Green Fingers Clear Minds

Striving to develop a strong evidence base on nature based interventions for people with mental ill-health

December 2015 Workshop
Findings and Suggestions Report

Dr Jenni Murray
Dr Helen Elsey
Leeds Institute of Health Sciences

Charles Thackrah Building
University of Leeds
101 Clarendon Road
Leeds
LS2 9LJ

UNIVERSITY OF LEEDS

Contact: j.y.murray@leeds.ac.uk ; 0113 343 0892

This report is a summary of the Green Fingers Clear Minds Workshop, held on 10 December 2015, at Leeds Institute of Health Sciences, University of Leeds. Included are findings from discussions and Care Farming UK responses to proposed suggestions.

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1. INTRODUCTION

The aims of the Green Fingers Clear Minds workshop were to 1) bring together parties interested in nature based interventions for improving mental ill health with a view to developing a plan to build collaborations to support the development of a better evidence base and 2) look at ways to support the development and sustainability of care farms in Yorkshire.

The workshop was organised as part of an ongoing research study funded by the National Institute of Health Research Public Health Research Programme. This was a feasibility study looking at the impact of care farming (also known as social farming) on the quality of life and re-offending behaviours of people serving community orders. The study also included the first systematic review of the literature on the effectiveness of care farming for improving quality of life for a range of vulnerable clients. Evidence emerging from the research study suggests that the way in which care farms appear to work for a range of client groups is by improving mental health. For the purposes of the workshop the main focus was on mood disorders, primarily depression and anxiety. This is where the greatest gaps in current service provision are considered to be. Data presented early in the workshop highlighted the overwhelming need for alternative options to mainstream talking therapies and anti-depressants. Nature based interventions could play a much greater role than that currently provided in caring for those with mental ill-health. In comparison to talking therapies and anti-depressants, nature based interventions are lacking in robust evidence and information about clinical and cost effectiveness.

The workshop was attended by 29 participants (11 from nature based organisations; nine from national organisations/Councils/Clinical Commissioning Groups/MIND/Care Farming UK; nine researchers). Despite efforts to increase attendance from Clinical Commissioning Groups (CCGs) there was limited attendance. This was not unexpected given the cuts in public services and pressures on staff. However, this does reflect the ongoing challenges that third sector organisations such as care farms have in engaging effectively with CCGs and Local Authorities.

The findings of the workshop have been reviewed by Care Farming UK whose responses to several suggestions made on the day are included in this report.

The following presentations were given on the day and the slides are available to download from the Academic Unit of Public Health, LIHS website. They are referred to where appropriate within the list of sections below:

Helen Elsey, University of Leeds The impact of care farms on quality of life among different population groups: systematic review
Rachel Bragg, Care Farming UK Care Farming in the UK and the role of CF UK
Jenni Murray, University of Leeds Care Farming and mental ill-health – where do we stand?
Jim Kinsella, University College Dublin Establishing and Delivering Social Farming in Ireland (RoI) and Northern Ireland (NI): The case of the SoFAB Project
James Smith, Growing Well Farm 1) Growing Well: commissioning for mental health 2) Inspirational organic growing - enabling mental health and wellbeing.
Sara Kyrö Wissler, Swedish University of Agricultural Sciences The Swedish model – New approaches in primary healthcare in relation to care farms
Anna Maria Palsdottir, Swedish University of Agricultural Sciences How can we do research well in care farms? Critical reflections
Paul Nolan, The Merseyside Forest Team Consortia based approaches – time for a new game?

2. FINDINGS - KEY AREAS

The workshop participants discussed the way forward for nature based interventions that are considering or currently offer support for people with mental ill-health. The findings are organised into 10 key areas:

- Working within a recognised framework
- The culture of care farms
- Training for care farmer staff

- Opportunities on the farm
- Engaging with the local market
- Referral processes
- Measuring health benefits
- Funding
- Leadership
- Networks

2.1. Working within a recognised framework

- Jenni Murray outlined the NHS stepped care model for management of depression and anxiety which refers to four levels of need and associated treatment options (see Figure 1).
- This model provides a useful framework for care farms to identify who they can support and the skills that might be required on the farm.
- It was considered that at levels 1 and 2 non-specialist support could be provided on a care farm as a therapeutic space.
- At level 4 a trained mental health professional would be required to provide therapy tasks.
- A further group of clients not covered by the stepped care model includes those in recovery / maintenance.
- This theme of catering for service users at different levels of the care model was further continued by Growing Well.

