

A sustainable approach to depression: moving from words to actions



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‘A human being can survive almost anything, as long as she sees the end in sight. But depression is so insidious, and it compounds daily, that it’s impossible to ever see the end. The fog is like a cage without a key.’

Elizabeth Wurtzel, *Prozac Nation*. Riverhead Books, 1994





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Executive summary

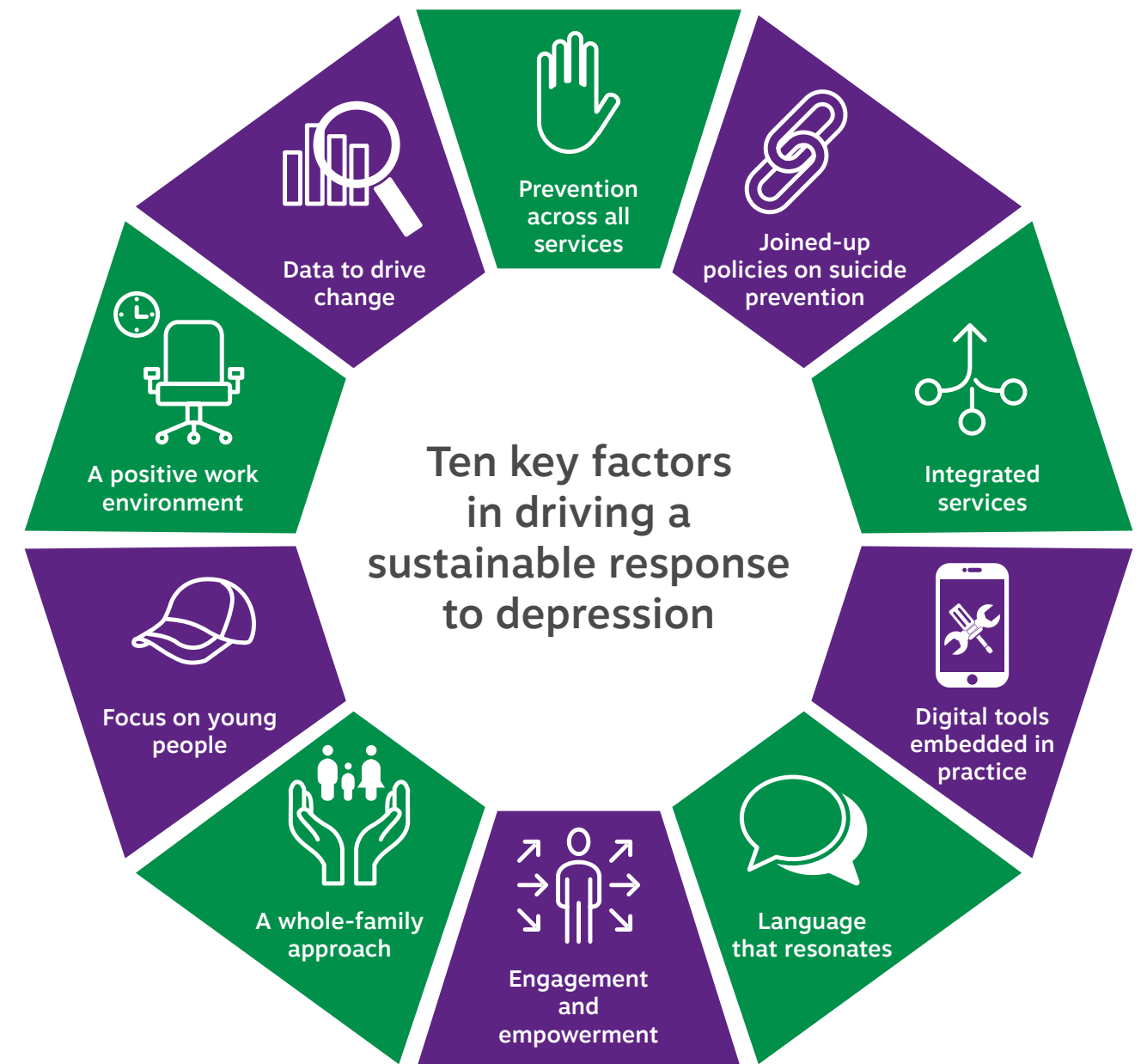
Depression is an urgent and growing concern for our societies: the number of people living with depression rose by 18% between 2005 and 2015.¹ In 2030, depression will be the leading cause of disease burden in high-income countries.²

Depression affects every aspect of a person's life. It has a multiplying effect on other conditions and a significant impact on quality of life. It is a leading cause of low productivity, with a considerable cost to society: €92 billion per year, or 30% more than stroke.³ And tragically, nearly one in five people with depression ends their life by suicide.

Despite these figures, our policy response to depression has, so far, been insufficient. As a society, we lack both understanding of the condition and empathy for those affected. There are huge gaps in diagnosis and care. Mental health services are chronically underfunded. Several promising programmes have been launched to address depression, but sustainable implementation and funding are a frequent problem.

With depression on the rise, it is time to take our social response to depression to the next level. Greater prevention would reduce the incidence of depression by 21%.⁴ Providing all people with depression with evidence-based treatment would reduce the disease burden by a third.⁴ But solutions should not be limited to the clinical setting: we need an integrated, comprehensive response to depression, which tackles its clinical and social causes; engages young people and other vulnerable groups; and addresses the impact of depression across the home, school and workplace.

This report aims to identify key factors that will ensure programmes for depression are sustainable and have a lasting impact on people affected. Drawing from the practical experience of 19 case studies and the published literature, we have identified ten lessons learnt that may help policymakers build a sustainable response to depression in years to come.



1 Incorporate prevention into all services

Prevention is key to responding to the challenge of depression – and a preventive approach should be built into the design of all services. Prevention and early intervention are essential, particularly among younger people and those harder to reach through traditional medical services. Greater clarity about what early intervention means in practice is needed, however, to get more people into appropriate care.



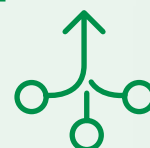
2 Create joint government accountability for the prevention of suicide

Prevention of suicide is a key goal in depression care. Suicide can have multiple causes, therefore a cross-sectoral approach to suicide prevention is key. This needs to be reflected in joint government department responsibility and accountability.



3 Integrate services to make it easier for people to seek help

The legacy of discrimination around mental health means that people are generally averse to the term 'mental illness' and may be disinclined to seek care. Better integration of mental health services within other services may help reach more people. Using a different term, such as 'wellbeing', to denote mental health services may also help remove some of the associated stigma.



4 Embed digital solutions into practice

Digital health tools can help improve treatment choices for people and encourage them to take greater control of their care. However, these tools can meet resistance from some patients and also from health professionals who may not know how to integrate them into their treatment approach. Better training of health professionals and therapists is needed to facilitate blended care, which combines traditional and digital services.



5 Use language that resonates with people

Using language based on people's experiences of care can be an important therapeutic tool. Terms such as 'recovery' are critical to convey a sense of hope and clarify treatment goals. Professionals working with people with depression should be encouraged to use a common language that is easy to understand by everybody and speaks to the experience of those being helped.



6 Engage people in their own and others' recovery

Involving service users and carers in service and policy development will help ensure services work for the people who use them. Services should also draw on the strengths and capabilities of those who have overcome mental health challenges to empower others, for example through peer support.



7 Take a whole-family approach to care

Depression can affect the whole family – therefore, treatment should focus on the whole family, not just the person affected. Services that support carers are particularly important to protect their health and wellbeing.



8 Empower children and young people to talk about depression

Depression is increasing in young people at an alarming rate. We need to help young people use their own resources and skills to become more resilient and cope better with pressure. Digital tools can break through the isolation of young people battling depression and encourage them to seek help.



9 Create a positive work environment for people with depression

Adults spend most of their life in the workplace and depression is one of the leading causes of low productivity. More workplace education programmes are needed to promote a positive workplace culture, help management recognise the signs of depression and support people who are managing depression or returning to work after taking time off.



10 Evaluate practices to drive meaningful change

Lack of real-world data is a key gap in depression. We need greater investment in real-world data on the epidemiology of depression, service use and the impact of interventions and services if we are to better understand existing care gaps and implement sustainable change.



In summary, it is time to take policies targeting depression to the next level and provide sustainable funding to match policy goals. An integrated, cross-service approach, focused on prevention and early intervention, and leveraging new advances in digital medicine, can save lives, reduce the economic impact of depression, and have a dramatic effect on the quality of life for over 35 million people affected by depression across Europe.

Preface

More than 35 million people in Europe are estimated to live with depression.⁵ By 2030, it will become the leading cause of disease burden in high-income countries.² It costs 30% more than stroke³ – up to €92 billion per year.

Mental health awareness has come a long way, but we are still far from providing an adequate response to depression in our societies. Mental health services, particularly in the community, suffer from chronic underfunding.⁶ There is too little focus on prevention, which could reduce the number of new cases by 21%.⁴ Gaps in treatment range from 35–70% between countries; redressing this would reduce the disease burden by a third.⁴ There is also a general perception of people with depression as being uninterested and hard to talk to.⁷ This stigma can deter people from seeking help and achieving recovery.⁸

With depression on the rise, it is time to take our response to depression to the next level. This requires an integrated approach, with partners from all sectors working together towards common goals – and the needs of individuals and their families at the core of all solutions.

This report aims to develop a sustainable response to depression in Europe. It draws from 19 case studies to offer recommendations grounded in the practical experience of addressing depression. It is our hope that these recommendations may help policymakers advance meaningful actions to prevent and reduce the impact of depression across our societies in years to come.



Part 1







What is **depression**, and why does it **matter**?

‘[Depression] is so difficult to describe to someone who’s never been there, because it’s not sadness. Sadness is not a bad thing – to cry and to feel – but it’s that cold absence of feeling, that really hollowed-out feeling.’

JK Rowling, *The Oprah Winfrey Show*. Harpo Studios, October 2010



Depression: key facts and figures

 <p>More than 35 million people in Europe are estimated to be living with depression.⁵</p>	 <p>By 2030, depression will be the leading cause of disease burden in high-income countries – and the second-leading cause globally.²</p>
 <p>It is increasing in young people – and affects one in ten Europeans aged 75 and over.⁹</p>	 <p>It costs €92 billion across Europe³ – 30% more than stroke.</p>
 <p>It is a leading cause of low workplace productivity.^{10 11}</p>	 <p>Around 15–20% of people with depression end their life by suicide.¹²</p>
 <p>Suicide is the leading cause of death among 15–29 year olds in Europe.¹³</p>	 <p>Preventing 20% of suicides would result in cost savings of €1 billion in England alone.¹⁴</p>

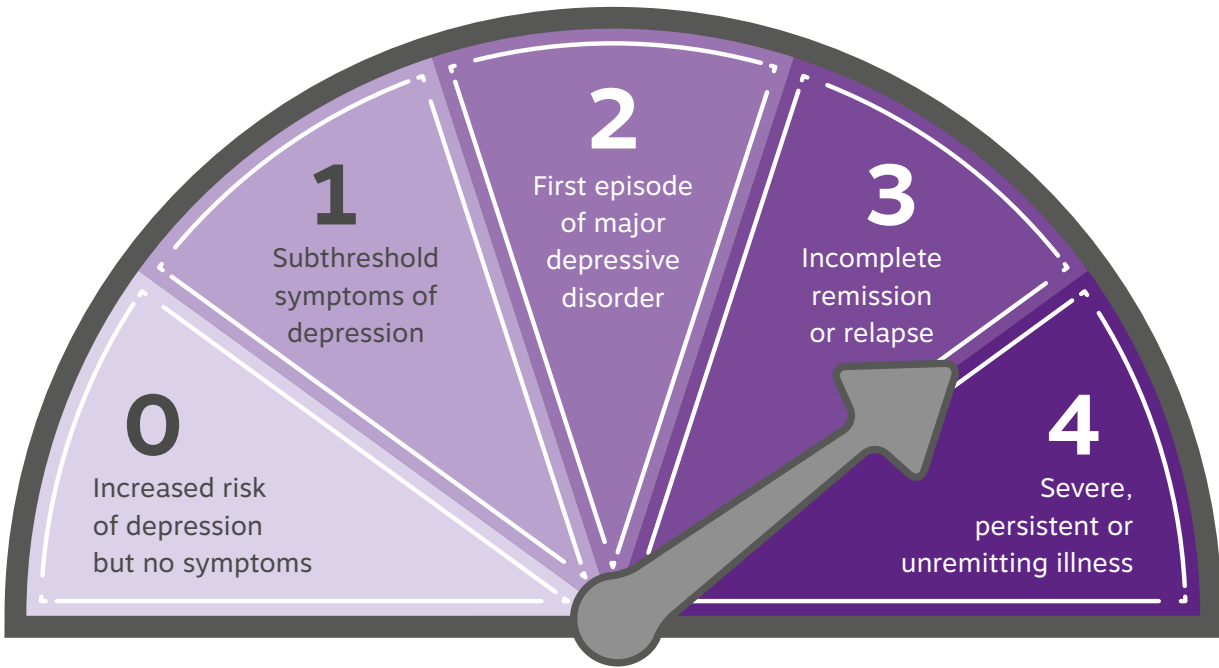
1 A common and enduring condition

Depression* is a common but serious mood disorder affecting over 35 million people in Europe.⁵ According to current diagnostic standards, symptoms include low mood, feelings of hopelessness and guilt, appetite or weight changes, loss of pleasure, lethargy, fatigue and disrupted sleep patterns, among others.¹⁵ A diagnosis of depression is given when a certain number of these symptoms have been present all day, every day for at least two weeks.¹⁵

Depression is a spectrum which evolves along five stages of risk¹⁶ (see *Table 1*). It can present and evolve very differently depending on the individual.¹⁷ A precise, individualised approach is therefore needed to achieve the optimal combination of prevention, treatment and therapy at each stage.

In many cases, depression can be cured from the first episode; in others, it evolves and fluctuates in severity over time. For all cases, the aim of treatment is to reduce severity and duration of the episodes and prevent relapse. Prevention of suicidality is also a critical goal of care.

Table 1.
Clinical stages of depression



* Depression is also referred to as major depressive disorder or clinical depression.

