex and "needy" clients
[148]Fair Access to Care Services is a system for deciding whether and how much publicly funded social care support a person with social care needs can expect.

In summary

CIPTS is recognised by stakeholders as a high quality service and this is supported by national audit findings

Capacity is small and waiting lists are very long with average waits of over a year for two of the three CIPTS services

Whilst waiting, a person's condition can deteriorate

People from Asian and mixed ethnic groups have poorer access the CIPTS service

The service reports that access to CIPTS has become more difficult for people in crisis and that access to CIPTS is difficult for asylum seekers.

The need that individuals meet certain criteria (CPA or FACS eligible) in order to access some services is seen as a barrier to improving outcomes.

Recommendation 22

As a priority, commissioners need to reduce waiting times to talking therapies for people with complex needs who have depression.

Recommendation 23

That commissioners, primary care and the CIPTS service explore the reasons behind lower access to CIPTS by Asian and mixed ethnicity groups, and take steps to improve access for these populations.

Recommendation 24

That commissioners work with the CIPTS service to explore how best to improve access by young asylum seekers and people in crisis.

Recommendation 25

That commissioners consider reviewing the CPA / FACS criteria whereby only people on CPA or who are FACS eligible can be referred to some services such as social inclusion services.

8.6.3 MAP community teams

People can be referred to the MAP CAG (mood anxiety and personality disorder clinical academic groups) community teams for a number of reasons. An individual may need a medication review, have social needs such as mental health related housing issues, and/or be suicidal or self-harming. People accepted on to the MAP teams may only need one or more outpatient appointments, for example, to review their medication. Others may need a care coordinator (CC) who can help the service user achieve one of more goals such as getting back to work, reducing their social isolation, or improving their housing.

Between the 12 months November 2011 to end October 2012, 1,679 referrals were made to MAP East and MAP West of which 1007 (60%) were accepted following assessment. Over 80% of referrals were made by GPs, with the remaining referrals made by other clinical specialities, hospital, by A&E, by the local authority or by self-referral.

Access by BME groups

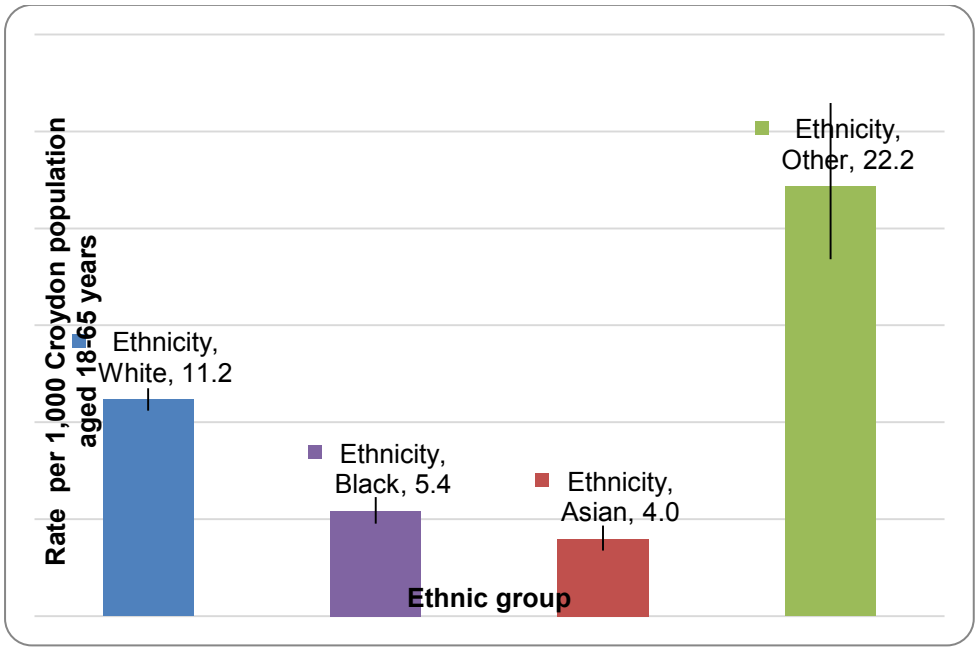
Figure 16 shows the variation in ethnicity for the individuals on the MAP East and MAP West caseload. The graph shows that people of black and Asian ethnic origin are half as likely to be on the MAP team caseload than white populations. It may be that some of this poor access is explained by the lower depression diagnosis rates for BME groups in primary care. The graph shows that people from "other" backgrounds are more likely to be on the MAP Team caseload. This finding is statistically significant although it may reflect a problem with data quality.

Access to community mental health services by people from black and minority ethnic groups is one of the quality indicators in the mental health Commissioning Outcomes Framework (COF) recently published by NICE.[149]

Recommendation 26

That commissioners, primary care and MAP teams explore the reasons behind lower access to MAP CAG teams by black and Asian groups, and consider what steps might improve access for these populations.

Figure 16: Variation in MAP CAG caseload by ethnicity, Croydon Oct 2011-Sept 2012



[149] http://www.nice.org.uk/aboutnice/cof/MentalHealth.jsp

Source: South London and Maudsley (2012) data extract and GLA 2011 population projections by ethnicity.