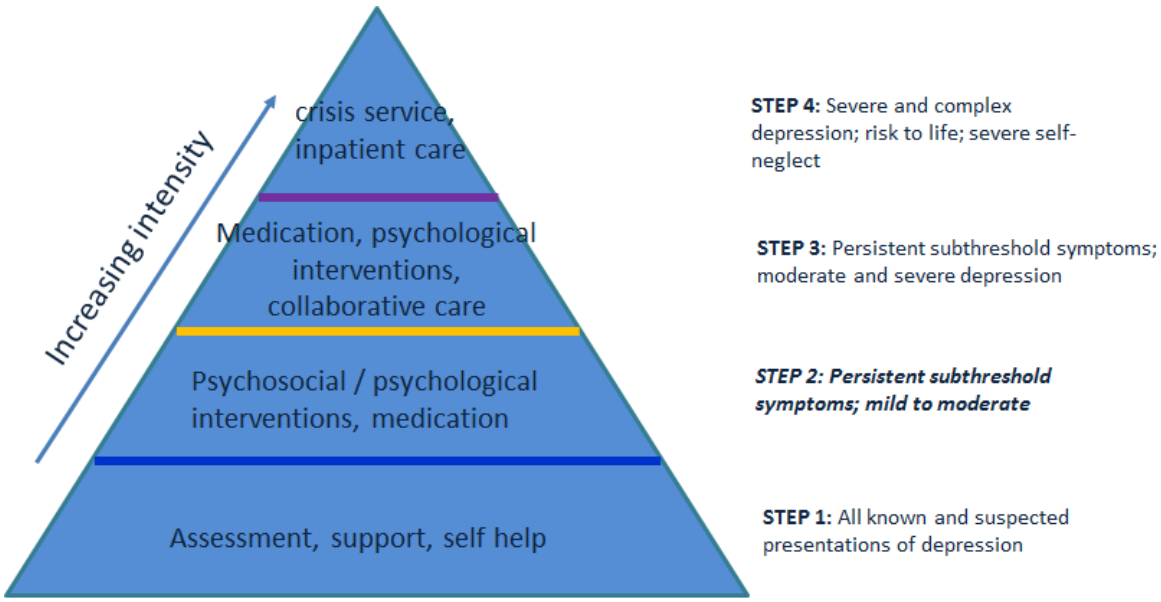

Figure 1 Stepped care model. Reproduced from the NICE clinical guidelines for depression in adults: diagnosis and management CG90 https://www.nice.org.uk/guidance/cg90

Care Farming UK response:

This is a valuable framework offering a common language between nature-based service providers such as care farms and the referring/commissioning health services.

It also is helpful in supporting farmers to consider the skills required at each level and the costs of delivering services in mental health care.

Most care farms currently working with people with mental health issues do so at levels 1 and 2.

2.2. The culture of care farms

- There was a feeling in the discussions that care farms and other nature based interventions provide similar cultural characteristics to a 'therapeutic community' (*see further reading section, Haigh reference*). These are:
  - ❖ Attachment (a sense of belonging)
  - ❖ Containment (safety)
  - ❖ Communication (openness)
  - ❖ Involvement and inclusion (participation and citizenship)
  - ❖ Agency (empowerment).

- Evidence from the literature review of care farm research studies conducted by Drs Elsey and Murray (not yet published) has found that people attending care farms talk about these characteristics and appear to value them. Elsey and Murray suggest that feelings of attachment, safety, openness, participation and empowerment are likely to be mechanisms of positive change that may lead to improved mental health and wellbeing (see Helen Elsey presentation).

- The question of what benefit might be accrued through promotion of this cultural identity externally has been suggested through the experience of Growing Well in Cumbria (see James Smith presentation 1) who have obtained separate funding for their own therapeutic community provided for people with a diagnosis related to a personality disorder.

- The extent to which a care farm or a nature based intervention might feel it is appropriate to align itself more closely with the concept of a therapeutic community is a topic for discussion.

2.3. Training for care farm staff

- Care farm staff not already working with people with mental ill-health may be deterred from working with the mental health client group because of uncertainty about the extent of expertise that may be required.

- In addition to prior learning through awareness raising or experience, some form of further training or education specific to mental health may be valuable for care farm staff. Signposting to a level of training that would be appropriate for supporting clients at levels 1 and 2 of the stepped care process is also likely to be useful (see Figure 1).