2 A complex condition with multiple causes

Depression has multiple, often coexisting, causes. For example, people who have a chronic disease¹⁸ or are overweight¹⁹ have a higher risk of depression. Women report depression more often than men,⁹ but this may be because men are less inclined to report symptoms. Social factors are also important: low educational attainment, material disadvantage and unemployment are associated with a higher rate of anxiety and depression.²⁰

The rise of depression in youth is a serious concern: it is the leading cause of disease burden in 10- to 24-year-olds.²¹ For example, a study in London found 25% of 14-year-old girls and nearly 10% of 14-year-old boys self-report symptoms of depression.²² Depression beginning in youth is associated with a higher rate of recurrence and poorer outcomes relative to adult-onset depression.²³ It is also less likely to be recognised or treated.¹⁶

Depression is also a concern among the older population, particularly in older women and people living alone.²⁴ One in ten Europeans aged 75 and over reports chronic depression.⁹ The effects of depression in older age exacerbate the effects of chronic conditions, more so than in younger populations.²⁴

3 A considerable cost to society

Depression has a profound impact on all aspects of a person's life – with symptoms affecting how they feel, think, sleep, eat, work and relate to others. This translates into a significant social cost.

Depression bears a considerable cost for people affected, their families and society at large:

- **Depression is a leading cause of low workplace productivity.** People with depression are more likely to take sick leave and early retirement.^{10 11}
- **Having depression increases the risk of chronic conditions.** People with depression have a higher risk of cardiovascular disease, diabetes, stroke, Alzheimer's disease and osteoporosis.²⁵ The health impact of having depression with a chronic condition is greater than the sum of having the two conditions, suggesting unknown interactions between depression and chronic diseases.²⁶ The presence of other conditions (comorbidities) also increases costs of care.²⁷
- **People with depression have significantly lower quality of life²⁸ and depression takes a toll on carers and family members.** Around four in ten carers of people with mental health disorders feel they are unable to cope with the constant anxiety of caring, and one in three feels isolated.²⁹

4 A leading cause of suicide

Depression is one of the major and treatable risk factors for suicide.³⁰ About 15–20% of people living with depression end their life by suicide,¹² and the risk is particularly high during and after major depressive episodes requiring hospitalisation.^{31 32} Suicide is four times more common in men than in women.¹³

Suicidality is not just the act of taking one's life; it is a behavioural spectrum covering suicidal ideation, suicide planning and suicide attempt.³⁰ People who have previously attempted suicide are at greater risk of future attempts and suicidal death:³¹ on average, one in three people contemplating suicide progresses to suicide attempt,³³ and one in five people who attempt suicide will eventually die by suicide.³⁴

Multiple factors other than depression contribute to the risk of suicide, such as unemployment, lack of social support, limitations in activities of daily living, recent stressful life events³⁵ and losing a loved one to suicide.³⁶ Effective suicide prevention thus requires a collaborative care model, including social support or rehabilitation programmes in addition to medicinal treatment.³²



Part 2

Creating a **sustainable approach to depression**: key lessons learnt

‘To change the way we see depression, we need to focus on the person’s journey through society and use a multi-sectoral approach that addresses all aspects of their lives – in particular family, education, and workplace.’

European Federation of Associations of Families of People with Mental Illness (EUFAMI)

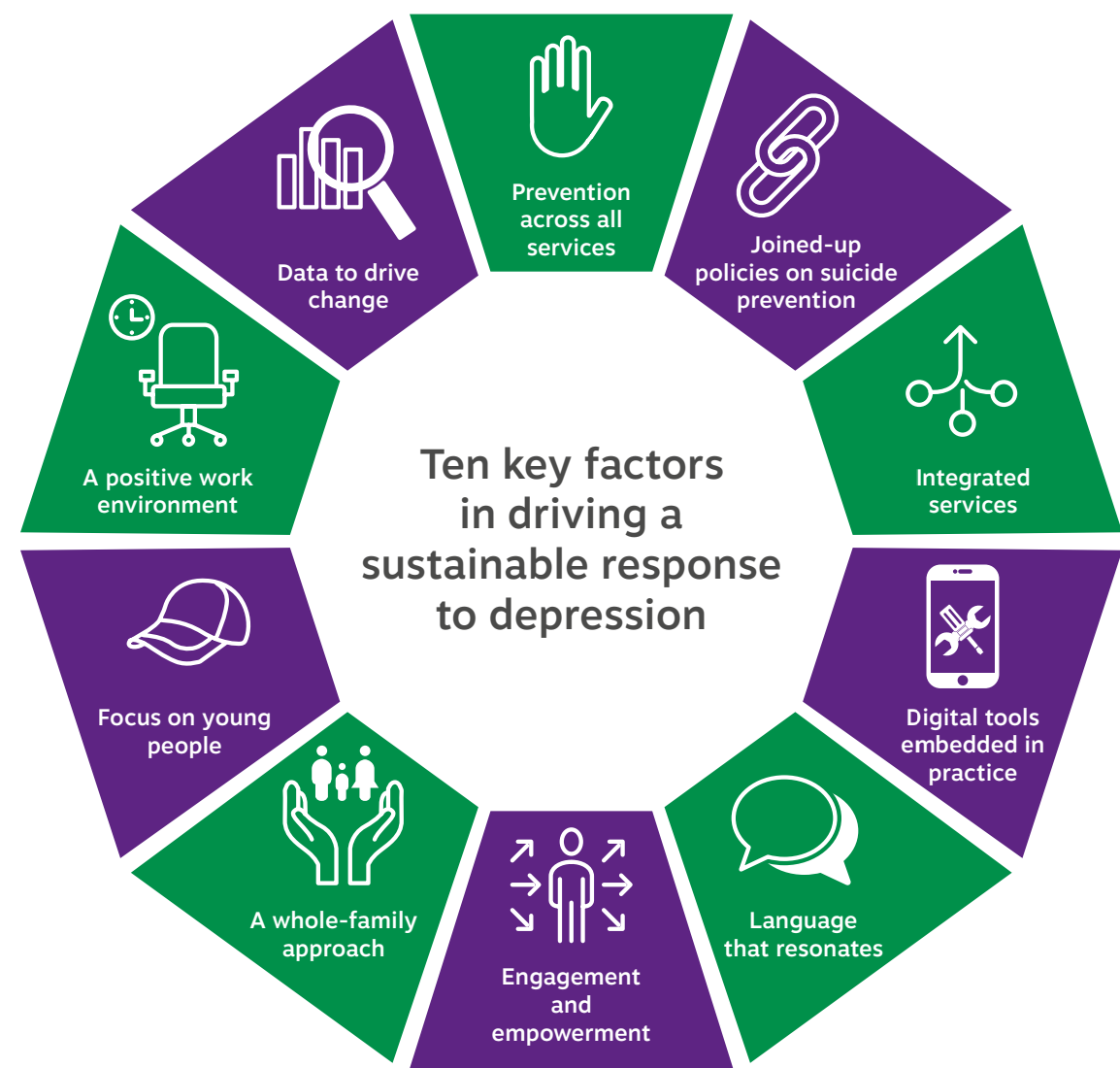


Introduction

There have been several positive examples of programmes, policies and practices targeting depression in recent years. Yet a common challenge for many of these programmes is implementation. Crucially, many programmes focus on an isolated aspect of depression, so they need to be brought together in a comprehensive policy response that matches the complexity of depression.

Against this background, we sought to identify key factors that would create a sustainable, comprehensive framework to respond to depression in our societies. We selected 19 projects or programmes for interview using predefined selection criteria to obtain a broad representation of action areas, level of prevention, target age groups and geographic scope (see *Box 1*). The aim of the interviews was to learn from case study leads' experience of how to ensure the sustainability of programmes targeting depression. We also drew from the literature key examples from which important lessons could be learnt. These combined lessons are summarised in the following section and illustrated in the framework below (*Figure 1*).

Figure 1. Framework for action to provide a sustained policy response to depression



BOX 1 About the chosen case studies

Before selecting case studies, we developed a framework to ensure we had a broad range of case studies covering the following aspects:

- Population targeted
- Setting (e.g. clinical, workplace, school, digital health etc.)
- Aspect of depression addressed (prevention, early intervention, suicide prevention)
- Country.

Case studies that fit the different cells in this framework were then identified through web-based research and suggestions from the expert group.

The 19 projects identified are by no means a comprehensive list, but were selected to cover each of the action areas represented in the framework.

We conducted telephone interviews with case study leads between March and August 2018. We asked what had made each project a success, and what lessons had been learnt from implementation. We particularly sought to identify crucial factors and enablers to developing a sustainable policy response to depression.

Case studies are described in detail in Part 3 of this report, and the framework used to classify them is presented in Appendix 1.



LESSON 1

Incorporate prevention into all services



‘More community services need to be developed to treat mental health illness before it progresses.’

Global Alliance of Mental Illness Advocacy Networks (GAMIAN) – Europe

A preventive approach should be embedded in the design of all services

Prevention is key to responding to the challenge of depression. However, an area requiring clearer definition is early intervention: it is sometimes unclear to different professionals what this means in practice³⁷ and what effective early intervention should look like. This has led to inappropriate referrals and confusion about treatment objectives.³⁷ Common definitions and approaches are needed between all services to improve diagnosis rates and get people into appropriate care.

The focus of preventive efforts must also be appropriate to the severity of depression in each individual (see *Table 2*).

Table 2. Types of prevention across the spectrum of depression

Type of prevention	Aims
Primary prevention	Raise awareness and build resilience to help people develop coping strategies to prevent depression using their own individual resources and skills.
Early intervention	Effectively diagnose and treat the first episode or presentation of depression to improve symptoms and prevent the development or exacerbation of risk factors for relapse. ³⁸
Prevention of progression and relapse	Prevent recurrent episodes and the accumulation of stressors – avoiding an evolution in illness severity and complexity as well as poor response to subsequent treatment. ³⁹
Suicidality prevention	Minimise the risk of suicidal ideation and suicide attempt throughout all stages of depression through the appropriate combination of treatment, counselling and support. ⁴⁰

LESSON 2

Create joint government accountability for the prevention of suicide



‘Suicide is an extremely complex issue which is everyone’s responsibility. It cannot be addressed by the Department of Health alone; it requires active engagement and accountability by all stakeholders in a cross-departmental task force.’

National Office of Suicide Prevention, Ireland

Prevention of suicidality is of critical importance in depression care. Policies for suicide prevention must involve a cross-sectoral approach where all the possible causes of suicide are considered. For example, Ireland’s National Office for Suicide Prevention (see *Box 2*) coordinates and monitors the cross-departmental suicide prevention strategy which is held to account at meetings chaired by the Department of Health. This structure means all the relevant governmental departments are accountable for the progress and outcomes of the strategy.⁴¹

BOX 2

The National Office for Suicide Prevention, Ireland

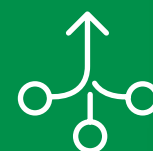
Cross-departmental coordination and accountability

The National Office for Suicide Prevention (NOSP) supports, informs, monitors and coordinates the implementation of Connecting for Life, Ireland’s national suicide-prevention strategy. The NOSP has monitoring and evaluation support, allowing staff to liaise with other departments to identify barriers and work together to overcome them. It ensures the Connecting for Life strategy remains a priority and that its implementation plan is followed and monitored.



LESSON 3

Integrate services to make it easier for people to seek help



‘The repetitive use of the word stigma in mental health is stigmatising in itself: an association between depression and stigma has developed in the minds of people living with mental illness, policymakers and the general public.’

European Psychiatric Association

Mental health services need rebranding

The legacy of discrimination around mental health means that people are generally averse to the term ‘mental illness’. Some programmes have found that using a different term, such as ‘wellbeing’, may better engage individuals in seeking help.^{42 43} For example, having a name that did not sound like a mental health service enabled the STEPS programme in Scotland to appeal to populations who might not have approached a mental health service traditionally.⁴²

Integrating mental health services into other relevant services may also increase rates of care. For example, working with other sectors that have good engagement with certain ‘hard to reach’ communities may help secure engagement with mental health services.^{42 44} This is particularly true for preventive services (see Box 3).

BOX 3 Doing Well programme, Scotland

Merging support for depression with other services

A Scottish self-help service targeting mild to moderate anxiety and depression is merging with smoking cessation and lifestyle advisor services (e.g. weight management), as common mental health disorders are often linked to these health behaviours.

The merger of these primary care-based services will allow:

- parity of funding for mental and physical health services
- development of an accessible service which will provide holistic care to support behaviour change and physical and mental wellbeing
- targeted resources to address health inequalities
- fewer referrals between services
- reduced stigma.

We need to make it ‘easy’ for people with depression to seek and find help

‘When people are made to “jump through a lot of hoops” to obtain appropriate diagnosis and referrals, they may lose hope and effectively lose out on timely treatment.’

STEPS, Scotland

Giving people the power to self-refer and choose their treatment can also be an effective way to engage them in seeking care, especially those who slip through the net in traditional primary care settings (see Box 4). For example, the Improving Access to Psychological Therapies (IAPT) programme in England found that self-referral led to more people from minority ethnic groups accessing services, as well as people who had been experiencing mental health challenges for longer, compared with the traditional GP-referral model.⁴⁵

BOX 4 STEPS programme, Scotland

A high-volume, multilevel, multipurpose approach to common mental health problems

STEPS was a primary care mental health team in Glasgow. The STEPS model provided:

- interventions to people already experiencing common mental health problems (CMHPs)
- preventive and/or early interventions to help stop the development of CMHPs
- interventions to promote wellbeing and resilience in communities.

The STEPS approach actively encouraged people to use the service, instead of waiting for others to refer them, and offered an immediate intervention (within a week) to anyone who felt they needed it.