Primary / secondary care interface

The service reports that the current care coordinator (CC) caseload is very high – up to an estimated 30 service users per CC. The high workload means that CCs are dealing with crises rather than planning for discharge back to primary care.

The service reported that there was a need for CCs to focus on achieving pre-agreed goals with service users and discharging them back to primary care when their needs are lower. The service also reported that there was scope for improvements in the interface between primary and secondary care – some GPs are less willing than others to take back the management of people discharged from secondary care. The chapter consultation also identified this as a key issue and it is further explored in the schizophrenia chapter.

Service users and carers also identified a need for more training for CCs in social care.

Recommendation 27

That commissioners, working with the MAP CAG teams and primary care, explore ways to improve the primary / secondary care interface.

8.6.4 Experiences of service users and carers

This section looks at the issues identified by services users through two mechanisms:

- Linkworker project run by Hear-Us
- PEDIC ((Patient Experience Data Information Centre) information collected by SLAM

It is also informed by the chapter consultation.

Good patient experience is central to delivering a high quality service and one of the government's six mental health objectives outlined in its mental health strategy is that "more people will have a positive experience of care and support."[150]

Chapter consultation

Key themes arising from the service user and carer consultation were poor communication between staff and service users and poor attitudes of staff in secondary care when talking to services users. These comments related to the whole of mental health service users' experiences and were not linked to specific

[150] Department of Health (2012) *No health without mental health: A cross-government mental health strategy for people of all ages*. London: Department of Health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

services. Service users and carers identified the need for greater empathy and sensitivity and noted a lack of staff engagement during inpatient stays.

Linkworker project

The linkworker project aims to monitor and evaluate mental health services in Croydon through speaking to service users.[151]It works with many services, including those based at Tamworth Road,(which includes CIPTS and the MAP East team) and is planning to work with services based at the Purley Resource Centre (which includes the MAP West team). Issues identified by service users are collated and published and SLAM regularly works with the project to respond to issues. The main issues raised during linkworking sessions centre around care and patient experience rather than clinical treatment. One of the top five reported issues is of poor quality of care from staff in terms of availability, supportiveness and caring attitudes.[152]

The two specific issues reported for Tamworth Road were that the atmosphere in the reception area was unwelcoming and that care coordinators were perceived to be unavailable and reluctant to make home visits.

Advice about benefits and housing

One of the top five issues reported by the linkworkers is concern around welfare and benefits with frequent requests for more advice or input from welfare/benefits services. The need for more advice and support about not only benefits but also housing and employment was also identified in the consultation.

Housing needs delay access to services. If an individual has a primary need for housing, they do not qualify for CIPTS therapy. It can take months until housing issues are resolved, and this will mean a delay for people in accessing services.

The huge national changes in the welfare benefits system and cuts to the benefits budget mean that additional support is needed now and over the next few years to help service users and their carers claim their appropriate benefits and, for many, manage the transition to lower levels of welfare support.

PEDIC (Patient Experience Data Information Centre)

SLAM uses PEDIC (Patient Experience Data Information Centre) to analyse patient satisfaction data across all teams, CAGs and services within SLAM, not only in Croydon, but also Lambeth, Southwark and Lewisham. It is not currently possible to separate out the issues that affect Croydon and findings can therefore only be used as a general indication of potential issues within Croydon.

[151] http://www.hear-us.org/aboutus/linkworking/linkworkingsindex.html
[152] http://hear-us.org/aboutus/linkworking/linkworkingreports.html

The PEDIC outpatient report for the first quarter of 2012 / 13 (April 2012 to June 2012) identified six areas for improvement. [153]

1. **Having a copy of care / recovery plans.** (60% said they did not have, or did not know if they had, a copy)
2. **Crisis planning**. (45 of all respondents said they had not been offered a crisis plan for emergency mental health situation)
3. **Developing care / recovery plans jointly**. (34% said they did not jointly develop their care/recovery plan with a member of staff, or did not know)
4. **Understanding the different treatment options**. (21% said they did not understand the different treatments available to them, or did not know).
5. **Receiving emotional support**. (21% said they did not receive emotional support from the service when they needed it, or did not know)
6. **Knowing how to make a complaint**. (38% did not know how to make a complaint**).**

The report also highlighted areas where responses had been positive:

1) 81% were actively involved in making decisions about their care
2) 76% understood their assessment when they first came to the service
3) 84% understood their diagnosis
4) 90% felt supported in maintaining their well-being
5) 88% felt they were treated with dignity and respect

There are plans within SLAM to develop the ways in which the collection of service user experience are collected and used to improve services. These plans should include the provision of borough specific feedback.

In summary

A positive experience of care is one of six national mental health objectives.

Croydon specific information cannot be identified from SLAM's PEDIC information.

The Linkworker project is expanding into more services and provides service specific feedback.