- There should also be some form of support mechanism or contact point that care farm staff can access in the event of a crisis. It may be that through developing an awareness of local care pathways that a local support contact can be found. Any risk assessments conducted on the farm should therefore address this and build this into their health and safety protocols.

Care Farming UK response:

It is important that those wishing to deliver services for mental health are familiar with the framework of levels at which their care is best suited. Some form of additional education or training may be useful for those who are considering providing services for people at levels 1 and 2.

Many care farms have a member of staff who is experienced in working in mental health, who is responsible for ensuring that all safeguarding and risk policies are appropriate for mental health clients and that other staff are aware of best practice.

Although we do not offer specific advice for those working with people with mental ill-health, Care Farming UK provides support to members regarding setting up a care farm, which urges careful consideration of the most appropriate client groups for individual care farms depending on staff skills and resources. We have also helped to develop Countryside Educational Visits Accreditation Scheme (CEVAS) care farmer training (two day courses accredited by the Open College Network). See Care Farming UK website for details on training dates and venues.

2.4. Opportunities on the farm

- All at the workshop agreed on the importance of providing meaningful and varied activities that include life skills provided within small groups. Evidence from the literature review conducted by Drs Elsey and Murray (not yet published) suggests these activities are being provided on care farms. The review also found that in a few studies, clients felt uncomfortable when mixed with other client groups with different needs. Conversely other studies reported that some clients found working with other groups rewarding. This highlights the challenges and benefits of balancing the needs of individuals with providing support to a range of client groups.

Care Farming UK response:

Evidence from a recent Care Farming UK and Mind report published by Natural England (see Bragg & Atkins, 2016 in Further Reading section below) also points to the importance of the meaningful farming activities provided on care farms. The report suggests that it is the combination of the three key components (the natural environment, the meaningful activities and the social context) which characterise care farming that contributes to mental wellbeing benefits.

Some care farms cater only for a particular client group, some for a range of client groups simultaneously (where appropriate) and others cater for different groups on different days.

2.5. Engaging with the local market

- Services at the care farm should be tailored to local needs and should use a language that appeals to local providers. This echoes the findings from Natural England and Care Farming UK reports (see Further Reading section below) and extends beyond attracting new clients, to include maintaining communication with referring providers about existing clients. Although care farms accept referrals from social care, probation and many others, those commissioning or referring clients with mental ill health (such as community mental health teams) come from the medical profession.

- It was suggested that 'Taster' events could be provided for people to try out – this could include both clients and also commissioners. The use of Open Days on social farms in Ireland and Northern Ireland (SoFab network – see later for discussion on networks and Dr Jim Kinsella's presentation) have helped create opportunity for local authorities, including commissioning body representatives, to see what is offered and to hear from farmers, service users and their families on their experience to date. This has assisted in the creation of local champions, who have influence in the area.

- Ongoing communication between care farms and health centres is equally important. For example, in Ireland the SoFAB network has set up individual support plans that enable the sharing (two-way) of information on the clients, between the farmer and the commissioning body. A further example comes from Sweden (see Sara Kyrö Wissler and Maria Palsdottir presentations), in the south region (Scania). Nature-based rehabilitation on care farms is now established as part of regular healthcare. A new model of joint working was launched in order to enable communication between policy makers, commissioners, primary healthcare, the Social Insurance Agency, the Public Employment Services and care farms (agricultural businesses). The communication chain between these stakeholders is very long and it can be difficult to reach agreement on subjects such as green care services for the healthcare centres. However the healthcare authorities have initiated a new position, a contract manager that enables communication between care farms and healthcare centres. Information sessions are held regularly for caregivers who refer clients to the farms. The contract manager holds meetings with the care farms to address issues for discussion. Caregivers and care farms meet annually for discussion about the services provided, improvements and a patient focused care. The new approach is an innovative application in healthcare in Sweden and has now spread to other parts of Sweden. Information sessions are held regularly for care providers who refer clients to the farms.

- The contract manager role reported in Sweden is similar to the Self Directed Support Worker role in NHS Highlands as reported by one of the delegates. Here the role is to help people locate 'non-conventional organisations' to access their services. This is part of NHS Scotland's Self Directed Support Act which enables people to plan how to use their personal budgets to better effect.