LESSON 4

Embed digital solutions into practice



‘We are not going to keep up with the demand for therapy; we are already struggling. Using technology will allow clinicians to treat more people and meet the growing demand.’

eMEN, Europe

eHealth interventions in mental health may allow service users to exercise greater choice and control, and manage their own condition more effectively

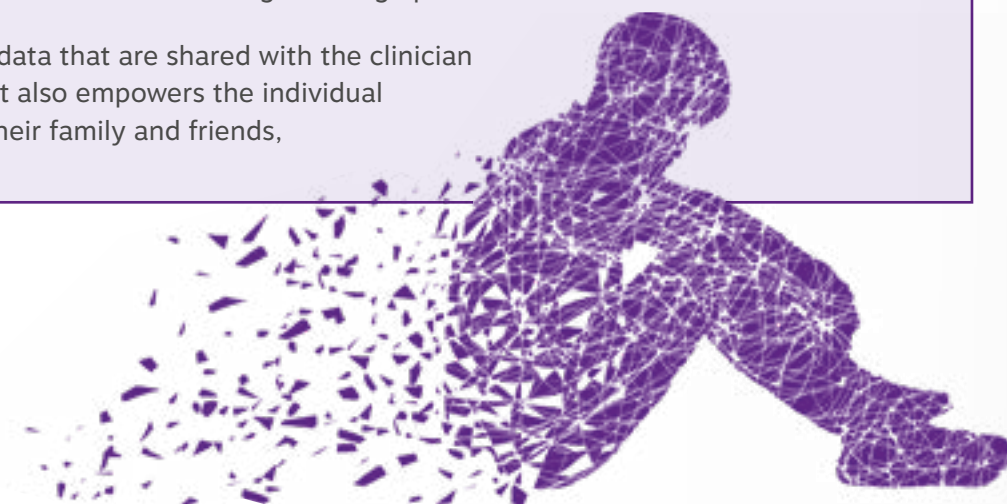
Depression presents diagnostic and treatment challenges. Even when a correct diagnosis is made, psychotherapy and pharmacotherapy are often not tailored to the individual person. Finding the appropriate combination of eHealth and physical services (so-called blended care) will empower people to ask for and receive care that works best for them, and ultimately encourage them to be more engaged in their own care and recovery (see *Box 5*).

BOX 5 iFeel, Israel

Using smartphone technology to track depression-related behaviour

iFeel is a platform enabling sophisticated continuous monitoring of depression-related behaviour. It collects real-time information and alerts the individual and their chosen ‘trust buddy’ when clinically significant deviation from regular usage patterns occurs.

This produces reliable data that are shared with the clinician to support treatment. It also empowers the individual to seek support from their family and friends, not just their doctor.



Professional training on digital technologies is needed to secure integration into mainstream care

Some healthcare professionals may be resistant to adopting digital solutions into existing ways of working. Therapists must be equipped with the right skills to work in a blended care environment.^{42 45 46}

Blended care, combining traditional clinical care and digital approaches, can be more efficient for patients and the health system. Digital health tools require fewer face-to-face meetings and therefore fewer resources. Digital health also allows more choice of treatment options and flexibility.⁴⁶ However, implementation may be difficult in traditional care settings. The eMen project aims to help overcome some of these barriers (see *Box 6*).

BOX 6 e-Mental health innovation and transnational implementation platform (eMEN), Europe

Implementing digital tools in clinical settings

eMEN is a platform for the cooperation and implementation of e-mental health tools in north-west Europe by furthering the notion of blended care. The project develops digital technologies for mental health by holistically addressing the different implementation factors, such as policy and product development, quality and safety, communication, digital skills development, financial and organisational sustainability and management. All technologies are piloted in clinical settings and incrementally scaled-up.

Marketing algorithms can be used promote support services online for high-risk people

Social media marketing algorithms can be built into awareness campaigns to identify people experiencing suicidal thoughts and the people close to them. For example, a suicide prevention campaign in Switzerland worked with a commercial agency to target high-risk individuals (see *Box 7*).⁴⁷

BOX 7 Speech can Save suicide prevention campaign, Switzerland

This campaign was initiated by the Department of Health Canton of Zurich and the Swiss Federal Railways. It made use of social media algorithms to target advertisement banners promoting open discussion with friends and family, along with crisis hotline numbers, to high-risk individuals and their networks. This led to a 584% increase in the number of visits to the campaign’s website, a 141% increase in the number of young people calling the hotline due to suicidal thoughts and a 271% increase in people calling the hotline because they were worried about a friend.

LESSON 5

Use language that resonates with people



‘Having a conversation to reach a mutual understanding of expectations between the therapist and the intervention participant leads to a more successful intervention, where all expectations are met.’

Finnish Association for Mental Health, Finland

Using language that resonates with people is an important therapeutic tool and can aid recovery

Allowing people with depression to describe what they are feeling in their own words helps them take ownership of their experience and their ability to get better.⁴⁸ Taking this person-centred approach is particularly important in addressing suicidality. Physicians tend to focus on treating the psychiatric disorder (e.g. depression) associated with suicidal behaviour, but for the individual, exploring the subjective experience of a suicidal crisis is just as important⁴⁹ (see Box 8).

BOX 8 Attempted Suicide Short Intervention Programme, Finland

Preventing further suicide attempts through empowering the individual to empathise with themselves

The Finnish Association for Mental Health offers a four-session talking therapy service for people who have attempted suicide. The crisis worker films the individual telling their own story of their suicide attempt, and in the next session they watch it to identify trigger points that make/made them suicidal. They create a ‘safety card’ on which they write these triggers, with an emergency number to call and some practical tools to change their thought patterns. In the final session, they bring a family member or trusted person to the meeting, so they can explain why they tried to kill themselves, explain their safety card and what they will do if they start thinking about suicide again.

People listening to themselves speak about their trauma is transformative. It is associated with empowering the individual to empathise with themselves.

Talking about recovery may help patients better understand treatment goals

The notion of recovery is usually used in serious mental illness management, such as schizophrenia. Recovery is about staying in control of life despite experiencing a mental health problem. Using this concept and a positive, help-seeking model in depression may give people the confidence to recognise when they are becoming unwell and access appropriate support services.⁴²

Using more consistent language around treatments for depression may improve adherence

Poor adherence and acceptance of antidepressant medication is a significant problem, particularly in young adults.⁵⁰ Changing the names of medicines to clarify their intent may make them more acceptable (see Box 9).

BOX 9 The Neuroscience-based Nomenclature project, Europe

Renaming medicines pharmacologically to promote transparent prescribing practice and increase patient trust and adherence to treatment

Psychiatric medications are often used for conditions other than the indication for which they are named (e.g. antipsychotics or antidepressants). This can make people feel uncomfortable, for example, if they are prescribed antipsychotics but not diagnosed with psychosis. It also means prescription rates may be misrepresented; for example, antidepressants are sometimes prescribed for conditions such as anxiety, post-traumatic stress disorder, obsessive-compulsive disorder or phobias.

The Neuroscience-based Nomenclature project proposes using the pharmacological names for these medications, in an effort to clarify their use in patients. This also helps improve people’s trust in the medicines they are being given, and improve adherence as a result.⁵¹

All professionals or organisations working with people with depression need be trained to adopt this nuanced language

It is not just healthcare professionals who need to use the right language about depression. In Ireland, for example, the National Office for Suicide Prevention aims to have all police cadets trained in ASIST (Applied Suicide Intervention Skills Training). Cadets participate in a two-day interactive workshop in suicide first-aid and learn safeTALK, a step-based approach to communicating with someone experiencing a crisis.⁴¹

LESSON 6

Engage people in their own and others' recovery



Involve people affected by depression to guide service delivery

Involving service users and carers in service and policy development is important to create services that work for the people who use them. For example, in France, the World Health Organization (WHO) Collaborating Centre for Research and Training in Mental Health has implemented local mental health councils, which are built on a working partnership between the local elected official, psychiatry, the service user and carer, and anyone interested in mental health. This multidisciplinary core allows for effective policy development with all relevant actors: housing, community, local development and health and education (see *Box 10*).⁵²

BOX 10 Local mental health councils, France

Putting the service user at the heart of local mental health policy

Chaired by a local elected official and co-facilitated by public psychiatry, the councils integrate users and carers, health and social care professionals and anyone interested in mental health.

This provides a centre for collaboration and coordination among the relevant stakeholders to improve population wellbeing. The themes of the local councils differ from one area to another, but all have prevention, mental health promotion and reduction of health inequalities in common.

Since 2016, the local councils have been recommended by the Inter-ministerial Committee for Equality and Citizenship as a tool for developing local mental health policy.



Use the strengths and capabilities of people who have overcome mental health challenges to empower others

‘Some people have hellish lives; the fact that they get up in the morning and get through life shows they have amazing strength. We need to focus on this strength.’

STEPS, Scotland

People who have experienced mental health challenges have a valuable skill set in helping others who are experiencing mental health challenges. Peer support is associated with reduced hospital admission rates and better community engagement in people with depression.⁵³ It can promote feelings of hope, empathy and stigma reduction, and also helps the peer-support worker manage their own ongoing recovery and empowerment.⁵³ A number of countries have developed training programmes to formalise this role (see *Box 11*).

Empowerment refers to the level of choice, influence and control that people can exercise over events in their lives.⁵⁴ It can also refer to a person’s psychological and physical resource to identify with themselves and exercise their will.

BOX 11 Médiateur de santé pair (peer-support workers), France

Developing professional training for peer-support workers in mental health

The WHO Collaborating Centre for Research and Training in Mental Health and the National Association of Users in Psychiatry in France worked with a French university to develop a course for people who have experienced mental health challenges to become peer-support workers.

The first cohort of students has now been working in mental health teams for three years and professionals are noticing the power of this role. Demand from clinical teams is increasing and more universities are developing similar courses. This is the most successful programme in France to educate and reintegrate people on long-term mental health leave into the workforce.

This is an excellent model of care which has benefits for all parties involved. It also exists in the UK, Italy and USA.

LESSON 7

Take a whole-family approach



‘Every member of the family is impacted when anyone is affected by depression. Therefore it is imperative that all family members are engaged in a participative way in the design and implementation of services.’

EUFAMI

Family relationships and child development have a strong bidirectional influence on each other, so developing services that involve the whole family can have a significant impact⁵⁵ (see *Box 12*).

BOX 12 The Family Wellness Project, Northern Ireland

Supporting families and children to build resilience

A five-year early intervention mental health project was introduced in Northern Ireland to support children aged 5–12 and their families to express their emotions and build resilience.

Mental health services for children were able to make direct referrals to the Family Wellness Project rather than to a GP. This meant the family had access to mental health expertise, resources and targeted therapy that would not have been available in primary care. Cases referred to the project were prevented from deteriorating to a point of statutory intervention due to the project’s intensive work with the child and family.



Services that support the needs of carers are crucial

The extent to which family members provide care for people with mental health disorders, including depression, has increased over the past three decades – mainly due to a trend towards community care and deinstitutionalisation of psychiatric problems.⁵⁶ Up to 90% of people with mental disorders live with relatives who provide long-term practical and emotional support.⁵⁶

Carers are twice as likely as non-carers to experience depression.⁵⁶ Family members who become informal carers of someone with depression are also at risk of myriad poor health and wellbeing outcomes. Services should therefore focus on addressing the psychological burden of caring⁵⁶ (see *Box 13*).

BOX 13 Caring for someone with depression: Caring for two, Europe²⁹

Information booklet informing carers of how to take care of themselves

EUFAMI developed a brochure to support carers to look after their own health as well as that of their loved ones. This included two sections of advice and information:

- Care for yourself
 - Make sure you take the time to care for yourself
 - Safeguard your own boundaries
 - Managing the difficult times as a carer
 - Start building your personal support system
- Care for your loved one
 - Identifying symptoms of depression – is your loved one affected?
 - Seek professional help and begin the process of recovery
 - Finding online support

The booklet emphasises the importance of looking after mental and physical health. It encourages open communication and strong support networks to maintain a good level of health and wellbeing.

Campaigns targeting the family and friends of someone experiencing suicidal thoughts can be very powerful. Often people in a suicidal crisis are not aware of external stimuli such as awareness posters or online adverts. However, family and friends are, and by targeting these people it is possible to create a large network or awareness around the person experiencing a crisis, who can help that person.⁴⁷

LESSON 8

Empower children and young people to talk about depression



‘We need to intervene early so young people are not cycled through services which steadily deteriorate their health and wellbeing.’

Family Wellness Project, Northern Ireland

We need to build resilience in young people

Care in young people should focus on fostering individual resources to build resilience and coping patterns.

For example, successful workshops in Slovenia focused on encouraging young people to build social and emotional skills. This helped teenagers form stronger relationships and greater personal strength so they could deal with challenges more effectively (see *Box 14*).

BOX 14 This is Me prevention programme, Slovenia

Engaging and supporting adolescents

This is Me is an e-counselling service and course of ten prevention workshops delivered to 13–17-year-olds in some schools in Slovenia.

e-Counselling

Since 2001, the e-counselling service has answered over 42,000 questions using a multidisciplinary network of 56 voluntary experts.

Workshop

Over the past six years, 6,000 workshops have been delivered to approximately 10,000 adolescents every year across Slovenia. Each workshop addresses one of the important fields of adolescent experiences and behaviour, such as self-respect, individuality, taking responsibility and managing emotions. These workshops enable the development of social and emotional skills, helping adolescents deal with the challenges of growing up.

Digital tools may help young people see that they are not alone

Online forums help break the isolation that many children and adolescents feel when grappling with depression. Chat rooms offer anonymity for participants and ease of access to various professionals, and may be more appealing to young people than traditional medical interventions. Teenagers may benefit from feeling part of an e-community and realising that their ‘normal’ peers struggle with the same challenges they do.⁵⁷

LESSON 9

Create a positive work environment for people with depression



People spend a considerable amount of time at work, so the workplace is a natural setting to help prevent depression. Workplace mental health interventions, particularly cognitive behavioural therapy programmes, can reduce the level of depression symptoms among staff. However, large-scale workplace-based interventions are sparse and inconsistently delivered.⁵⁸ A helpful framework for such interventions is provided in *Box 15*.

Workplace mental health education can create a positive culture, reduce stigma and help managers recognise the signs of depression. Training programmes appropriate to the type of workplace are particularly helpful; for example, organisations with multiple locations may prefer an interactive online course rather than in-person training.⁵⁹ Crucially, commitment is required beyond the training course; reinforcing the content is essential for sustainable change.

An open workplace culture is important to support people who are managing depression at work or returning to work after taking time off. Return-to-work processes are more likely to be successful if genuine and caring communication is already the norm when the person goes on leave, and continues while they are off work – including respectful checking-in and messages of support.⁵⁹

BOX 15 Not Myself Today, Canada

Supporting employees with mental health issues

This evidence-informed practical workplace initiative, developed in Canada, focuses on three outcomes:

- Building greater awareness and understanding of mental health among the workforce
- Reducing stigma
- Fostering safe and supportive work cultures.

Members receive ongoing support and a physical and digital toolkit that includes different plan options; materials such as slide decks, videos and posters; six different engagement activities; and evaluation tools.

This simple programme has been associated with almost 100% success in increasing awareness and understanding, prompting conversations in the workplace and creating a more supportive work environment.



LESSON 10

Evaluate practices to drive meaningful change



‘We need strong data to inform policy changes and strengthen effective practice.’