Issues raised include:

- Poor communication skills, poor attitude and the need for greater empathy in some staff
- Perceived unavailability of care coordinators

[153]PEDIC Survey results for Trust Wide baseline scores for Community Services. Outpatient new PEDIC results July 2012

- Need for more access to advice on benefits, employment and housing

Recommendation 28

That commissioners work with the voluntary sector and statutory services to support and strengthen provision of advice about welfare benefits and housing.

Recommendation 29

That commissioners and SLAM consider providing Croydon-specific information when developing the PEDIC (Patient Experience Data Information Centre) system.

Recommendation 30

That commissioners and providers together with service users and carers strengthen the gathering of service user and carer experiences and the engagement of service users and carers in the development of services.

9 Next steps

This chapter provides an overview of current and future need in relation to adult depression, a common mental health problem. It identifies **gaps** as well as **assets** and identifies **priorities for future development**. The ultimate aim, however, is to improve mental health outcomes for Croydon's population. Identifying a **process** for taking forward the recommendations is a vital next step.

Many of the recommendations can only be implemented through partnership and multi-agency working. The mental health partnership group has a key role in taking forward this work. Commissioners, providers from all sectors, service users, carers and other stakeholders should work together to consider how the recommendations can be implemented. They need to consider identifying priorities for action in the **short, medium and long term** and how the recommendations fit with the other mental health JSNA chapters. The new commissioning arrangements arising from the Health and Social Care Act may provide an opportunity to review and develop the partnerships.

Evidence of what works and examples of **best practice** and effective models could inform this work. Some examples are given in the text. Given the challenging financial environment, the effectiveness of existing resources needs to be maximised and optimally aligned with the recommendations. Opportunities for disinvestments should be identified where investment in other areas is prioritised.

One of the difficulties experienced in undertaking the JSNA was the lack of data on activity, outcome, effectiveness and cost effectiveness. There is a need to improve the collection and dissemination of data and information about outcomes, activity and support for higher risk or vulnerable groups. Evaluation and monitoring information should be collected and made available so that it is possible to assess the effectiveness of services and support.

Recommendation 31
That commissioners work with providers to improve the collection and dissemination of data around experience, outcomes and activity, as well as access by higher risk and vulnerable groups.

Recommendation 32
As a priority, that the mental health partnership considers developing a mental health strategy based on the recommendations of the JSNA chapters and other relevant mental health work. Such a strategy should include an action plan and identify short, medium and long term SMART (specific, measurable, achievable, relevant and timely) targets with clear timescales and owners.

10 Appendices

10.1 Appendix 1 - JSNA implementation group members

Bernadette Alves, Public Health Consultant, NHS SW London Croydon Borough Team

Patrice Beveney, Commissioning Manager, Mental Health, NHS SW London Croydon Borough Team

Pauline Dawkins, Mental Health Forum facilitator

Dudley Edwards, Croydon Shadow HealthWatch (Imagine Mental Health)

Sue Gurney, Primary Mental Health Pathway Project Coordinator, NHS SW London Croydon Borough Team

John Haseler, Senior Commissioning Manager, Mental Health, NHS SW London Croydon Borough Team

Susan Hector, Service User Representative for users of depression services, Depression Alliance

Alex Luke, Head of Clinical Pathway & Performance Lead Psychological Medicine, South London & Maudsley NHS Foundation Trust

Dev Malhotra, Croydon Clinical Commissioning Group board member

Rachel Nicholson, Health Improvement Manager - Health Inequalities and Mental Wellbeing

Tim Oldham, Coordinator, Hear Us

Richard Pacitti, Chief Executive, Mind in Croydon

Martina Pickin, Locum Public Health Consultant, NHS SW London Croydon Borough Team

Millie Reid, Service User Representative for users of depression services, Croydon Association of Pastoral Care

10.2 Appendix 2 – Acronyms used in the chapter

BME	Black and minority ethnic
BMJ	British Medical Journal
BOP	Books on Prescription
BWW	Big White Wall
CAG	Clinical Academic Group
CAT	Cognitive analytical therapy
CBT	Cognitive behavioural therapy
CC	Care coordinator
CHD	Coronary heart disease
CIPTS	Croydon Integrated Psychological Therapies Service
CMHTs	Community mental health teams
COF (NICE)	Commissioning outcomes framework
CORE-OM	Routine evaluation outcome measure
CSIP	Care Services Improvement Partnership
CPA	Clinical pathway accreditation
CUH	Croydon University Hospital
ePACT	Pharmacy reporting system
ERS	Exercise referral scheme
FACS	Fair Access to Care Services
HMG	Her Majesty's Government
IAPT	Improving access to psychological therapies
LD	Learning disability
LTCs	Long term physical health conditions
MAP	Mood anxiety and personality disorder
MUS	Medically unexplained symptoms

NICE	National Institute for Health and Clinical Excellence
NSC	National Screening Committee
OAMH CAG	Older adults mental health clinical academic group
PHQ	Patient health questionnaire
PND	Post natal depression
SLAM	South London & Maudsley NHS Foundation Trust
SSRI	Selective serotonin re-uptake inhibitor

10.3 Appendix 3 - Views of stakeholders

The chapter consultation included

- A Croydon wide consultative event
- An online survey
- A consultation event held by the Mental Health Forum
- A number of informal stakeholder meetings

10.3.1 Croydon wide consultative event

Held on the 13th September, this event was attended by 42 people including representatives from commissioning, voluntary sector organisations, statutory providers, public health, service user and carer groups.