Care Farming UK response:

Several care farms currently offer taster days for potential new clients; knowledge exchange between care farmers and information days for commissioners. Like SoFAB, Care Farming UK also supports these events and recognises that this can be a very useful process.

2.6. Referral processes

- Care farms should increase their knowledge of local health care referral pathways so that they can maximise opportunities for clients to find out about and be referred to their service. By having a good awareness of these pathways there is the opportunity to develop professional relationships with NHS providers. Suggestions were made regarding the development of a common/standardised referral process which could be adopted across care farms/nature based interventions. Whilst this would seem to echo the health service drive for all third sector organisations to have one referral process (e.g. social prescribing), referral processes are usually determined by commissioners rather than the service providers. Care farms need to be able to fit in with local prescribing practices, regardless of what they are. Care farmers may need help or support in identifying what that process is and how to get engaged.

- Care farms themselves should be clear on who they can accept given the level of expertise and activities on the farm. Referral routes to care farms could potentially include social prescribing where it exists and where appropriate.

- This could circumnavigate the difficulties that GPs experience in keeping up to speed with the numerous local projects that are intermittently available in their area and their reticence about completing referral forms for individual interventions. Care farms are currently not well known in the health sector. Social prescribing hubs (which can be run by charities such as MIND or BARCA) may also not know about local care farms. Care farmers should find out if social prescribing is i) appropriate for them and ii) available in their local Clinical Commissioning Group area (see

further reading section for the NHS website address listing all CGGs with links to further details).

- It should be noted that CCGs and Local Authorities around the country have different social prescribing service models. In some areas service providers (such as care farms) who accept clients through social prescribing may not receive a payment through the CCG /LA. Payment for these clients will still have to be sought from elsewhere but ability to demonstrate a sustainable source of clients may help with acquiring funds. Additionally many social prescribing service models are evaluating their approach through the use of reliable outcome measures so there is the potential for care farms to access this data on their own client group which again may support applications for grant funding. Further, these clients may not be clinically depressed or anxious or at least the reason for their referral to social prescribing may not be because of these particular needs.

Care Farming UK response

The Natural England survey (see Further Reading & Resources section below) found that CCGs and Local Authorities responsible for commissioning services prefer to be approached by consortia of service providers (including but not exclusively nature-based interventions) which provide services for a particular client group rather than by individual services such as care farms.

The importance of communication between nature-based intervention providers such as care farms and GPs and medical centres has also been recognised and Care Farming UK is currently working with Mind, Natural England and the University of Leeds to explore how social prescribing models can be used to refer clients to care farms and how care farms can best engage with these models. As is the case in Ireland, Sweden and the Scottish Highlands, many social prescribing models in the UK also have a link or key worker at a health centre who refer clients to particular interventions and good communication with these people is crucial.

Referral processes may be influenced by nature-based intervention providers such as care farmers – or even Care Farming UK in the future, but at the present time imposing a 'standardised' or single model referral process is unlikely to be accepted by different types of commissioner or between different commissioning regions.

Care Farming UK, Natural England, and Mind are currently undertaking a review of social prescribing projects to establish if social prescribing is an appropriate model for care farms to increase referrals and if so how farms can best engage with social prescribing.

2.7. Measuring health benefits

- Health outcomes represent just one of the many potential measurable outputs from care farming. Measuring health outcomes is important for funding purposes (including grant income) but also for negotiating with commissioners. Health research in care farming has seen a wide range of outcome measures applied.

- Traditional medical research models (such as Randomised Control Trials) are problematic since individual care farm research studies traditionally involve relatively few clients, meaning that they lack the statistical power to prove benefit. Three options are available to address this: 1) to run larger studies across multiple farms; 2) combining data across a number of studies that use the same outcome measure enabling average changes in mood scores to be calculated; or 3) combining data across multiple studies that use different measures but where the measures have well defined cut offs for depression.

- Whatever approach is adopted it should allow a critical mass of evidence to be accumulated and requires the co-operation of farms to move this forward. To date according to the Elsey review, the most frequently applied outcome measure reported in care farming research studies involving individuals with depression has been The Beck Depression Inventory (see Appendix 1). Key factors that might influence choice of outcome measures include cost (some outcome measures require a licence fee and licensed researchers), acceptability to the client group ensuring good completion, validation (ensuring that the measure has been fully tested and is trustworthy). Designing an in-house questionnaire is not necessary and may be of limited value. Any tool should be meaningful to the health services. Other tools that might be considered include PHQ2 (2 items), PHQ9 (9 items), Warwick & Edinburgh Wellbeing Mental Health Scale (see Appendix 2). While this document offers guidance about what tools might be useful no one tool is specifically recommended.