International Federation of Psychotherapy

Better data are needed to guide service improvement

Inconsistent and incomplete data make it difficult to define gaps in treatment and drive systematic improvement. Country-level epidemiological data on depression are not comparable due to varying diagnostic criteria and survey methods;⁶⁰ data on suicide are particularly difficult to interpret.⁶¹ Stigma contributes to underestimation of depression and suicide rates.^{61 62} Data on service availability are also incomplete, and widely variable methodologies make estimations and comparisons difficult.^{62 63}

Mental health-focused projects must, therefore, embed processes to collect reliable outcome measures. Monitoring patient outcomes helps to identify good practice, giving hope to service users that mental health can improve, and garnering support from policymakers who want to see change⁴⁵ (see *Box 16*). Unfortunately, funders do not always allocate budget for evaluation, and evaluation is often internal and unplanned.^{43 48}



BOX 16 Improving Access to Psychological Therapies (IAPT) service, England

Systematically collecting and publishing data

The IAPT service offers timely psychological therapies – recommended by the National Institute for Health and Care Excellence – delivered by appropriately trained individuals for a broad spectrum of mental health disorders. Each patient completes an anxiety and depression survey at every appointment, and software monitors and visualises the data in different ways depending on the audience (the individual themselves, the clinical team, government or the general public). The data are made publicly available, which has resulted in continued funding of the service because the benefits are recognised. IAPT has shown that mental health problems can be treated and measured in the same way as physical health problems; this helps change mindsets and bring hope to people with depression and other mental illnesses.

Putting data in the public domain may help secure visibility for programmes and drive improvement

Publishing data can encourage shared learning, but clinicians and management need a mindset change to see this constructively. Some services have introduced systematic outcome measurement collection for all people seen by the service. However, such a change in practice requires sufficient staff training and leadership so that clinicians can use the data to better help people and learn from other services, and not view the intervention as a review of their own performance.⁴⁵

Digital health tools also offer opportunities for learning and analysis

e-Counselling enables documentation of all exchanges for transparency and research purposes, while retaining the anonymity of the user.⁵⁷

Conclusion

This report is a blueprint for change, which can be applied to depression and suicidality prevention in local contexts. It is based on quantitative and qualitative evidence obtained through extensive research and key lessons learnt in a selection of best-practice case studies from across Europe. Policy based on evidence is more likely to lead to sustainable change, and we hope this report will help reduce the burden of depression and suicidality across Europe through promoting effective, nuanced initiatives.

Prevention of depression and suicidality needs to be multilevel. Building a more resilient population through primary prevention and addressing risk factors in early intervention can reduce up to 20% of the burden of disease.⁵ If illness does progress, we need to provide people with accessible, evidence-based interventions which empower them and work for them; this can reduce the burden by a third.⁵ Suicidality prevention should be included in all sectors and across all levels of depression prevention.

Prevention must also be multidisciplinary. It is not enough to improve the clinical environment alone; we must improve the sociocultural and environmental contexts from which depression and suicidality originate. This means implementing informed policy changes, educating people via schools and the workplace, utilising emerging digital technologies, and building awareness and resilience in families and society, as well as improving service provision. We must foster change by using nuanced language which communicates empathy so that we empower people to use their internal resources to deal with life's challenges.

We all have a responsibility in preventing and treating depression. Too many people suffer with little or no access to effective therapies, and too many lives are lost to suicide. A positive commitment to changing mindsets in healthcare, government and among the general public will help to ensure people living with depression are able to seek the support they need to live healthy, productive lives. It is our sincere hope that this report will help policymakers across Europe achieve this goal.

In conclusion, wiser investment in reducing depression is timely and essential. Funding should be targeted, evidence-based and sustainable. An integrated, cross-services approach, focused on prevention and early intervention, and leveraging new advances in digital medicine, can save lives, reduce the economic impact of depression, and have a dramatic effect on the quality of life of over 35 million people affected by depression across Europe.



This report
is a blueprint
for **change**



Part 3

Best practice in depression and suicidality prevention and management: **case studies**

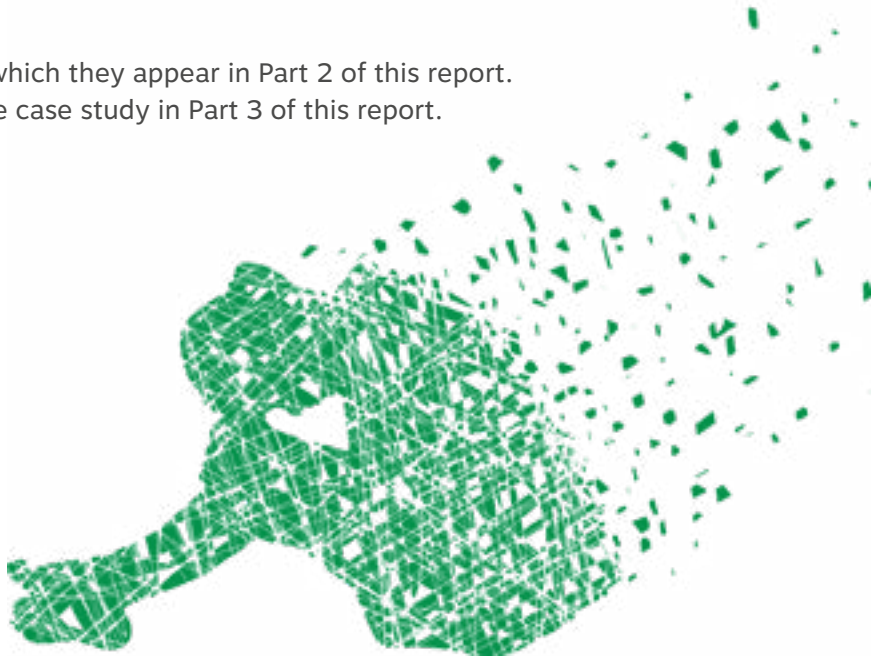


List of case studies

Interviewee	Project	Description	Country	Page
John Meehan	National Office for Suicide Prevention	Governmental office implementing and monitoring the national suicide strategy	Ireland	44
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Interviewee	Project	Description	Country	Page
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Note: Case studies are listed in the order in which they appear in Part 2 of this report. Page numbers refer to the full write-up of the case study in Part 3 of this report.



National Office for Suicide Prevention



Objective

Support, inform, monitor and coordinate the implementation of the national suicide prevention strategy, Connecting for Life – a national strategy that sets out a vision for Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.

Description

Ireland’s National Office for Suicide Prevention (NOSP) was set up in 2005 to implement the first Irish suicide strategy, Reach Out. This was set out under a Health Service Executive reshuffle, in response to the political will which evolved from an increasing suicide rate and lobbying by the health service, non-governmental organisations (NGOs) and service-user advocates.

The NOSP implements the Connecting for Life Strategy 2015–2020. Its other functions include commissioning research, sharing the emerging learning and delivery priorities, monitoring stigma reduction and coordinating national training.

There are 17 local Connecting for Life action plans across nine areas in Ireland, which implement this strategy with local awareness and sensitivity.

What did it achieve?

It makes use of cross-sectoral monitoring and evaluation. The NOSP uses a cross-departmental dashboard to monitor the progress of each department, which helps the team evaluate continuously and identify barriers across departments. This facilitates accountability and cross-sectoral working, as departments can come together and use the data to decide how to overcome their barriers.

It has created cross-sectoral accountability. Every quarter, the NOSP and the other departments involved report to a National Cross Sectoral Steering and Implementation Group chaired by the Department of Health. They discuss the Connecting for Life strategy and monitor progress against strategic goals.

It has fostered alignment with the third sector.

The NOSP is piloting an alignment guidance document that will allow increased funding prospects for NGOs by aligning their services with Connecting for Life. It also publishes an annual report on suicide and provides training resources to the voluntary sector.

It initiated training for public service employees.

For example, the office has worked collaboratively with the Department of Justice so that, by 2020, all new recruits to the national centre for police training will receive ASIST (Applied Suicide Intervention Skills Training) – a two-day interactive workshop in suicide first-aid – and learn safeTALK, a step-based approach to communicating with someone experiencing a crisis. The NOSP is currently training first-responders in ASIST and safeTALK, and this training has been made available to the general public. It has also worked with the Department of Education to train school staff across Ireland.

Through collaboration with national partners, it is working to define a pathway for suicide and improve surveillance. The NOSP is working with the health sector and others to develop a pathway. It works with the coroner’s office to improve surveillance data by collecting information on deaths in individuals with self-harm risk factors, to understand the link to suicide.

Time and inter-agency working are important in changing hearts, minds and cultures. The NOSP is aware that achieving seven goals and 69 actions in five years is challenging and, by 2020, some actions may not be complete.

Funding

The project is funded by the Department of Health.

Stakeholders involved

Departments of Taoiseach, Health, Defence, Justice, Social Protection, Enterprise, Agriculture, Community and Rural Affairs, Children and Youth Affairs, Local Authorities, Education, Communications, Transport and Tourism, and the Health Service Executive.

Key lessons learnt

- **Buy-in from government is essential.** Having government support has been vital to maintain funding and engagement from all departments.
- **It is necessary to develop the infrastructure to implement change.** The NOSP has recently defined the infrastructure and governance to achieve the strategy’s goals. This includes 22 local Connecting for

Life action plans in each of the nine areas in Ireland. Each action plan must reflect the multi-sectoral working of the NOSP from a local perspective, have a clear plan and follow an agreed process.

- **Each locality requires a robust strategy and associated plan.** Every area of Ireland has different demographics and barriers. Overall, there are 22 local plans because some of the nine areas are too large and diverse to have one action plan. For example, Donegal includes an island population whose demographics, geography and levels of deprivation differ greatly from those of the mainland. Each local action plan will have to demonstrate how it is reaching out to different populations, especially priority groups such as people who experience mental health challenges.
- **Cabinet committee meetings help maintain the project’s focus.** The National Cross Sectoral Steering and Implementation Group reports to the Cabinet Committee on Social Policy and Public Service Reform, which focuses all stakeholders’ minds on the strategy and its progress.

Next steps

- The NOSP will continue to progress the implementation of Connecting for Life (2015–2020), and will complete implementation of local Connecting for Life action plans.
- A mid-strategy review will help NOSP identify which parts of Connecting for Life have been implemented and which need further implementation. It will also refresh the strategy using emerging evidence, which will inform future national policy on suicide prevention.
- The NOSP is developing a best-practice guide to suicide prevention services. When published, this will implement national standards for all organisations working in suicide prevention.

Source
Interview with John Meehan, head of the National Office for Suicide Prevention



Doing Well



Objective

Work with people experiencing mild to moderate depression or anxiety to prevent the further decline of mental health and the need for a higher-level service, by providing self-help interventions and/or signposting to other therapeutic services.

Description

Doing Well is a brief, one-to-one, tailored intervention delivered by trained advisors in health centres. Three sessions are delivered to people with mild to moderate depression, anxiety or psychological distress. People with mild to moderate anxiety are enrolled in a three-session anxiety-management programme following an initial assessment to determine suitability.

This service is distinctive in selecting staff who may have no previous clinical experience. Following a rigorous selection process to identify candidates with the required attributes, the staff receive in-house training from clinical psychology. All Doing Well advisors are closely supervised by psychologists to ensure clinical governance and provide ongoing skill development.

The service was developed during the Scottish national project called Doing Well by People with Depression, which distributed funding to all National Health Service (NHS) Scotland health boards to be used in any way they saw fit to improve the lives of those with depression. When the national funding stopped in 2006, NHS Borders continued to fund the service model due to its success. This maintained the service across the seven GP practices in which it was already being delivered, but meant it was not able to expand further.

What did it achieve?

Funding continued beyond the initial project. Due to the success of this programme, NHS Borders continued to fund it when the national funding stopped in 2006.

It has been embedded into general practice. GPs feel that the Doing Well service is embedded in their team, and all the notes and Doing Well referrals can be seen on the patient records. This is important for transparent communication between the primary care medical team and Doing Well advisors.

It fosters long-term retention of staff. The Doing Well service addressed high staff turnover with its decision not to employ psychology assistants, as was common in other NHS boards’ self-help services, because assistant psychologists often leave such roles after a year to continue training.

Funding

The project was initially funded by NHS Scotland and is now funded by NHS Borders.

Stakeholders involved

GPs, Doing Well advisors, psychologists, NHS Scotland, Doing Well by People with Depression national programme.

Key lessons learnt

- **Be clear about where the project sits within the wider pathway of care.** It must fit into an integrated service which includes primary and secondary care, the community and third-sector services. For example, this service is the first referral stage for people with mild or moderate depression or anxiety. If the service user is not feeling better after three sessions, the team should refer them to more intensive services. However, some advisors are seeing people for more than three sessions, so the feasibility of the programme being delivered in such a short time frame is being reconsidered.
- **Weekly supervisions with a psychologist provide support and learning.** Advisors see a psychologist for clinical supervision and continuing education. Psychologists also provide a safety net in case there are patients who have more complex needs. This support and learning is extremely important

for staff who are working in isolation with people who have emotional problems.

- **Advisors do not need a clinical background.** Staff do not need to have a professional qualification to deliver this service. People with the correct skill set and ability to work psychologically receive high-quality training and support to become excellent advisors.
- **A holistic approach is effective.** Mental health challenges are often linked to other health issues, and a holistic approach is more effective. For example, people with weight problems may be referred to lifestyle services, but their weight challenges may be linked to psychological distress – this results in a back-and-forth cycle of referrals. This interrupts continuity of care and is time-consuming and inefficient for both the patient and the prescribing practitioners.

Next steps

- The team is investigating the appropriate service model under which to merge Doing Well with the smoking cessation and lifestyle services. This will increase coverage in the areas where there is more need, improve sustainability in an environment of limited resources, and provide a holistic approach to physical and psychological wellbeing. Challenges have so far included addressing the complexities of governance and convincing all practitioners of the new approach.
- In the new organisation, the intervention will continue to follow the structure as it is now: a short-term intervention for physical and mental health. It will be delivered across the NHS Borders trust area so there is equity of access to smoking cessation, lifestyle and self-help mental health services.

Source
Interview with Haylis Smith and April Quigley, project coordinators



STEPS



Objective

Develop an effective primary-care based mental health service that breaks down barriers for people seeking help.

Description

This service created a multilevel, multipurpose primary care mental health team in Glasgow. It was developed to support many people experiencing common mental health problems (CMHPs). STEPS offered help to service users at several levels simultaneously or sequentially e.g. high-intensity individual therapy and low-intensity self-help, or self-help followed by individual therapy. This model is a variant of stepped care, in that the person does not necessarily ‘step up’ towards more intensive treatment, but rather ‘steps onto’ the service most relevant to their needs.