When asked what Croydon does well to support people with depression, delegates listed the following assets:

- Listening and acting GPs
- Attendance at CUH for non-Croydon residents – referred on to borough-specific services
- Giving out antidepressants
- Consistent follow-up
- Refer to Rape Crisis South London
- Existing talking therapies are good on diversity
- Production of depression guidelines to ensure uniformity of management and prescribing
- SLAM psychological therapies
- Maintaining choice of therapies and interventions for people with depression
- An IAPT service that has a good success rate with client treatment
- SLAM CAG development

Areas for improvement were identified and grouped into themes. For the first two themes, delegates identified specific recommendations:

- Getting into the system – improving access
- More Partnership working
- Early Intervention
- More services in the community
- Better joining up of existing services
- Improving data collection and access to data
- Information and advice
- Professionals following evidence based guidelines and standards
- Targeting specific at-risk groups more effectively.

Recommendations for the theme *Getting into the system – improving access*

- Fairer commissioning – especially to older adults / BME / LD / men / refugees – including more psychotherapists (at all levels)
- "One stop shop" – accessible via GPs, etc. All basic information available in Croydon by voluntary organisations, etc. May need a coordinator and publicise.

Recommendations for the theme *More Partnership working*

- In-reach and outreach of services e.g. advice services in GP surgeries / referrals between services
- Coordination of information and available resources.

10.3.2 Online survey, mental health forum event and stakeholder meetings

To inform this needs assessment, a survey was conducted to gather the views of stakeholders on Croydon's strengths and weaknesses in providing support for people with depression and in providing services to keep people with serious mental illness out of hospital. The full report is available at Croydon Observatory. In addition, stakeholder events were held to discuss the survey questions. This included discussions within the older adults' network and Depression Alliance peer support group, and an event for service users and carers held by the mental health forum, where service users and carers considered the survey questions.

This section describes the responses to the survey depression questions and stakeholder events. The survey was made available online. To encourage responses, it was widely promoted in many ways: a briefing distributed across NHS Croydon, Croydon Council and its partners particularly the voluntary sector, websites (Talk2Croydon), GP newsletters, emails to practice managers. Organisations were encouraged to gather views of staff and service users through promoting it directly.

The survey was open for six weeks between mid-August and end of September 2012. **Table 13** shows that almost 90 people responded. Analysis was carried out for two groups, service users and carers (Group A) and GPs, health and social care professionals, organisations, members of the public and others (Group B). For both groups, themes were identified from the responses to each of the survey questions.

Table 13 Survey respondents

	Type of respondent	Number	Percentage
Group A (33 people)	Service user	19	22%
	Carer	14	16%
Group B	Member of the public	14	16%

(54 people)	GP	4	5%
	Health or social care professional	23	26%
	Other	13	15%
	Total	**87**	100%

Source: online survey analysis (November 2012)

The organisations who responded to the survey were:

- Croydon / Guyana Link
- Family Resource Centre UK Counselling Centre, Thornton Heath
- Mental Health Community Development Worker
- Local surgery Patient Participation Group
- Advice services provider
- WORLD
- Voluntary sector - Mind in Croydon
- Supported housing for young people
- Carers Information Service
- Cruse Bereavement Care in Croydon
- Depression Alliance
- Croydon Council.

Of the 37 people who were service users, carers or members of the public and who completed their personal characteristics:

- 30 (81%) were female
- 25 (67%) were aged 36 to 54, 7 (19%) were aged 65+ and 5 (13%) aged 19 to 35
- 23 (62%) were White British
- 24 (73%) had been diagnosed with depression.

Summary of themes arising from survey responses

Table 14 summarises the themes emerging from the two groups. Some themes came up consistently across both, others were more commonly mentioned by one of the two groups. The challenge of social isolation was mentioned very strongly by service users and carers. Each theme lists in brackets the number of respondents who mentioned the theme and they give an indication of the strength of the theme. There was huge overlap between the survey themes and those identified at the consultative event and the stakeholder meetings. This commonality of issues adds validity to the survey findings.

Issues mentioned by only a small number of people can be as important as issues mentioned by many.

A theme arising from the survey but mentioned more strongly by the service user and carers at the mental health forum event was around staff attitude. Mental health forum service users and carers identified poor communication between staff and services users, fear of reporting abuse, lack of staff engagement and poor staff attitude as key issues. In common with other stakeholders, the need was identified for more non-medical sources of support. Mental health forum respondents also identified the need for better training for staff like care coordinators in social care.