- There was interest from a local authority attendee in SROI (Social Return on Investment) that was quoted as an outcome in the Merseyside presentation by Paul Nolan. Here it was reported that for every pound spent on the programme there was a social return of £6.75. It is unclear if SROI is the sort of outcome that would be of interest to Local Authorities / CCGs as a measure of value for money as opposed to more formal health economics studies and it may be that Care Farming UK explores further if this could be a powerful persuader. It is clear that SROI captures the wider benefits of interventions such as care farming which may include a reduction in reliance on housing and unemployment benefits due to clients returning to work as a consequence of increased confidence and skills building. Funders often look for some form of evaluation and Care Farming UK should

advertise a limited number of tools. Care farms should also consult with Care Farming UK on what measures to use, when to apply them and how best to administer them.

Care Farming UK response

In a recent study (Expanding delivery of care farming services to health and social care commissioners, Care Farming UK), CCGs told us of the importance of general evidence for the effectiveness specific to the intervention in addition to evidence of effectiveness from the individual care farm. Evidence of cost effectiveness and cost benefit is also beneficial.

Evaluation of the benefits of care farms is crucial and using validated tools to measure benefit is valuable for attracting funding through both grants and commissioners. Care Farming UK is currently working with the Green Care Coalition (and others) in recommending and providing guidance on a suite of outcome measures for use on care farms and other nature based interventions.

2.8. Funding

- It was thought that clients who fall into level 1 on the stepped care model (see Figure 1 above) might self-fund but that those at levels 2 & 3 should be financially supported to attend and that the NHS should support these costs.

- Separate to this, grant funding is an important source of income and looking at agricultural and other commercial companies which have Corporate Social Responsibility Schemes might be fruitful. Examples were also given of companies providing employees as volunteers and there was a suggestion that some universities could offer students for research as part of their student placements if the right connection to various degrees could be found. Growing Well provided the example of how Northern Rock part funded a pilot to enable the development of their onsite therapeutic community through a GP referral route. The Co-Op is also known to be very supportive of local community-based initiatives so period checking their website for announcements of upcoming funding opportunities may be worthwhile. Care Farms should tailor the messages within their funding requests to fit with the objectives of the organisation to which they are applying.

- The multi-functionality of many care farms is a strength in this sense, enabling it to apply to different funding streams for different purposes. Dr Jim Kinsella provided a good example of how the application for funding to the EU was tailored to meet the needs of farmers enabling them to connect with their communities rather than

health outcomes of clients as a primary objective. This is a common approach in research funding applications where funding streams have a narrow specification. A "buyer - seller" consortia-based approach for care farms aligned with other nature-based interventions (unifying under a green care umbrella) and with other non-nature based interventions was considered a potentially powerful way of increasing sustainable funding.

- The Natural Health Service run by the Merseyside Forest Team was an example of how this could work to secure funding from large charities, however in terms of engaging with local CCGs there was still some way to go. The challenge for care farmers is finding the time to devote to funding and making the first steps towards this process is very daunting.

2.9. Leadership

- Care Farming UK should provide a leadership role that includes advertising the potential benefits that can be offered through care farming. Care farmers require greater clarity on the support available to farmers. A higher level national discussion on support available to care farmers should be encouraged, led by Care Farming UK and Natural England.

Care Farming UK response:

Providing leadership and advertising the benefits of care farming is a primary objective of Care Farming UK and since the early days in 2005 (as the National Care Farming Initiative) we have been working hard to raise the profile of care farming in the UK.

We have given care farming a unified voice under the Care Farming UK banner, conducted the first scoping study of care farming in the UK and continue to add to the evidence base on the benefits of care farming. We have worked to enable a strong network of practitioners to evolve and have developed resources to assist potential care farmers, commissioners and policy makers.

We are a small charity and with our limited resources we are working strategically with other major charities and national organisations (such as Mind and Natural England) to increase our profile (and that of care farms) and strengthen our position.

