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Firstly, we would like to thank you for agreeing to be part of this research project by delivering the intervention to older people* participating in the study; your help is invaluable.

This resource is for you to use in your role as a ‘Non-Traditional Provider’ (NTP) or ‘Support Worker’ in the NOTEPAD study.

Much of the content of this manual is provided in the training; however, this manual is for your reference throughout the study. At the end of Section 2, you will find copies of the participant contact sheets and activity diaries, which will help you to deliver the intervention and work with study participants* in NOTEPAD.

If there is anything you do not understand or if you want to know more about the study, please contact one of the team either by telephone or email.
SECTION 1

What is NOTEPAD?

NOTEPAD is a research study at Keele University. We are testing a new way to help older people who are experiencing low mood or stress.

Evidence suggests that if older people who have low mood or stress are supported in engaging in social activities that they find meaningful, then their low mood or stress will improve.

The aim of NOTEPAD is to find out whether it is possible and practical for us to train workers from the third sector to work with older people who have low mood or stress, and help them to increase their social activity.
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Introduction to anxiety and depression

Depression is a major health problem, and by 2030, it is predicted to be the second leading cause of disease burden and disability worldwide. Anxiety and depression commonly go together.

Depression severe enough to need treatment is one of the commonest mental health problems facing older people, and affects more than one in ten older people in the community.

Depression and anxiety are more common in people with long-term physical conditions: so 30% people with diabetes may also have depression, and 25% of people with chest problems, such as COPD (chronic obstructive airways disease) may have anxiety. Treatment of depression and anxiety will improve outcomes of the physical condition.

Loneliness and depression are strongly linked in older people, and loneliness is an independent risk factor for depression.

Older people with depression may have a variety of symptoms such as feeling sad, worthless, not enjoying things, having a lack of energy and motivation, having a poor appetite and losing weight, feeling guilty, or having thoughts of self-harm. People with anxiety disorders may complain of worry, irritability, tension, tiredness or ‘nerves’.
Older people may be reluctant to admit they are having difficulty coping and Health Care Professionals may be reluctant to diagnose the patient with depression, due to the stigma still attached to mental health problems.

If you want to read more about this topic, see: http://fampra.oxfordjournals.org/content/23/3/369.short

Management of older people with anxiety and depression

Most people with Anxiety and Depression are managed in primary care by their General Practitioner (GP). Treatment may include referral for a psychological treatment and/or the prescription of antidepressants.

NICE (National Institute of Health and Care Excellence) has produced two useful guidelines on the management of depression. Guideline CG90 discusses the management of depression in adults (including older adults) and guideline C91 discusses to the management of depression amongst people with physical health problems. This latter guideline is especially important since a significant proportion of older people will also have long term health problems. In relation to anxiety, there is a helpful guideline which summarizes the psychological approaches to generalised anxiety disorder and social anxiety (CG113).

You may wish to read the ‘Executive summaries of these NICE guidelines: https://www.nice.org.uk/guidance/cg90
https://www.nice.org.uk/guidance/cg91
https://www.nice.org.uk/guidance/cg113
### Stepped Care Model for Depression (NICE 2009)

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>All known and suspected presentations of depression</td>
</tr>
<tr>
<td>2</td>
<td>Persistent subthreshold depressive symptoms; mild to moderate depression</td>
</tr>
<tr>
<td>3</td>
<td>Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression</td>
</tr>
<tr>
<td>4</td>
<td>Severe and complex depression; risk to life; severe self-neglect</td>
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<table>
<thead>
<tr>
<th>Nature of the intervention</th>
<th>Focus of the intervention</th>
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<tbody>
<tr>
<td>Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, and multi-professional and inpatient care</td>
<td>Medication, high-intensity psychological interventions, combined treatments, collaborative care, and referral for further assessment and interventions</td>
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### Stepped Care Model for Anxiety (NICE 2010)

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>All known and suspected presentations of GAD</td>
</tr>
<tr>
<td>2</td>
<td>Diagnosed GAD that has not improved after education and active monitoring in primary care</td>
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<tr>
<td>3</td>
<td>GAD with an inadequate response to step 2 interventions or marked functional impairment</td>
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<tr>
<td>4</td>
<td>Complex treatment-refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm</td>
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<thead>
<tr>
<th>Nature of the intervention</th>
<th>Focus of the intervention</th>
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<tr>
<td>Choice of a high-intensity psychological intervention (CBT/applied relaxation) or a drug treatment</td>
<td>Highly specialist treatment, such as complex drug and/or psychological treatment regimens, input from multi-agency teams, crisis services, day hospitals or inpatient care</td>
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<tr>
<th>Nature of the intervention</th>
<th>Focus of the intervention</th>
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<tbody>
<tr>
<td>Identification and assessment; education about GAD and treatment options; active monitoring</td>
<td>Low-intensity psychological interventions: individual non-facilitated self-help*, individual guided self-help and psychoeducational groups</td>
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</table>

*Self-help without guidance or supervision.
A number of psychological approaches or ‘talking treatments’ can be used in the management of depression and anxiety, and each of these can be used in the treatment of depression amongst older people. Psychological treatments tend to focus on changing unhelpful ways of thinking or behaviour which occur when someone is depressed or anxious. One of the most commonly used approaches is Cognitive Behavioural Therapy (CBT). Behavioural Activation (BA) is a form of CBT.

According to the BA theory, depression is the result of a lack of positive events or feedback in everyday life, and depression continues because of negative experiences (or lack of experience of anything positive). People with depression may purposely avoid doing certain things, to minimize negative emotions and situations which they anticipate might be unpleasant. Behavioural Activation (BA) aims to encourage people to try to do some rewarding activities as well as trying to discourage them from avoiding certain activities.