Table 14: Summary of survey themes

Group A respondents Service Users and Carers	Group B respondents GPs, health and social care professionals, organisations, members of the public
What does Croydon do well?	*What does Croydon do well?*
• Nothing / not a lot (13) • GPs (10) • Many secondary care services (mentioned by name) (7) • Voluntary sector support (4)	• IAPT (10) • GPs (8) • Voluntary sector (8) • Quality of secondary care services (5)
Challenges	*Challenges*
• Social isolation, difficult to get out of the house (9) • Delays in accessing talking therapies (9) • GPs (8) • Lack of information (7) • Difficulty accessing services (6) • Stigma / discrimination (6) • Not being listened to / treated with respect (5) • Cost is barrier in accessing services (transport, etc.) (3)	• Waiting times for therapies (mostly) and other services (17++) • Inconsistent referrals from GPs (lack of awareness of what is out there) (10) • Stigma / discrimination preventing people from seeking help (8) • Lack of information (4) • Isolation / loneliness / lack of meaningful activity (4)
Most important change	*Most important change*
• Quicker / easier access to talking therapies (10) • Better patient care pathways – not seeing lots of services (5) • Continue funding support to voluntary sector (4) • Inclusion of carers (4)	• Quicker and more access to talking therapies (15) • Greater support for the voluntary sector and non-medical support (8) • Better public awareness (4) • Referral pathways and information

• Early intervention (4) • More community / well-being services of the kind provided by voluntary sector (7)	(7)
Anything else	*Anything else*
• Negative impact of benefit reviews and the new readiness for work assessment process (3) • More support for carers and family (4)	• Early intervention • On-going support for voluntary sector • Use staff appropriately – i.e. big need for debt, benefits, housing support, not effective for mental health professionals to do this • BME need language specific and culturally specific services • Change in commissioning

Source: online survey analysis (November 2012)

10.3.2.1 What Croydon does well

When asked what Croydon does well, both groups mentioned **GPs** and the **high quality of the services** including IAPT, voluntary sector and secondary care services

> *"I think GPs are generally good at managing depression." Group B respondent*
>
> *"Some GP services have expert primary care professionals in house who are excellent at managing mental health presentations and supporting people with mental health difficulties. However, this is not standard in all GP services - just luck of the draw". Group B respondent*
>
> *"Some GPs are very able and helpful with diagnosis and care / signposting". Group A respondent*
>
> *"Croydon has an innovative and creative IAPT service that is staffed with very motivated people who are working effectively to support people with depression in the borough" Group B respondent*
>
> *"Some of the SLAM employees are brilliant and do a great job." Group A respondent*
>
> *"Good voluntary sector services (esp. counselling and supporting people to make lifestyle changes)" Group B respondent*
>
> *"Joint working with voluntary and charity organisations" Group B respondent*

"My GP & CMHT are brilliant - they see me whenever there is a need" Group A

However, a few Group A respondents said that there was "nothing" or "not a lot" that Croydon did well – a related issue came up again in the final question asking for any other comments, when respondents from Group A said **they felt abandoned** and let down:

"I am not aware of anything that is done well"

"Not a great deal to be honest but in parts the GPs seem to care and are well informed"

10.3.2.2 The challenges

What asked about the challenges, the issue **of long waiting times and difficulties in accessing talking therapies** was the most commonly mentioned theme across the two groups. Many mentioned the **deterioration in an individual's health** whilst on a waiting list

"There are not enough councillors available to carry out treatments for service users. The waiting lists are too long" Group A respondent

"Lack of Staff make it almost impossible to get an appointment" Group A respondent

"Those who's symptoms are "mild" at the moment have to wait a year or more so by the time they are seen, their symptons may be at the point of chronic and developed in to a more serious Mental Health condition" Group B respondent

"The waiting list is well over a year for therapy in the integrated psychological therapies service, which is not helpful or cost effective, as one year on the depression is all the more entrenched, may have involved suicide/ attempted suicide, or hospitalisation or home treatment team involvement, not to mention the length of time the distress has been endured by sufferers and their carers, or the economic implications of being long term off sick or losing their job." Group B respondent

"The speed to get an appointment. I have been waiting months already for a counselling appointment. People with anxiety and depression need help quickly" Group B respondent

However, an issue mentioned much more often by Group A than Group B was **social isolation** and the **difficulty of getting out of the house** as well **as not being listened to**:

"….the totally mind-numbing effect of serious clinical depression, from my experience, makes one unable to do anything, even to organising getting the money together to go out for a bus trip, and, at an even more alarming stage, getting out of bed at all." Group A respondent

"Low self-esteem; No confidence; Being negative; Lack of motivation;" Group A respondent

"Being listened to by service providers" Group B respondent

"We know that people want peer support services to allow people to end loneliness and isolation but these are not supported" Group B respondent

Both groups mentioned the **variability of GP support** – some were excellent, others were not and it felt like a lottery.

"I have suffered from severe depression for some years and have had a great GP who fought hard to get me the services I needed.... I was lucky. You should not have to be lucky. "Group A respondent

"Support is not the same across the borough, it all depends where you live and how fortunate you are with your G.P" Group B respondent

"…. in parts the GPs seem to care and are well informed, sadly this is not in any way a majority experience" Group A respondent

"Some GPs are amazing and others are no good" Group B respondent

Lack of information and the **lack of a coordinated, integrated system** were mentioned by both groups as well as the difficulties in approaching GPs.