We are also working with care farmers to professionalise the sector and ensure quality of service provision. We provide care farmer training through CEVAS (see our website for details) and have developed and are rolling out a care farming Code of Practice (a set of minimum standards) which has been welcomed by health and social care commissioners. We are also looking at accreditation but we are aware that this process may be valued and needed by some but not others.

2.10. Networks

- There was a suggestion that local/regional offices and networks to support and assist care farmers would be of value particularly around the development of networks. Care Farming UK is already providing support and assistance to regional networks in the UK and works closely with the national organisations such as SoFAB.

- Local/regional offices could possibly be funded through the EU but in order to do this a local group would need to be established to push this forward. The local office would help with identifying and applying to organisations that provide grants, supporting contacts with the health sector including social prescribing hubs, organising training and in time possibly overseeing accreditation and developing branding. The SoFAB project presented at the workshop was a good example of how some of these things could be achieved.

3. OTHER AREAS

The workshop touched on costs of providing care for people with mental health problems (see Jenni Murray's presentation) but this was not one of the key areas that delegates discussed. Cost and duration of 'treatment' are standard questions that commissioners are concerned with (in addition to data on effectiveness) and care farming (and other nature based interventions) should be able to offer a package that is in line with more traditional and well known treatment options (such as anti-depressants and talking therapies).

4. FURTHER READING & RESOURCES

1. HAIGH, R. (2013). The quintessence of a therapeutic environment. Therapeutic Communities: The International Journal of Therapeutic Communities Vol. 34 NO. 1, pp. 6-15 Available free on line at; http://growingbetterlives.org/wp-content/uploads/2014/06/Haigh-2013-Quintessence.pdf

2. How to set up a care farm: http://www.carefarminguk.org/faq/starting-care-farm

3. Care farm training - http://www.carefarminguk.org/faq/starting-care-farm#anchor3

4. Care farming Code of Practice: The quality of provision delivered by care farmers is assured through a process of self-assessment, enabling them to demonstrate that they follow the Care Farming Code of Practice. The Code is a clear set of guidelines, intended to meet the requirements of commissioners, clients and other authorities

to ascertain that care farms which adhere to the Code are safe, professional and efficacious See: http://www.carefarminguk.org/resource/code-practice

5. Courses on social and therapeutic horticulture for people with mental health problems: http://www.thrive.org.uk/products/training/using-social-and-therapeutic-horticulture-to-benefit-people-with-mental-health-support-needs.aspx

6. List of all the Clinical Commissioning groups with future details https://www.england.nhs.uk/ccg-details/

7. BRAGG, R., EGGINTON-METTERS, I., ELSEY, H. & WOOD, C. 2014. Care farming: Defining the 'offer' in England. Natural England Commissioned Reports, Number 155. Available at http://publications.naturalengland.org.uk/publication/6186330996342784

8. BRAGG, R., EGGINTON-METTERS, I., LECK, C. & WOOD, C. 2015. Expanding delivery of care farming services to health and social care commissioners. Natural England Commissioned Reports, Number194. Available at http://publications.naturalengland.org.uk/publication/5628503589388288

9. BRAGG, R. & ATKINS, G. 2016. A review of nature-based interventions for mental health care. Natural England Commissioned Reports, Number204. Available at https://www.gov.uk/government/news/connecting-with-nature-offers-a-new-approach-to-mental-health-care

APPENDIX 1. BECK'S DEPRESSION INVENTORY

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all of the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my fortune is hopeless and will get only worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty most of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticisms
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation
0 I am no more restless or would up than usual.
1 I feel more restless or would up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless that I have to keep moving or doing something.

12. Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than usual.
3 I have trouble making any decision.

14. Worthlessness
0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Patterns
0 I have not experienced any change in my sleeping pattern.
1 I sleep somewhat more/less than usual.
2 I sleep a lot more/less than usual.
3 I sleep most of the day.
I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite
0 I have not experienced any change in my appetite.
1 My appetite is somewhat greater/lesser than usual.
2 My appetite is much greater/lesser than usual.
3 I crave food all the time or I have no appetite at all.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question.

You can evaluate your depression according to the Table below.

Total Score_____

Levels of Depression

1-10	_____These ups and downs are considered normal
11-16	_____Mild mood disturbance
17-20	_____Borderline clinical depression
21-30	_____Moderate depression
31-40	_____Severe depression
over 40	_____Extreme depression

APPENDIX 2. WARWICK-EDINBURGH MENTAL WELL-BEING SCALE (WEMWBS)

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

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