Using this model, STEPS focused on three aspects of care:

- Interventions designed to help those already suffering from CMHPs
- Preventive and/or early interventions to help stop the development of CMHPs
- Interventions to promote wellbeing and resilience in communities.

The service is called STEPS because the team did not want to disengage some hard-to-reach populations by including the word ‘mental’.

What did it achieve?

STEPS engaged diverse groups. This included groups who would not usually use mental health services: men, older people and ethnic minorities. Therefore, the health services needed to lower the barriers to accessing services and work with community leaders to engage vulnerable populations. For example, STEPS worked with imams to access Pakistani communities.

It empowered people to choose the treatment that worked for them. The team assumed some people would need individual therapy, but others would benefit from other methods, so the service gave clients the ability to choose their own treatment.

It applied the primary care model to mental health. Visiting a general practitioner (GP) is often seen as a positive choice in looking after one’s physical health. The team applied this approach to seeking help for mental health issues so that accessing a mental health professional directly was a positive, preventive measure.

It reduced treatment waiting times. The project used self-referral and a call-back system to ensure people were seen by a therapist quickly.

It raised awareness in the community. Through activities such as comedy nights, stalls outside supermarkets and events at the local library, people in south-east Glasgow came to recognise STEPS and hear more about mental health.

Funding

The service was funded by NHS Scotland.

Stakeholders involved

NHS Scotland and community partners e.g. libraries, places of worship, schools, comedy clubs and shops.

Key lessons learnt

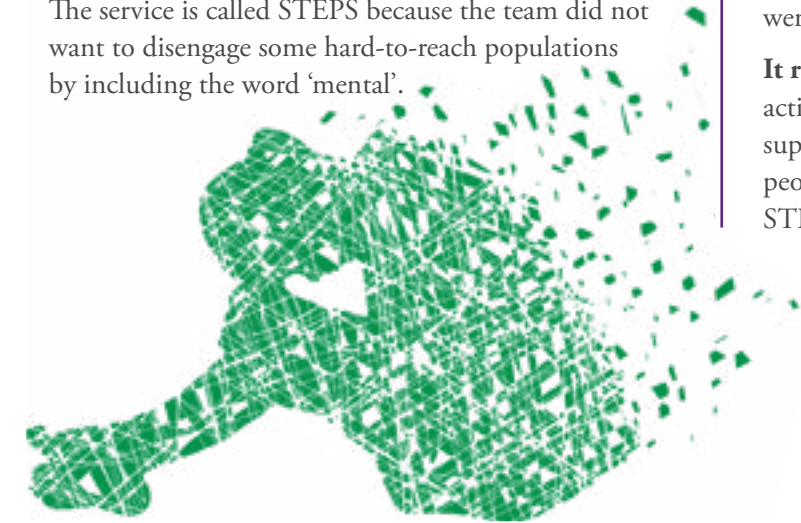
- **Diversifying staff roles allowed the service to access different parts of the community.** STEPS therapists offered more than just therapy: they wrote material and coordinated workshops, classes and advice clinics. The team held stalls outside supermarkets, coordinated comedy nights and presented in schools. These activities each targeted different people in a positive way.
- **Positive, high-quality leadership is important.** STEPS had a manager who really understood the project aims and was a confident ambassador accustomed to working in the community. This meant the team always promoted the initiative with confidence and was supported in doing so.

- **Get GPs on board.** In the United Kingdom, GPs hold a lot of power in changing practice and policy. Having GPs support this project gave the team a significant amount of freedom to try new things.
- **Look after therapists so they can better look after service users.** Therapists need to have fun and rest, so they can come to work with a positive mindset, believing in what they are doing. This is noticeable to service users and creates a positive, hopeful attitude.
- **Use terminology that has been useful in other areas.** STEPS introduced the concept of ‘recovery’ (well-established in severe mental health conditions) to CMHPs. This term communicates that sometimes mental health conditions can be cured and sometimes they can be managed – and that both experiences are OK.
- **Be aware of population diversity when looking at the evidence base.** Evidence-based methods are useful; however, each population is different and intervention methodology must reflect this. Conclusions drawn from research may be based on ‘perfect’ populations in perfect conditions, and are thus not always transferable to real-life settings.

Next steps

- The programme no longer exists as STEPS, but aspects of the project still exist across NHS mental health teams.
- Jim White (project lead) continues the STEPS concept of prevention through a stress-management course called Stress Control, which is used across the NHS and the Health Service Executive in the Republic of Ireland, as well as in schools. As a psychoeducational evening class, this course allows very large number of people to attend; for example, 450 people attended the last course delivered in Ireland.

Source
Interview with Jim White, project lead



eMEN project



Objective

Promote affordable and accessible mental healthcare by collaboratively developing and introducing digital tools into service provision.

Description

This multidisciplinary project was set up to implement e-mental health tools in north-west Europe. It works with private and public partners to pilot digital tools in real-world healthcare services, train therapists to use digital tools in their practice, and change policy to encourage the development and effective implementation of digital tools.

The programme encourages blended care, where the person sees a therapist in person and also shares information with them via digital tools and works with them virtually. Depression-specific digital tools implemented via the project include:

- Moodbuster version 2.0 (Manchester, UK) – an app that delivers online cognitive behavioural therapy (CBT) treatment and monitors mood, activities, sleep and social contacts. The second version is currently being piloted – although version 1.0 was successful, technology moves so fast that modifications and retesting were necessary.
- Stop Blues (France) – a web-based and mobile suicide/depression app for use by the general population, which offers information and provides primary and secondary prevention. Developed by the Institut national de la santé et de la recherche médicale (INSERM), it has been piloted in 44 regions of France with almost five million people.
- MindWise/eWell (Ireland) – an online CBT programme. The project piloted an app developed by the Health Service Executive.
- Pesky gNATS (Ireland) – a CBT game for children with depression.

What did it achieve?

It has created public–private partnerships. The public partners provide expertise in the area and access to the clinical setting, while the private partners bring skills and knowledge in terms of scaling.

It introduced a new type of randomised controlled trial (RCT). The team is testing low-cost, short-duration RCTs, which are better suited to the fast-evolving world of technology.

It fosters collaboration with universities. eMEN is working with universities in the Netherlands to train psychologists to embed blended care into their practice.

Funding

Interreg North West Europe European Structural and Investment Funds provided 60% of the funding, with 40% co-funded by private partners.

Stakeholders involved

Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde (German Association for Psychiatry, Psychotherapy and Psychosomatics), Landschaftsverband Rheinland – Institut für Versorgungsforschung (Institute for Health Services Research), Mental Health Foundation, EPSM Lille Metropole, Thomas More University of Applied Science, Pulso Europe CVBA, Mental Health Reform.

Key lessons learnt

- **It is important as a project lead to develop a good relationship with the developer.** There is a lot of commercial competition among digital developers, so a strong relationship will help to keep them engaged in the project.
- **Preparation is key in the fast-paced digital world.** Digital tools need to be developed and implemented in a short period of time, and preparation is key to having everything in place to achieve this. Needs and gaps must be understood, and detailed specifications given to the developer, as well as an efficient research protocol in which the clinicians and service users are motivated to participate.
- **Encourage and empower end-users to ask for different treatment options.** If service users can ask to use the new technology to help themselves, it will drive demand and ultimately improve patient outcomes.
- **Co-creation between therapists and developers is key.** It is necessary to involve the therapist in the process to develop high-quality digital tools and an effective evaluation.
- **Therapist training and change management is needed.** This is essential to integrate new technology into everyday practice.
- **Policy reform facilitates the implementation of mental health digital tools.** Changing practice and funding structures is facilitated by policy or legislation changes.
- **A multidisciplinary approach is essential to address various innovation challenges.** Different experts are needed, including developers, policymakers, clinicians, end-users and organisational consultants. Each partner brings a different skill set, all of which have value in addressing implementation factors.
- **A positive attitude engages people.** This helps everyone involved to understand the project's goals.
- **Awareness of different national cultures is important.** All countries have different cultures and health systems, and sensitivity to this is important when successfully introducing eHealth tools.

Next steps

- All pilots are ongoing, and results will be available for analysis from 2019.
- In 2020, the Netherlands will introduce a new funding structure for mental health which will promote e-mental health; this will be an opportune time to introduce digital tools.

Source
Interview with Oyono Vlijter, eMEN project leader



Speech can Save campaign



Objective

Reduce suicide acts and attempts in adults and adolescents through promoting open discussion with the family and friends of the individual in a crisis.

Description

The Zurich Suicide Prevention Programme 2015–2018 includes 18 wide-ranging actions such as training, enabling help and support in crisis, reducing access to firearms, and monitoring suicide rates and behaviours, as well as specific measures for high-risk people.

The programme fosters intersectoral collaboration across a broad range of professionals including teachers, healthcare professionals, police officers and government employees. The programme is coordinated by the Department of Prevention and Health Promotion Canton of Zurich, which is affiliated with the University of Zurich.

The Speech can Save campaign was developed as an addition to this programme. Speech can Save developed two campaigns targeting adults and adolescents, respectively. The campaigns were aimed at people at high risk of suicide, as well as their families and friends, to deliver tailored suicide prevention. Speech can Save used social media and online algorithms to identify high-risk individuals through trigger words or phrases. Identified individuals were shown advertising for the awareness-raising website where suicide information and crisis hotlines could be found. The adolescent campaign also included posters near schools, universities and other areas frequented by young people. Both campaigns emphasised the power of open discussion and publicised the crisis hotline numbers.

What did it achieve?

It used digital technology to develop a targeted campaign. By identifying high-risk phrases or words, the campaign was able to target high-risk people online and through social media. This meant that the campaign banners were less present in society but were effective because they addressed the appropriate population.

It developed a new public–private partnership. The Swiss Federal Railways and the Department of Prevention and Health Promotion of Zurich had similar objectives to develop a campaign to reduce suicide. They both provided funding and developed the campaign together using expert consultations (with both professionals and people who had previously attempted suicide).

It offered a new approach to suicide prevention campaigning. After consultation with experts, the team decided to target the campaign at the family and friends of those experiencing a suicidal crisis, as well as people experiencing suicidal thoughts themselves. The organisers felt it was important to include family and friends in preventive campaigns because people experiencing a crisis do not often take notice of their environment, such as posters or online adverts. In addition, family and friends can give important support and, together, represent a larger target group.

It was far-reaching and saw an increase in people accessing support services. Within the first two months of the campaign targeting adolescents, the Speech can Save video had been viewed more than one million times, and it became one of the most watched video clips in the second quarter of 2018 in Switzerland. Since the beginning of the campaign there

has been a 584% increase in the number of visits to the young people in crisis website, a 141% increase in the number of young people calling the hotline due to suicidal thoughts, and a 271% increase in people contacting the hotline because they were worried about a friend.

Funding

Three-year funding was provided by the Swiss Federal Railways and the Department of Prevention and Health Promotion of the Canton of Zurich (2015–2018).

Stakeholders involved

Swiss Federal Railways, the Department of Prevention and Health Promotion of the Canton of Zurich, and organisations providing crisis hotlines.

Key lessons learnt

- **Campaign posters should not be near suicide hotspots.** Consultation with experts found that a suicide campaign poster should not be displayed near suicide-attempt hotspots such as railways or bridges, to avoid creating an association between suicide and that location.
- **Campaigns should promote the solution, not the problem (suicide).** Experts suggested that the campaign should not focus on suicide or on suicide methods, but rather encourage open discussion of suicidal thoughts.
- **It is important to have the experts onside.** This gave the campaign organisers confidence that their approach was appropriate and safe, and it gave the campaign credibility.
- **Different target groups require their own campaign approaches.** Adults and adolescents respond to different messaging. An effective campaign should understand its target audience and tailor its messages and approach accordingly.

Next steps

- This campaign will not have its funding renewed by the Swiss Federal Railways, so if it does continue past 2018 it will be at a much-reduced capacity.
- The Zurich Suicide Prevention Programme will continue beyond 2018.

Source
Interview with Annett Niklaus, Speech can Save campaign lead, and Martina Blaser, Zurich Suicide Prevention Programme coordinator



Attempted Suicide Short Intervention Programme



Objective

Prevent and reduce suicide attempts and suicide acts in Finland by supporting suicide attempters.

Description

This four-session talking therapy programme was adapted from the Swiss model:¹

- **Session 1:** The crisis worker asks the service user to tell the story of their suicide attempt in their own words; this is filmed. The crisis worker only talks to prompt the speaker and never interrupts them. This means the crisis worker and the service user discover and understand together why the person wanted to end their life.
- **Session 2:** The crisis worker and individual replay the video and focus on how the person started to consider suicide. They analyse the processes step-by-step to identify the trigger points and warning signals that make or made them suicidal. The helps the service user to understand their vulnerabilities in the context of their life, and identify their own strategies to protect themselves in the future.
- **Session 3:** They create a ‘safety card’ where they write the triggers and warning signs they identified from the recording, long-term methods and practical tools such as self-awareness or antidepressants to change their thinking, and a crisis mitigation strategy including an emergency number to call.
- **Session 4:** The service user can take a family member or trusted person to the meeting. They can tell that person why they attempted suicide, explain their safety card and what they will do if they start thinking about suicide again. *(This step was added in the Finnish model as it was felt that family inclusion was important for recovery and prevention.)*

For two years after the therapy, the programme checks how the service user is and whether they need help. This follow-up involves sending them a letter every three months in the first year and every six months in the second year.

What did it achieve?

It has helped a large number of people. Since 2013, the programme has seen 700 people.

It has potential for a dramatic reduction in secondary suicide attempts. In Switzerland, this programme was associated with an 80% risk reduction of participants making another attempt.¹ The project is currently being evaluated in Finland.

It established a permanent intervention. The project has been made permanent in the newly developed SOS Crisis Centre in Helsinki and Kuopio.

Funding

The project was funded by the Ministry of Social Affairs and Health.

Stakeholders involved

Finnish Association of Mental Health, Helsinki Psychiatry Centre, Hospital District of Helsinki and Uusimaa, University Hospital of Psychiatry in Bern, Switzerland.

Key lessons learnt

- **Use evidence-based models and talk to the people who developed the original programme to understand the details.** To implement this model, organisers should contact the University Hospital of Psychiatry in Bern, Switzerland, and ask for training either in person or via Skype, to understand the nuances.
- **Make good contacts and build working relationships with the hospital and its staff.** It requires time and persuasion to create relationships with each doctor, as they are the people who will refer patients. This may not always happen if they are simply directed to do so by management.