"Knowing where to go and who to approach especially if you are isolated, linguistically challenged or uncomfortable with the idea of approaching their GP". Group A respondent

"It's not easy to access the help....if you're depressed you're not motivated to have to trawl through all the information to find out what is correct." Group B respondent

"a lack of knowledge by health care professionals of the full range of other non-clinical support options available to clients" Group B respondent

"All should be better educated and fully aware of all the services, including voluntary, that are available to their patients and also have a better understanding of when would be best to recommend one service or another." Group B respondent

Stigma and difficulties in accessing help were mentioned by some

"The challenge is to combat the stigma around mental health and encourage people to seek help". Group B respondent

"Taking the first steps to seek help from a GP, trusting people - letting down their guard" Group A respondent

"…..depression is a major illness, causing talented people to leave the work place and become pariahs in their society with little respect and support" Group A respondent

"It should be possible to show positive images of the way people with depression continue despite their condition to lead useful lives. This image would be in contrast to the usual view of depressive people as dangerous, difficult and thus to be avoided." Group B respondent

10.3.2.3 Most important change

In responding to the question about what single change would they like to see, **increasing access to talking therapies** was mentioned by both groups and was the most commonly mentioned theme.

"The chance to access talking therapies as soon as possible" Group A respondent

"More funding for therapy treatments both in secondary care and primary care. People have to wait too long for treatment at both primary and secondary care". Group B respondent

"More access to long term talking therapies and reduced waiting time to access this service" Group B respondent

More services of the kind provided by the **voluntary sector** and **more non-medical interventions** were mentioned.

"More investment in non-medical support to help people maintain recovery. Access to peer support services, evening and week end support, and the budget available to be get involved in services" .Group B respondent

"Improved co-ordination between health care professionals and support services offered by the voluntary sector" Group B respondent

"Encourage activity and contact with others" Group B respondent

"I believe that if the voluntary sector is cut anymore it will seriously damage our community. Please do not cut it. We value what we gain and not all of us are eligible for personal budgets to buy the services that keep us well!" Group A respondent

"people given personal budgets to do holistic things that treatment does not provide though medication" Group A respondent

10.3.2.4 Other issues

When asked about other issues, people described a whole range of broad issues including: importance of **early intervention**, targeting vulnerable groups such as **BME populations**, reaching people earlier, the risk of losing focus on service caused by the huge **changes in commissioning** arrangements as a result of the health and social care bill and many others. The negative impact **of benefit reviews and the new readiness for work assessment process** was also mentioned:

"Since the loss of the PCT it is difficult to know how the GP dominated commissioning process will improve services for this client group. The future appears very uncertain with a lack of clear direction" Group B respondent

"There are many people living in Croydon with depression who do not speak English. As such they are less able to easily access community supports (e.g. MIND, Imagine, etc.). It would be really positive there were more social /support services within the community for this group" Group B respondent

"It makes life very difficult for a person with depression to concentrate on getting better when you are being hounded to go out and look for work when you are not ready". Group A respondent

10.4 Appendix 4 - NICE guidance

Below is a list of mental health and well-being NICE guidance and tools:

- The Clinical Commissioning Group Outcome Indicator Set (CCG OIS), Mental Health. (2012)
- Depression: Evidence Update April 2012
- Depression in adults with a chronic physical health problem: Evidence Update March 2012
- Depression in adults quality standard (2011)
- Common mental health disorders: identification and pathways to care. NICE clinical guideline 123 (2011)
- QS14 Service user experience in adult mental health (QS14) Quality Standards, QS14 (2011)
- CG136 Service user experience in adult mental health NICE Clinical Guidance (2011)
- NICE Commissioning guide - Commissioning stepped care for people with common mental health disorders NICE Commissioning Guide CMG41 (2011)
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010)
- Promoting mental well-being at work. NICE public health guidance 22 (2009)
- Depression in adults with a chronic physical health problem: treatment and management. NICE clinical guideline 91 (2009)
- Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009)
- Vagus nerve stimulation for treatment-resistant depression. NICE interventional procedures guidance 330 (2009)
- Mental well-being and older people. NICE public health guidance 16 (2008)
- Promoting physical activity in the workplace. NICE public health guidance 13 (2008)
- Transcranial magnetic stimulation for severe depression. NICE interventional procedures guidance 242 (2007)

10.5 Appendix 5 – Read codes and British National Formulary (BNF) Codes

Clinical Terms Version 3 (CTV3) Read codes and British National Formulary Codes used in the analyses of this chapter