- **Work to change healthcare professionals’ perceptions of suicide.** There is significant stigma and judgement in clinical settings regarding people who attempt suicide. Working with healthcare professionals to change their mindsets is critical.
- **An enthusiastic, competent workforce is a necessity.** Staff must be ready to try something new and remain positive when confronted by people’s traumatic stories.
- **Allowing people to tell their story in their own words and play it back is transformative.** People begin to empathise with themselves when they see themselves telling their story, and they can start to think about their story in a more positive, constructive way.

Next steps

- The team is in the process of evaluating this programme and will compare its results with the Swiss programme to understand what factors give rise to any observed differences.
- The team will continue delivering this programme at the new SOS Crisis Centre as a permanent project.

Source
Interview with Reija Tuomisalo, Head of SOS Crisis Centre

References
1. Gysin-Maillart A, Schwab S, Soravia L, *et al.* 2016. A Novel Brief Therapy for Patients Who Attempt Suicide: A 24-month Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP). *PLoS Med* 13(3): 1-21



Neuroscience-based Nomenclature (NbN) project



Objective

Reduce stigma and improve adherence to treatment by naming psychotropic medication using contemporary knowledge of pharmacology, rather than disease-based nomenclature.

Description

Psychotropic medication is often named through a disease-based nomenclature, but the conditions for which medication is prescribed may not match the name of the medication; for example, people with anxiety are often prescribed antidepressants, while people with depression may be prescribed second-generation antipsychotics. This discrepancy between the name of the medication and the condition is often confusing for patients and their carers. It can lead to stigmatisation and poor adherence because people misunderstand the effects of the prescribed medications.

Five international organisations collaborated to establish a taskforce that was directed at embedding neuroscience advances into the nomenclature. The taskforce met three times and published a peer-reviewed paper that formed the basis of the nomenclature.

Nomenclature is based on three elements:

1. Pharmacology: this reflects current knowledge and understanding about the pharmacological domain, such as the neurotransmitter/molecule/system being modified.
2. Mode of action: this reflects current knowledge and understanding about the mechanism of action.
3. Additional dimensions: for every drug in the nomenclature, information on the indication, efficacy and side effects, neurobiology and any practical notes are included.

This information is updated twice a year.

What did it achieve?

The work has been widely published. The taskforce published a neuroscience-based nomenclature book and various peer-reviewed articles.

It uses digital technology to support dissemination. An app and website with a sophisticated search engine and feedback system allow doctors to easily access the neuroscientific names of the medication to better communicate with patients and caregivers.

It has a growing community of users. To date, there have been 35,000 downloads of the app, which had doubled since 2017. The app is being downloaded all over the world.

It has been included in high-level guidance. In the US, this app is officially part of the training programme for resident doctors. It has also been included in the *New Oxford Textbook of Psychiatry* and adopted by the *International Journal of Neuropsychopharmacology*.

Funding

The project was initially funded by the European College of Neuropsychopharmacology, and recently gained some industry funding.

Stakeholders involved

European College of Neuropsychopharmacology, American College of Neuropsychopharmacology, International College of Neuropsychopharmacology, Asian College of Neuropsychopharmacology and the International Union of Basic and Clinical Pharmacology.

Key lessons learned

- **Collaboration was key to the project's success.** Collaboration with major players across the world enabled the development of something that will be accepted and promoted by leading organisations in different countries.

- **Feedback and continuous updating are essential for a sustainable app.** Scientific knowledge and technology developments mean that an app must be continually checked and updated according to user and expert feedback.
- **Having a coordinator facilitates effective collaboration.** The European College of Neuropsychopharmacology paid a scientific secretary, who was integral to managing and organising the partners all over the world.

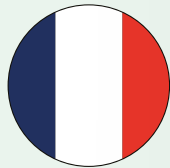
Next steps

- The taskforce is developing a child and adolescent edition of the NbN tool. This will involve more description and explanation as there are more available data and considerations in child and adolescent medication.
- It is hoped that an app will be developed for the general public, so people can access reliable evidence to understand their medication.
- The project aims to diversify its funding to ensure sustainability and longevity of the app.

Source
Interview with Professor Joseph Zohar, project manager



Les conseils Locaux de Santé Mentale (Local mental health councils)



Objective

Define and implement local policies and actions, with all relevant actors, to improve the mental health of the populations concerned.

Description

Chaired by a local elected official and co-facilitated by hospital-based psychiatrists, the council integrates users and carers to establish and publicise local mental health policy. The themes of the local councils differ from one territory to another, but all have prevention, mental health promotion and reduction of health inequalities in common. There is usually a full-time project manager; however, given the different policies and funding priorities of regional health agencies, the status of the local mental health council and roles within it are variable.

Each local council meets the needs of its area and therefore has different work themes. Every three years, the national centre conducts an inventory of the various practices and activities of the local councils.

What did it achieve?

It has democratised mental health. The local mental health council is a space for consultation, coordination and co-decision by multiple actors. This allows any interested member of the community to contribute to identifying needs and priorities, and implementing actions.

It has had substantial coverage. In 2006–07, there were about 15 local mental health councils in France; in 2018, there were 200 active councils across the country.

The model has been integrated into national legislation. Since 2016, the local councils have been recommended by the Inter-ministerial Committee for Equality and Citizenship as one of the tools for local mental health projects.

The regional set-up utilises local knowledge. Each of the local councils has a detailed knowledge of the needs and dynamics of its own locality, so is in the best position to analyse need, implement interventions and evaluate success.

It has benefited from continual development. Since 2017, a communication officer has been developing the website and communication tools to promote the centre’s actions to the public.

Funding

The Local Mental Health Council National Centre is funded by the General Commission for regional equality (Commissariat général à l’égalité des territoires) and the General Directorate of Health (Direction Générale de la Santé). The centre also works with several regional health agencies that integrate the local mental health council development into their regional health projects and support them financially.

Stakeholders involved

Local elected officials, psychiatrists, service users and carers are the core of the local mental health councils, but any organisation or individual that is involved in social protection and care can be a partner.

Key lessons learnt

- **Have a clear direction and be patient.** Change can take a long time and may face many obstacles.
- **Getting professionals on board is not easy, but is essential.** Persuading professionals to change their practice and approach was the most difficult part of this project.
- **National-level policy is not effective enough in mental health.** Local initiatives based on research and understanding of the area are important to make meaningful change in mental health.

- **Divergent professional opinions have led to weaker advocacy.** France has comprehensive mental health policy, but implementation is lacking because psychiatrists all have different advice and theories; they do not speak to the government with one voice, so the government does not know how best to implement change.
- **Communication and promotion are important in informing the wider public.** The national programme has been funded since 2007, and most of the budget at local level is allocated to a full-time project manager who brings the different stakeholders and activities together. The introduction of a communication officer in 2017 has helped communicate the project’s aims and achievements more widely.
- **Having a project manager makes local organisations more powerful.** The local councils that have chosen not to allocate funding to a project manager have been less impactful in their respective areas.

Next steps

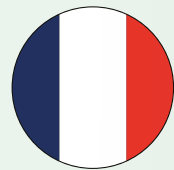
- The organisation is currently working with the National School of Public Health to evaluate the local mental health council approach.

Source
Interview with Jean-Luc Roelandt, director, World Health Organization Collaborating Centre for Research and Training in Mental Health



Médiateur de santé pair

(Peer-support workers)



Objective

Integrate people who have used psychiatric services into mental health teams to improve the quality of care.

Description

This project offers a training course for people who have experienced mental health disorders to become qualified peer-support workers. Training is developed through collaboration between the World Health Organization Collaborating Centre for Research and Training in Mental Health (WHOCC), the National Federation of psychiatric patients (Fédération Nationale des Patients en Psychiatrie) and a university.

In 2012, 29 students started a one-year course at the Paris-8 university to pilot a peer-support diploma. The course included academic education for one week per month, and work experience in an adult psychiatric institution for three weeks of the month.

In 2017, 31 students with experience of mental health started a training programme, with the same structure as the 2012 programme, at the Université Bobigny Paris 13 under the Science, Health and Social Sciences programme. Students will qualify in June 2019 with a Bachelor's degree in health and social sciences, specialising in peer mentoring. They can then go on to work in mental health teams and benefit from continued education and support.

What did it achieve?

It offered a high return-to-employment rate for people who were on long-term mental health sick leave. Three years after completing the course, 86% of students were working or studying; more than half of the pilot cohort (16 people) were employed in peer-support roles, nine changed jobs or went into further education, and four left the course.

It secured buy-in from healthcare professionals and management. Previously, high-level hospital management contacted the WHOCC to recruit peer-support workers. For the new course, however, demand has come from the care team, who want to work with peer-support workers because they see the benefit.

Mindsets and practice were changed on a large scale. Seven local authorities and 30 hospitals are in support of delivering standardised peer-support university qualifications and creating permanent positions within healthcare teams.

Funding

The project is supported by the National Solidarity Fund for Autonomy (Caisse Nationale de Solidarité pour l'Autonomie) and regional health agencies.

Stakeholders involved

WHOCC, the National Federation of psychiatric patients, Paris-8 university, Université Bobigny Paris 13, seven regional health agencies and the National Solidarity Fund for Autonomy.

Key lessons learnt

- **Teams need to be ready for a peer-support worker; a preparatory phase is essential.** Some of the peer-support workers were employed in teams whose practices were not ready to include this new role. Peer-support workers should not be forced onto unprepared teams by management; it is a bad experience for the whole team if the peer supporter arrives into a hostile environment where they are seen as a patient rather than a colleague.
- **Calm job insecurity fears by emphasising that peer-support workers are complementary.** Nurses are involved in a lot of clinical therapy in psychiatry, and may feel their role is threatened by peer-support workers. It is important to emphasise that a peer-support worker is complementary to the work of existing staff, and no substitute for their expertise and skills.
- **Peer-support workers can feel isolated in a team.** There is usually one peer-support worker in a team. Even if the team is not hostile, they may feel isolated because they have to learn a lot and create a new role.

Next steps

- An evaluation is underway, led by the WHOCC, the Institute for Inter-disciplinary Research on Social Issues (l'Institut de recherche inter-disciplinaire sur les enjeux sociaux) and the Laboratory of Health Education and Practice (Laboratoire éducation et pratiques de santé).
- Université Bobigny Paris 13 has announced it will deliver the course again in September 2019.
- A university in Lyon will also launch a peer-support worker degree programme in September 2019.

Source
Interview with Bérénice Staedel, project manager

- **Peer-support workers need continuous support.** They need someone to talk to about their caseload and their own mental health.
- **Communication and transparency promote healthcare professional buy-in.** Most negativity and resistance fades away when the peer-support worker explains how they can engage and help people who have had similar experiences to their own.
- **Universities can provide valuable insight when developing feasible training courses.** The Paris 13 university had a history of developing qualifications for professionals, and a degree programme that already encompassed some elements of the peer-support education programme. This meant the university could provide valuable insight on the course materials and feasibility, and suggest modules that it already delivered.



The Family Wellness Project



Objective

Support parents to help their child express and manage their emotions; develop and improve emotional understanding and resilience of families.

Description

This is an early intervention project for children aged 5–12 and their families, delivering the Wellness Recovery Action Plan (an individualised approach that helps track difficult emotions) to parents and children in their own homes.

What did it achieve?

It has relieved pressure on healthcare services. MindWise, the central organisation of the project, received the most referrals. This helped other organisations cut down their waiting times, and gave Child and Adolescent Mental Health Services (CAMHS) somewhere to refer families in need.

It provides intensive support to stop the cycle of mental ill health. The existence of the project has meant CAMHS no longer needs to refer families to a GP who would not be able to give them the intensive, targeted therapy needed to prevent mental ill health progression and potential statutory intervention.

Fewer people accessed statutory services. The project worked with nearly 400 families over four years; only ten of these families needed to access statutory services.

It has created an online resource for parents. Parenting NI, one of the organisations involved, pulled together wide-ranging information on child emotional and psychological wellbeing that was written for different audiences into an online information resource, using accessible language. This resulted in a portal that included the available support programmes

and information on relevant organisations, as well as videos and infographics. These will live on after the project has ended.

Families gave positive feedback. The intervention received positive feedback from the families it served, who appreciated the project addressing the mental health needs of the whole family in the privacy of their own home.

It has built a strong network. The project developed stronger connections between providers who previously knew each other through referrals but had never worked together. Partnership is key in this early intervention work: while each service can provide a segment of required support to part of the population, a partnership of services together can address the whole issue in a larger population.

Funding

Five-year funding was provided by the Big Lottery Fund, with availability for service users to extend their support by two extra years.

Stakeholders involved

MindWise, Action Mental Health, AWARE, Cause, Parenting NI, and CAMHS in the Southern and Western Health and Social Care Trust areas.

Key lessons learnt

- **Good planning and a strong partnership agreement are needed.** Effective planning helps to define responsibilities and processes, which is important as each organisation will have its own way of working. An agreement standardises delivery, makes referral pathways clear and supports the relationship in challenging times.
- **Open and honest working between partners is essential.** It is important to streamline each partner's aims and objectives. The progress of the project and each partner should be openly discussed to identify gaps and challenges. This is crucial for a good relationship.
- **A dedicated coordinator should maintain project oversight.** This provides a clear point of contact for service users, partners and external parties.

Next steps

- Learning and outcomes from this project may be incorporated into the upcoming Family and Parent Support Strategy (for which they have been part of an open consultation). Once this has ministerial approval it will be actioned, and will mean that this family support project would fall under the remit of the Department of Health.
- The online resource for parents will continue to grow.

- **Organisers should work strategically to optimise resources.** The project is working with CAMHS to identify areas of high referral rates within trusts and regions. Staff capacity will be planned around clusters of service users to keep costs down and maximise therapeutic time.
- **Correct terminology is important and should be communicated effectively to ensure access to the target population.** The service initially received inappropriate referrals due to misinterpretation of the term 'early intervention' among professionals and the public. It took some time to refine the language to communicate the project's aims and scope clearly.



Source
Interview with Maria Rogan, project partner and Rachel Cashel, project coordinator

This is Me prevention programme



Objective

Improve mental healthcare provision for adolescents and strengthen adolescent mental health by developing positive self-esteem, social and emotional skills and other life competencies.

Description

e-Counselling

Teenagers can post questions or concerns online and a team of experts respond. This e-counselling is further supported through self-image development workshops in schools.

School-based prevention workshop

In a programme of ten workshops, each session addresses one of the important fields of adolescent experiences and behaviour (such as self-respect, individuality, taking responsibility, and managing emotions). These workshops develop social and emotional skills, which empower adolescents to deal more effectively with the challenges of growing up, and help them build more quality relationships, personal strength and resilience.

What did it achieve?

e-Counselling

It has been running for 17 years. When it started in 2001 it was the first e-counselling service of its kind in Slovenia, and it has been growing ever since.

It has been replicated in another country. Since its introduction in Slovenia, the e-counselling service has been replicated in Pristina, Kosovo.

It provides a networking platform for counsellors, experts and adolescents. This programme has developed a network of volunteer e-counsellors, with 56 experts including medical specialists, psychologists, social pedagogues, social workers and teachers. The e-counselling service provides a networking platform for institutions, experts and users.

It has created an extensive database detailing the challenges of Slovenian adolescents. Since 2001, members of the team have answered over 42,000 questions. In 2006, they coded 10,000 questions from the e-counselling service, which allowed them to release the first analytical insight into the challenges faced by service users. A system for classifying the questions by type of problem was developed in 2012 by the e-counselling editor's office. Now, each new question sent by an adolescent is categorised according to the detailed typology of the problem. Each coded question is entered into the online catalogue, with 11 top-level categories and 90 subcategories.

School-based prevention workshop

Coverage has been extensive. This is Me has implemented more than 6,000 workshops in the last six years, engaging 10,000 adolescents per year.

It has gained recognition at the national level. The workshop programme was included in the 2018–2028 Slovenian National Mental Health Programme.

It has proven success in developing a positive environment. Evaluations of the workshops were performed in 2007 and 2018. The most recent results show a significant improvement in the class environment after ten workshops and a trend towards improved social and emotional learning.

Funding

The programme is funded by the Ministry of Health.

Stakeholders involved

Teachers and school staff, psychologists, social pedagogues, social workers, doctors and psychiatrists, Institute of Public Health Celje, National Institute of Public Health and the Ministry of Health.

Key lessons learnt

e-Counselling

- **There are many benefits for adolescents and healthcare systems.** Adolescents appreciate elements such as anonymity, quick response, easy access to experts, and insight into others' experiences and problem-solving approaches. The healthcare system benefits from the efficiency of a single online counsellor handling numerous questions.
- **Clear editorial protocols and expert guidelines are needed to ensure best practice in managing**

or mitigating a crisis. The number of adolescents experiencing crises and severe mental health disorders has increased since 2001. Crisis questions (e.g. relating to suicide or self-harm) are the most challenging for the e-counsellors to address and require specific editorial protocols and expert guidelines.

- **Standardising outputs is essential.** The editorial board is indispensable for ensuring outputs are professional and standardised.
- **A reliable technology platform is crucial when dealing with sensitive information about young people.** It is important to ensure a safe technical platform on which to start any e-mental health projects

School-based prevention workshop

- **High-quality materials co-created by experts are essential.** Workshop content should be based on robust literature and initially developed with the appropriate partners.
- **The intervention must be evaluated thoroughly to be included in policy.** A strong evaluation and process is required if the programme is to be incorporated into the national curriculum.

Next steps

e-Counselling

- The team is in the process of finalising an advanced online tool to allow the editorial board to research the contents of the e-counselling questions and answers.

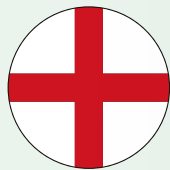
School-based prevention workshop

- The teachers' instruction manual will be upgraded in 2019.
- The workshops will be promoted across the Slovenian school system.

Source
Written communication from Ksenija Lekic, head of the programme



Improving Access to Psychological Therapies



Objective

Substantially increase access to psychological therapies for depression and anxiety disorders in England by training over 10,500 new therapists by 2021 and deploying them in new services to treat these conditions.

Description

Improving Access to Psychological Therapies (IAPT) is a service delivered by the NHS in England. It was championed in 2005 by psychologist David Clark and economist Richard Layard, who presented to the UK Cabinet Office the economic and clinical arguments for providing more psychological therapies. Through coordinating messaging with patient representative groups, such as the charity Mind, they received political support and the IAPT service was funded through NHS England.

IAPT is based on the stepped care model for the treatment of depression and anxiety disorders, as recommended by the National Institute for Health and Care Excellence (NICE). This details three levels of care with increasing intensity of therapeutic input: primary care, which includes assessment, psychoeducation, pharmacological treatment and referral; a low-intensity service for mild to moderate depression and anxiety, including guided self-help, computerised CBT and behavioural activation; and a high-intensity service, including weekly face-to-face sessions for people with more severe mental health problems, or for whom the low-intensity service has not been beneficial.

Training

The project includes training therapists in NICE-recommended therapies, particularly CBT, to ensure large-scale provision of these therapies to those in need.

Service provision

Through funding and increasing staff capacity for NICE-recommended therapies, IAPT has treated people for common mental health disorders and carefully monitored outcomes on a session-by-session basis.

What did it achieve?

In 2017, the service saw more than 960,000 people. Around 60% (over 560,000 people per year) received a course of treatment. Between January and July 2017, 51% of treated patients were judged to have recovered by the end of their treatment, and 67% improved.

The programme uses a unique session-by-session monitoring system to record clinical outcomes. The system captures pre-treatment and post-treatment depression and anxiety scores for 98.5% of people who are seen at least twice.

Public reports have been published, showing decision-makers that recommended treatments are effective. This gives hope to people that recovery is possible, and shows sceptics that mental health disorders can be successfully treated like any other illness.

Statistics of success have been published, ensuring sustainability. The publication of these statistics puts pressure on the government to continue funding an obviously successful service.

Funding

The project is funded by NHS England and the Department of Health and Social Care.

Stakeholders involved

NHS mental healthcare teams, NHS England, Department of Health and Social Care, Clinical Commissioning Groups, Health Education England, NHS Digital, Mental Health Charities.

Key lessons learnt

- **The economic argument is powerful.** The champions of the project garnered political support by demonstrating a strong economic argument that the savings incurred would pay for the cost of the project.
- **Coordination with patient advocacy groups can enhance impact.** Clark and Layard timed the release of *The Depression Report: A new deal for depression and anxiety disorders* to coincide with the publication of Mind's report, *We Need to Talk*. This coordinated advocacy created a powerful voice.
- **Piloting and evaluating two versions of the service was integral to developing the right model.** The team piloted a low-intensity therapy service and a full stepped-care model; the IAPT service is a combination of these two models. Evaluation highlighted that a strong low-intensity therapy element is needed to treat high volumes of patients, while a high-intensity component allows treatment of people across the entire spectrum.
- **Collecting outcomes data is important to avoid overestimating the service's effectiveness.** This service implemented a session-by-session outcomes monitoring system, which meant patient progress could be tracked and visualised to help communicate with both the service users and funders. The pilots showed that session-by-session monitoring is needed to ensure outcomes data are available on everyone who has a course of treatment and that complete data are essential for an accurate estimate of patient benefit.
- **Training staff in evaluation and good leadership is important so they do not feel like they are being monitored.** Staff sometimes felt threatened by the introduction of a new monitoring system; however, good leadership and training showed them how these data can be used to better help service users and allow staff to innovate.
- **Self-referral is effective.** Some people felt self-referral would be a waste of money because people with mild symptoms would access specialists. However, people who self-referred had symptoms as severe as people referred by GPs, were representative of the local population diversity and tended to have been experiencing symptoms for longer.
- **Good documentation is fundamental.** Organisers must develop high-quality reports and documents that can demonstrate the success of an initiative and highlight quality standards.

Next steps

- Organisers are looking into more digital delivery of therapy through eHealth. Apps will be introduced in a phased method once NICE and NHS England have identified a suitable product.
- New integrated IAPT services for people with depression or anxiety in the context of long-term physical health problems are being developed to ensure co-location and coordination of mental and physical healthcare.
- The project is expanding training in other NICE-recommended therapies, in addition to CBT.

Source
Interview with David Clark, National Clinical and Informatics Advisor for IAPT

Mirakle project

Building Blocks for the Mental Wellbeing of Older People



Objective

Mental health awareness-raising and promotion in people aged 60 and over.

Description

The Mirakle project, which ran from 2012–2016, focused on how older people conceptualise their circumstances. The project concentrated on the strengths and competences that people possess. It was based on a view of older people as independent, capable citizens with existing mental health skills, such as emotional awareness, resilience and coping strategies. Age-sensitive service models were developed with target-group experts, and materials to increase knowledge and skills of both older citizens and professionals were co-created with older people.

The Mobile Crisis Work pilot was one component of the Mirakle project, which looked at how crisis work could better meet the needs of over-60s. The crisis work was based on a booklet entitled *Veterans of Life* – a collection of coping stories from older people.

What did it achieve?

It was the Finnish Association for Mental Health’s first project for older people. The Mirakle project was the first large-scale project the association had undertaken for this age group.

It offered tailored wellbeing training. The wellbeing training was tailored to older people. It consisted of 10–12 sessions and was easily adaptable to different contexts.

It provided a tailored crisis model. The Mobile Crisis Work part of the project trained staff on how to engage and have difficult conversations with older people in emotional life situations.

It changed mindsets. The positive attitude of the project staff and the economic arguments for early support changed people’s mindsets, both within and outside the project.

Greater awareness was raised among the organisations involved. The four organisations involved in this project are now more aware of wellbeing in older people. In a country as small as Finland, this is a significant spread of knowledge and is powerful for changing public perceptions.

It created age-sensitive materials. The Mirakle project published a collection of stories, entitled *Veterans of Life*, and an easy-to-read, research-based booklet on the ageing mind.

Funding

The project was funded by Finland’s Slot Machine Association (RAY) and RAY’s ‘Active Age – Never mind the years’ programme, which is coordinated by the Central Union for the Welfare of the Aged.

Stakeholders involved

Finnish Association for Mental Health, Central Union for the Welfare of the Aged, Pensioners’ Union, Central Association of Finnish Pensioners and Union for Senior Services.

Key lessons learnt

- **A positive attitude is motivational.** A positive psychology and attitude to change are powerful and can motivate people to get involved in a project.
- **Pilots need to be ‘real world’ to ensure they are feasible and sustainable.** The Mobile Crisis Work pilot had strong financial support and an extremely enthusiastic and motivated coordinator. However, the success of the pilot was not replicated when the project was moved to a real-world setting, where there was not as much money or enthusiasm.

Next steps

- Different funding avenues are being investigated as there is currently only one staff member funded to continue the work.

Source
Interview with Sonja Maununaho, project coordinator

- **Projects need to run for long enough to effect change.** The funding period was not enough time to learn what the target group wanted, deliver it and see change.
- **The target group should be more focused.** A target group of over-60-year-olds is too broad, as there is such variability within that population. Change is more feasible when a narrower target group is defined because activities can be better tailored and more effective.
- **The training and learning components are sustainable because the knowledge exists.** Thanks to this project, there are people in various organisations who are prepared for difficult conversations with older people in a mental health crisis, and they know how this group would like to be treated. They can help to spread the training and promote ideas to influence public discussion.



Community Mental Health Centre in Blagoevgrad



Objective

Develop community services for the management of people who have been hospitalised for severe mental illnesses, including depression.

Description

This community health service pilot – part of The Mental Health Project for South-Eastern Europe – evolved in three phases:

1. Development of national mental health policies and legislation that complied with international and European standards (September 2002 – March 2004)
2. Establishment of pilot community mental health centres; in Blagoevgrad, this involved renovating a site which already had a hospital, so the day-care centre was on the same site (March 2004 – March 2006)
3. Development of training curricula and programmes for mental health professionals based on the Lieberman methodology, a method of communicating with patients that allows for meaningful connection, mental health screening and empowerment² (April 2006 – December 2008).

What did it achieve?

It changed mindsets. The centre had 365 visits in the last quarter of 2005, which steadily grew to 2,223 visits in the first quarter of 2008. This was due to more referrals by clinicians and popularity among patients.

It was part of the first Bulgarian national mental health plan. Development of national mental health policies was the first step in this programme.

It created a National Council for Mental Health. This includes representatives of all concerned institutions.

It fostered inter-ministerial collaboration. The Ministry of Health worked with and encouraged the Ministry of Labour and Social Policy to implement processes and guidelines which allowed non-clinical professionals, such as social workers, to be involved in rehabilitation centres.

It allowed for replication and expansion. The pilot has been replicated across Bulgaria, as well as in other countries that were not included in the original project.

Funding

The Mental Health Project for South-Eastern Europe was initiated under the South-Eastern European Stability Pact's Social Cohesion Initiative, which was supported by the World Health Organization (WHO) Regional Office for Europe and the Council of Europe. It was initially funded for six years, from 2002 to 2008. Funding has since been taken over by the Bulgarian national government, although changing political agendas mean this has been inconsistent.

Stakeholders involved

WHO, Council of Europe, Bulgarian Ministry of Health, Bulgarian Ministry of Labour and Social Policy, psychiatrists, social workers, psychologists, nurses, carers.

Key lessons learnt

- **Get psychiatrists on board.** In Bulgaria, this group holds the power to change mental health practice.
- **Implement flexible legislation.** There needs to be room in national policy and legislation to establish new facilities and services in an ever-changing environment.
- **Secure appropriate funding.** The funding for mental healthcare in Bulgaria is based on the turnover of patients and bed numbers; this encourages institutionalised treatment, leading to returning patients and a 'revolving door' phenomenon. A move towards a funding model based on the quality of care, provided through a defined clinical pathway, would likely lead to sustainable recovery and standardised practice. This would also mean that mental health could have access to national insurance funding.