CTV3 Read Codes used for 'GP diagnosed' Depression

Read Code	Term ID	Status	Term description
All codes under the parent CTV3 read code 'X00SO' grouped as Mild, Moderate, Severe depression or Other depression.			
X00SO	Y01FA	C	Depressive disorder
Including:			
Eu33.			[X]Recurrent depressive disorder (& [episodes of depressive reaction] or [episodes of psychogenic depression] or [episodes of reactive depression] or [seasonal depressive disorder])
Eu330	YMB49	O	[X]Recurrent depressive disorder, current episode mild
Eu334	YMB4D	O	[X]Recurrent depressive disorder, currently in remission
Eu33y	YMB4E	O	[X]Other recurrent depressive disorders
XE1Zc	YMB48	O	[X]Recurrent depressive disorder
But excluding:			
62T1.	Ya2XC	C	Postnatal depressive disorder
X00S8	Y01Cd	C	Post-schizophrenic depression
X40Dl	Y418V	C	Mild postnatal depression
X40Dm	Y418Y	C	Severe postnatal depression
Xa11O	Y01Fn	C	Maternity blues
XaY2C	Yaudm	C	Antenatal depression
XSKr7	YamzO	C	Cotard syndrome

CTV3 Read Codes used for Patient Health Questionnaire (PHQ-9) Scores

Read Code	Term ID	Status	Term description
XaLDN	Measurements	PHQ-9 score	Patient health questionnaire (PHQ-9) score

British National Formulary Codes for Anti-depressants and Anxiolytics:

Andti-depressants: Sections 4.3., 4.3.1., 4.3.2., 4.3.3., and 4.3.4.

10.6 Appendix 6 - Treating depression in people with long term physical health problems – evidence

10.6.1 Background and summary

There is evidence that treating depression with psychological interventions such as a course of Cognitive Behavioural Therapy leads to recovery rates of approximately 50%.[154] Such recovery rates mean that the costs of the IAPT (Improving access to psychological therapies) programme are more than recovered through savings to DWP (Department for Work and Pensions) and HMRC (HM Revenue and Customs) in reduced benefits and additional taxes, because more people work.

There is also evidence that the health costs of treating an LTC in someone with an LTC and depression is 45% higher than treating a person with an LTC only.[155]

This appendix summarises the evidence that as well as these wider savings (in tax and reduced benefits) there are savings ***within the NHS*** of treating depression in people with LTCs due to the reduced costs of health-care, through better self-management.

Summary

- UK evidence is strongest for COPD, angina (coronary heart disease), arthritis, diabetes and medically unexplained physical symptoms. However there is also evidence of reductions in use of healthcare in general populations and hospital populations including those with and without long term conditions.
- There were many studies that showed evidence of improvements in healthcare use such as reduced medication use, reduced admissions, better self-care, etc.; however an economic analysis was not always performed. These studies therefore do not add to the evidence base that compares healthcare costs saved with the costs of interventions.[156,157]
- Some evidence is based on economic modelling in the UK of interventions with evidence of effectiveness in the US.
- A number of studies are cited that look at cost effectiveness in the US.

[154] London School of Economics and Political Science. Centre for Economic Performance. (2012)*How mental health loses out in the NHS*. London: LSE

[155] King's Fund; Centre for Mental Health (2012) *Long term conditions and mental health: The cost of co-morbidities*. London: King's Fund

[156]Sharpe, L., T. Sensky, N. Timberlake, B. Ryan, C. R. Brewin and S. Allard (2001). "A blind, randomized, controlled trial of cognitive-behavioural intervention for patients with recent onset rheumatoid arthritis: preventing psychological and physical morbidity." Pain89: 275-283.

[157]Alam R, Sturt J, Lall R, Winkley K (2008) 'An updated meta-analysis to assess the effectiveness of psychological interventions delivered by psychological specialists and generalist clinicians on glycaemic control and on psychological status'. Patient Education and Counselling, vol 75, no 1, pp 25–36

10.6.2 Reports bringing together evidence of cost effectiveness within the NHS

1. **Centre for Economic Performance (2011) How mental health loses out in the NHS**

"When people with physical symptoms receive psychological therapy, the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of the psychological therapy. This is mainly because the costs of psychological therapy are low and recovery rates are high."

"treatments for the "common mental disorders" of depression and anxiety can be self-financing within the NHS."

2. **King's Fund; Centre for Mental Health (2012) *Long term conditions and mental health: The cost of co-morbidities*. London: King's Fund**

"Improved support for the emotional, behavioural and mental health aspects of physical illness could play an important role in helping the NHS to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge"

"providing better support for co-morbid mental health needs can reduce physical health care costs in acute hospitals".

3. **NHS Confederation Mental health networks (2012) Investing in emotional and psychological well-being for patients with long-term conditions** brings together the evidence across diabetes, chronic obstructive pulmonary disease and coronary heart disease, plus medically unexplained symptoms

"The savings associated with psychological interventions for long-term conditions far outweigh the costs"

10.6.3 Details of the UK studies within each report

COPD

Howard et al (2010)[158] looked at including a psychological component in a breathlessness clinic for COPD in Hillingdon Hospital. It led to 1.17 fewer A&E presentations and 1.93 fewer hospital bed days per person in the six months after intervention. This translated into savings of £837 per person – around four times the upfront cost.

Case studies cited in *Investing in emotional and psychological well-being for patients with long-term conditions* include:

- Respiratory well-being clinic, London Borough of Sutton and Merton reported significant cost-saving with reduced A&E attendance and emergency admissions.

[158] Howard C, Dupont S, Haselden, Lynch, Willis. (2010) The effectiveness of a group cognitive behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease. *Psychology, Health & Medicine* 14 4 371-85

A high cost user sub-group showed results suggesting a cost saving over one year of approximately £290,000 or £5 for every £1 invested

- Integrated clinical psychology in a pulmonary rehabilitation team at the Whittington Hospital was estimated to produce significant cost savings outweighing the cost of employing a dedicated psychologist

Angina

UK work done in the National Refractory Angina Centre (NRAC) in Liverpool. Moore et al (2007) found that in the year following a CBT-based disease management programme for angina, patients needed 33% fewer hospital admissions – saving £1,337 per patient per year.[159]

Diabetes

Simon et al 2007, Katon et al 2006, were cited in NHS Diabetes and Diabetes UK 2010.[160] Both are US studies and are described in section 10.6.4

Economic modelling in the UK of a collaborative care intervention involving CBT for individuals with Type II diabetes and depression found the intervention to be cost-effective in an English context after two years. It had high net costs in the first year (£4.5 million) and savings of £450K in the second year. The study also estimated the incremental cost per quality adjusted year (QALY) gained of £3,614 over two years. The estimates of the potential benefits, however, were very conservative; productivity losses due to premature mortality and quality of life advances due to avoidance of diabetes complications (amputations, heart disease etc.) were not factored in.[161]

Medically Unexplained Symptoms

Economic modelling in the UK of CBT for working age individuals who present to GPs with somatoform conditions identified various scenarios where the intervention was cost effective. When targeted solely at patients with full somatoform disorders, the model found net cost saving to the NHS after two years if face-to-face GP training is used. There were net savings after just one year (saving around £60 million in year one) if e-learning is used. When all patients with somatoform conditions (sub-threshold and full disorders) receive CBT, and e-learning is used to increase GP awareness the model shows an overall saving of £639 million over

[159]Moore, R. K. G., D. G. Groves, J. D. Bridson, A. D. Grayson, H. Wong, A. Leach, R. J. P. Lewin and M. R. Chester (2007). "A Brief Cognitive-Behavioral Intervention Reduces Hospital Admissions in Refractory Angina Patients."Journal of Pain and Symptom Management33(3): 310-316.
[160]NHS Diabetes and Diabetes UK (2010). Emotional and Psychological Care and Treatment in Diabetes. London: Diabetes UK
[161]Knapp M, McDaid D, Parsonage M eds (2011) Mental health promotion and mental illness prevention: the economic case. Department of Health

three years, mainly because of reduced sickness absence. The impact on the NHS is broadly cost neutral. [162]

Other conditions

Research in the United Kingdom found that referral to the IAPT programme was associated with a subsequent reduction in emergency department attendances, sickness certification and improved adherence to drug treatment (de Lusignan et al2011),[163]

There are many other examples across the whole age range of psychological need and service innovations in long-term conditions. This includes, for example, psychological need for the patients and carers post-stroke, neurodegenerative conditions, epilepsy, sickle cell disease, cancer and renal disorders. Evaluation of the efficacy of psychological therapies and economic arguments of actual or potential savings associated with provision of psychological care need to be developed in future.

10.6.4 US studies mentioned in the UK reports above

A meta-analysis of 28 randomised controlled trials in the US compared the physical health-care costs for patients given a psychological intervention with patients who were not. In 26 of the 28 trials which recorded the cost of the treatment, this cost was more than offset by the resulting savings in physical healthcare costs. It led to reductions in length of stay by 2.5 days and overall health care costs per patient by about 20 per cent (Chiles et al1999)[164]

Katon et al (2006) looked at the impact of a depression care manager offering education, behavioural activation, and a choice of problem-solving treatment or support of antidepressant management by the primary care physician in patients with diabetes. It found a net benefit of 1,129 dollars.[165]

Simon et al (2007) reported on the cost-effectiveness of systematic depression treatment among people with diabetes mellitus. An RCT of specialized nurses delivering a 12-month, stepped-care depression treatment programme for people

[162]Knapp M, McDaid D, Parsonage M eds (2011) Mental health promotion and mental illness prevention: the economic case. Department of Health
[163]Lusignan S, Chan T, Parry G, Dent-Brown K, Kendrick T (2011). 'Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: a before and after comparison'. Journal of Epidemiology and Community Health[online] doi 10.1136/jech.2011.139873 (accessed on 24 January 2011
[164]Chiles JA., Michael J. Lambert MJ, Hatch AL (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. *Clinical Psychology, Science and Practice* 6 2, 204-220
[165]Katon et al (2006) Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. Diabetes Care. 2006 Feb;29(2):265-70.

with diabetes found a net economic benefit of the intervention of $952 per patient treated.[166]

[166]Simon et al (2007) cost-effectiveness of systematic depression treatment Cost- among people with diabetes mellitus. Arch Gen Psychiatry. 2007 Jan;64(1):65-72.