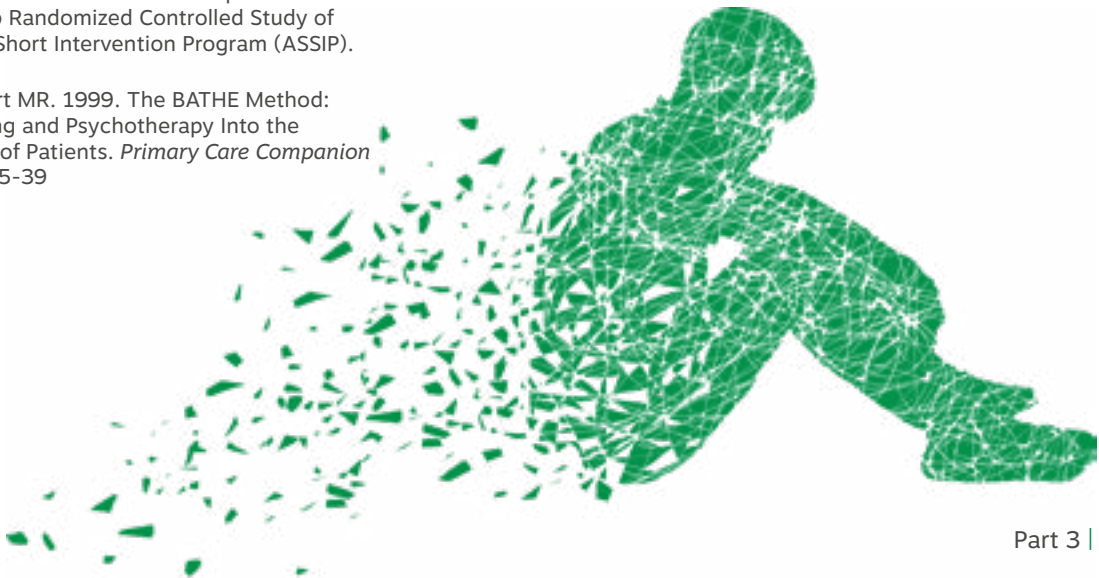
Next steps

- Many sites are being turned into complexes that include a community rehabilitation centre. It is hoped that this will evolve into a rehabilitation centre network, where learning can be shared and the mental health rehabilitation movement supported.
- A larger project is being established, which will focus on community centres for people who need long-term mental healthcare.

Source
Interview with Professor Hristo Hinkov, country project manager

References

1. Gysin-Maillart A, Schwab S, Soravia L, et al. 2016. A Novel Brief Therapy for Patients Who Attempt Suicide: A 24-months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP). *PLoS Med* 13(3): 1-21
2. Lieberman JA and Stuart MR. 1999. The BATHE Method: Incorporating Counseling and Psychotherapy Into the Everyday Management of Patients. *Primary Care Companion J Clin Psychiatry* 1(2): 35-39



Professionally guided peer-support groups



Objective

Utilise the shared experience and compassion of peers to prevent mental health disorders and suicide in people who have lost a loved one suddenly.

Description

Group meetings are held for people who have lost someone suddenly to accident, disease or suicide, and those who have lost a sibling or family member. In all the groups, a minimum of five individuals meet with a pair of coordinators for 15 weekly meetings, which are held at the same time and place for 2–2.5 hours. The coordinators are trained professionals who guide the discussion between participants. They ensure that everyone has a chance to speak, no one is offended and any conflicts are resolved.

The course follows an overarching structure but is adaptable to each group's needs:

- **Sessions 1 and 2:** Introductions and recounting of loss stories
- **Sessions 3 and 4:** Immediate reactions to loss and suffering different feelings
- **Sessions 5 and 6:** Effects and significance of loss
- **Sessions 7 and 8:** Trauma, grief and comfort
- **Sessions 9 and 10:** Supporting recovery and survival
- **Sessions 11 and 12:** Remembering loved ones
- **Sessions 13 and 14:** Resources and the future
- **Session 15:** Feedback and final thoughts.

In remote areas of Finland, such as Lapland, the course is condensed into two four-day courses delivered across six months. These intensive courses include food and accommodation for participants and counsellors.

What did it achieve?

Users gave it a high rating. The average score given in the final session is 4/5, and this score remains the same when the participants are asked to rate the course three months later. Participants state that the peer-support facilitated their recovery from their crisis and alleviated their sense of hopelessness.

It is sustainable and has opportunity for growth. This group-style therapy has been delivered by the Finnish Association for Mental Health since 1995, and has been expanded to help people who have lost someone through murder, lost a child, or lost someone suddenly. A similar structure has also been adapted for adolescent peer-support groups.

It is continually evaluated. The group programme and follow-up feedback from each group is summarised and discussed in professional working groups every six months. This means new ideas can be trialled and assessed, and successes or challenges identified.

Participants are empowered. Meeting by meeting, the course moves participants towards empowerment, which gives them the ability to change their life situation for the better.

Funding

The project is funded by the Ministry of Social Affairs and Health.

Stakeholders involved

Finnish Association for Mental Health

Key lessons learnt

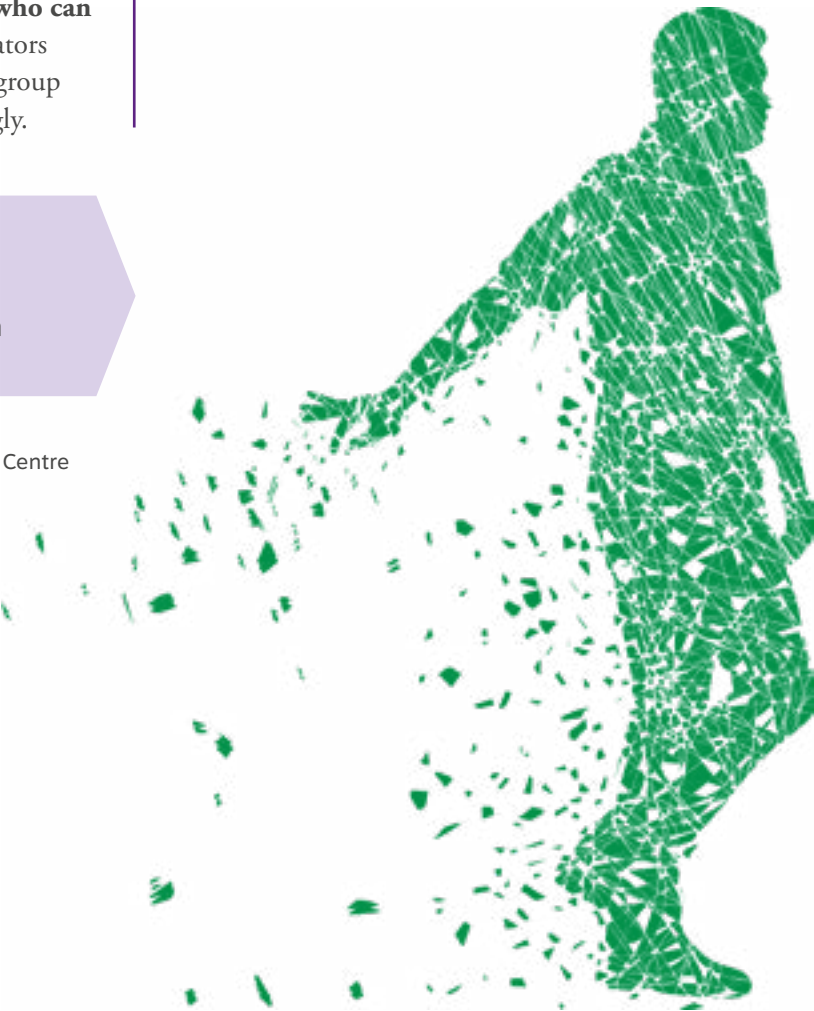
- **Language can be empowering.** People are usually eager to describe their experience and their feelings using their own words.
- **Participants may initially find it difficult to hear one another's stories of loss.** It is important that coordinators speak to participants in advance to make them aware of this.
- **Participants need to commit to attending all 15 sessions.** The group dynamic and relationships can be challenged and become less effective if there are changes in the group.
- **It is important to have two course leaders who can work together and be flexible.** The coordinators must be able to exchange ideas, listen to the group members and adapt their approach accordingly.

Next steps

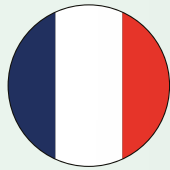
- The programme continues to be delivered by the Finnish Association for Mental Health.

Source
Interview with Reija Tuomisalo, Manager of SOS Crisis Centre

- **Recruitment is time-intensive.** The programme must allow for enough recruitment time at the beginning to ensure a large, diverse group.
- **Organisers should allow for reflection time before feedback.** This course seeks feedback at the final session and three months later. Comparing these results means the evaluation is more robust.
- **It is crucial to be clear about participants' expectations and tailor the intervention to meet them.** The counsellors clearly state the objectives of the groups from the start. For example, they explain that the group is not there to take away the grief. They also ask the participants about their expectations. This dialogue means the participants have reasonable expectations and the counsellors can ensure those expectations are met over the 15 weeks.



La Compagnie des Aidants



Objective

Provide informal carers with a supportive space to share, communicate and help each other, to improve the conditions of their personal lives.

Description

La Compagnie des Aidants is a private social network for carers of people with physical or mental health conditions. It provides practical and economic advice and was created by carers to facilitate the lives of other carers and improve their wellbeing. Services include:

- a support helpline
- an exchange and sharing zone, where carers can loan, sell or donate their used equipment
- a directory of carers to aid peer support
- a directory of volunteers to access support and help
- a section dedicated to practical solutions to equip and secure the place of residence of the person they support.

What did it achieve?

It is a sustainable model. This is a sustainable social network because it can be adapted and updated according to need and technology developments, and has a stable, diversified funding structure. It has been extended to several French ‘departements.’

It gained funding to develop educational videos. La Compagnie des Aidants received support from the European Regional Development Fund (ERDF) to develop practical, educational videos that teach carers basic caring tasks. These videos give credibility to the experience gained by informal carers and can be used towards a diploma in caregiving.

Funding

The project received an initial grant from the Fondation de France. It now has a sustainable, diversified funding structure consisting of contributions from insurance companies, departmental councils, local authorities, the ERDF and a small subscription fee from members.

Stakeholders involved

Informal carers, volunteers, banks, insurance companies, local organisations.

Key lessons learnt

- **Any web-based service like this one requires continual updating.** La Compagnie des Aidants is always learning about what carers need and want on the site. It is currently developing the third version of the site, which will include extra features suggested by members.
- **There are some age barriers to using the social network.** Overall, carers have been engaged as they can see the benefits of the site. However, there are difficulties in engaging people over 75, because they are often unfamiliar with the technology.
- **Some partners need to see proof of success before joining.** To convince some partners to join the project, the organisation needed to show them the number of people using the site. This was the case when the team was convincing the local collectives to fund the project.

Next steps

- The new version (version three) will host a ‘chatbot’ to facilitate instant conversations with people who are geographically near one another. This means people can know there are others around and talk with them about their challenges.
- An evaluation of the social impact of this initiative is currently underway with partner organisations.
- The founder and president of La Compagnie des Aidants has been to London to talk to Carers UK about adapting and implementing a similar social network in the UK.

Source
Interview with Claudie Kulak, founder and Anne Jouhet, project coordinator



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Research strategy and selection criteria for case studies

The Health Policy Partnership (HPP) conducted a pragmatic review of peer-reviewed and grey literature using Google Scholar, PubMed and Google. Two levels of selection criteria were used. First, we tried to identify the most relevant case studies using the selection criteria defined in *Table A1*.

Table A1. Case study selection criteria

Inclusion	Exclusion
European country (non-European case studies will be included only if they are of great interest)	Outside European countries
Depression and suicidality	Other mental health conditions
2010–present day (initial search will not restrict time period and pre-2010 case studies of great interest will be included)	Pre-2010
Broad social, health, education, policy, workplace intervention	Individual, clinical intervention studies
Follow-up length >3 months	
Responsive contact for interview	

Secondly, we classified identified case studies using a framework to ensure we obtained a reasonable distribution of case studies across multiple criteria. The framework for classification is presented in *Table A2*. We then selected case studies for interview to obtain a representative group of examples covering each of these categories.

We contacted 42 case study leads, of which ultimately 19 were included in the report, and were able to secure an interview with 17 of them. We then conducted 45-minute semi-structured telephone interviews with each case study lead. All persons interviewed were asked to validate the findings of this report as well as the lessons learnt from their experience.

Table A2. Case study interview selection framework

Action areas	Type of intervention by level of prevention	Target age group	Geographical scope
Policy	Early intervention	Children and mothers	International
Family	Primary prevention	Adolescents	National
Workplace	Progression and relapse prevention	Adults	Local
Education	Suicide prevention	Old people	
Health and social care service provision			



A checklist to ensure sustainability: from planning to evaluation

One of the key challenges in depression policy and practice is sustainability. Changing political landscapes, social stigma, and inconsistent evaluation and reporting mean projects often do not affect long-term, large-scale change. This checklist collates lessons and recommendations from leading experts that will help ensure a sustainable project. We urge decision-makers to change the depression landscape by considering this checklist when implementing new policy or practice.

Pre-planning

- ✓

Have you critically looked at the evidence base, considering how your population differs from the study population?
- ✓

Have you considered a diversified funding structure to ensure sustainability?
- ✓

How long is your project planned for? (Understand and plan for a project with sufficient time to pilot, implement and see change in mental health)
- ✓

Have you considered a training or education element of your project? This can ensure sustainable practice in uncertain environments.

‘We piloted two methodologies and we realised both had merit, so the full roll-out was a combination of these two pilots and has led to a very successful service.’
IAPT, England

Project planning

- ✓

Have you planned a pilot that mimics the real-world setting of this project? Have you anticipated what else a full roll-out will involve?
- ✓

Have you considered the language you are using in your project?
- ✓

Where does your project sit in the overall referral pathway?
- ✓

If you cannot meet someone's needs, do you know where to refer them?
- ✓

Who is the ambassador of this project? Are they confident and able to defend and report on the project?
- ✓

Does your plan allow for flexibility to accommodate different individuals and consider policy/priority/funding changes?
- ✓

Have you included staff training to introduce this new service or model?

‘To address the complexities of mental health, you need different partners who can address different factors – one organisation cannot address the entire spectrum of the problem.’
Family Wellness Project, Northern Ireland



‘We need strong data to inform policy changes and strengthen effective practice’

International Federation of Psychotherapy

Partnership planning and collaboration

- ✓ Have you included all relevant partners? Have you developed a partnership plan with clear roles and responsibilities?
- ✓ Does your budget allow for enough staff respite, to ensure positive and resilient staff?
- ✓ Have you developed relationships with local individuals and not just their association/representative/management?
- ✓ Is there a certain professional group who can help you implement your project if brought on board? Have you engaged them?
- ✓ Are you employing previously trained professionals or training people yourself? What are the benefits and challenges of each approach?
- ✓ Have you considered a central coordinator or project manager to ensure streamlining and oversight?

Evaluation

- ✓ Have you set aside enough funding for a thorough evaluation?
- ✓ Have you made explicit the nuances of your population in your evaluation to aid replication and adaptation to different settings?
- ✓ Have you trained your staff to use evaluation methods and the results to improve their practice and not feel threatened?



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