The most common types of treatment for anxiety disorders are psychological approaches. These approaches aim to tackle the thoughts that people have before or during situations that they find stressful or difficult. A person may obtain short-term relief from anxiety by avoiding a difficult situation, but this keeps the underlying anxiety problem going. Whilst effective psychological approaches try to challenge unhelpful thoughts and to gradually expose people to situations they find stressful, this takes time and requires specialized therapists. For mild symptoms of anxiety BA, distraction and active relaxation can be helpful.
What is the Intervention?

**Background:** Changing demographics are leading to increasing numbers of older people. Depression and anxiety are common in older people, particularly those with long term physical health problems. Depression and loneliness in older people are strongly associated, and loneliness is an independent risk factor for future depression and increased morbidity and health service use.

Access to standard treatment for depression and anxiety in older people is poor due to a combination of factors: including low levels of detection in primary care, poor access to services, and unacceptable interventions. There is limited evidence for the effectiveness of one-to-one interventions such as befriending for depressive symptoms. There is evidence that the most successful interventions for anxiety and depression in older people, measured by improvement in the domains of physical, mental and social health, tend to be group based, participatory and offering some activity (social or educational). Third sector services are increasingly commissioned to provide these services but the effectiveness of non-traditional or third sector providers delivering a psychosocial intervention has not been evaluated.
Aims:

We want to see if it is feasible to engage non-traditional providers (NTPs) or ‘support workers’ in the third sector to deliver a psychosocial intervention based on the principles of Behavioural Activation (BA) to older adults with anxiety and depression.

This will be followed by a ‘feasibility study’, which will evaluate acceptability and uptake of the intervention and make recommendations for a full trial.

Methods:

The NOTEPAD team has developed:

- **An intervention** (from existing research evidence and some preliminary work talking to older people and third sector practitioners) for non-traditional providers (NTPs) or ‘support workers’ to deliver to older people with anxiety and/or depression in the NOTEPAD study:

  The intervention includes a psychosocial assessment and an individually tailored programme based on principles of Behavioural Activation (BA) plus the option of the support worker accompanying the participant to attend existing community groups. The aim is to encourage the patient to resume previously enjoyed activities, and help overcome barriers to participation in social activities.

  - **A training package for support workers** which includes training over three
days and a manual to complement the training, and support the delivery of working with older people.

The feasibility and acceptability of the training and the intervention will be tested in a ‘feasibility study’ in Stoke and North Staffordshire. The target population will be over 65s who are living in the community, and who are identified as having anxiety or depression.

**The Intervention:**
The framework is Behavioural Activation (BA) delivered by the support worker on a one to one basis – either face to face or telephone (likely to be a combination, and depends on the study participant’s preference). Each study participant will receive up to six sessions with the support worker.

Session one will be face to face and last up to an hour. Subsequent sessions can be up to an hour (face to face) or thirty minutes if delivered on the telephone. At least one of the sessions will involve the support worker accompanying the older person to (or meeting the person at) a local group (so long as the study participant is happy to do this).

The support workers will be asked to record some of the face to face sessions with study participants, and document all contacts using a ‘contact sheet’.
What is Behavioural Activation (BA) and why does it work?

How to explain BA to NOTEPAD study participants - You may wish to use the following phrases:

“Mood is linked to activity - what we do is related to how we feel.”
“For example, if we are feeling low, we may behave differently:
We avoid doing necessary activities, such as paying bills.
We find it more difficult to do routine activities, such as shopping, cooking, cleaning.
We stop doing pleasurable activities such as seeing friends and family, going out.”
“These changes in behaviour maintain low mood: the less we are able to do, the worse we feel.”

You can explain to the patient/client that the treatment (BA) will help them to:

Re-establish daily routines
Increase pleasurable activities
Deal with necessary tasks.

You will be helping the client/patient do things that they will find rewarding (or continue to do these activities), as well as ensure that necessary and routine tasks are done. In NOTEPAD, the aim is also to encourage people to attend local groups, in order to increase their activity and social contacts – if this is something that the study participant is willing to do.
**What does BA involve?** How to explain what is involved to NOTEPAD study participants.

*You may say something like:*

“The goal of BA is to help you do the things you find rewarding and meaningful, including activities you have stopped doing, due to feeling low, or physical health problems or other changes in your life. You may wish to start doing something new, or try something different. You might wish to consider joining a local group. This can improve your mood, reduce your stress, and help you think about things more positively.”
Six steps of BA:

Step 1 – complete diary of usual activities

Step 2 – make a list of things you would like to do (or resume doing)

- Routine
- Pleasurable
- Necessary

Step 3 – list activities in order of difficulty

BA: Step 3 – Order activities

Most Difficult

Easiest

Mix routine, pleasurable and necessary activities throughout list

Step 4 – Plan activities over the next week, using a diary sheet

Step 5 – Start doing planned activities and record on diary sheet

This may include attending a local group

Step 6 – Discuss diaries and activities at next session.
How the NOTEPAD feasibility study will work:

The aim of the feasibility study is to assess whether it is possible to recruit enough participants and deliver the intervention.

We will recruit participants from six GP practices who will search their lists for people aged over 65.

The resulting list of potential participants will be sent an ‘Invitation Pack’ consisting of an invitation letter, an information sheet about NOTEPAD, a postal questionnaire screening for depression and anxiety, and a stamped addressed envelope.

Those people who return a completed questionnaire to the study team, and their scores indicate that they may be depressed or anxious, and who consent to further contact, will be invited into the feasibility study. A Research Nurse from Keele University will contact these people and re-complete the questionnaires over the phone to ensure the symptoms of depression and anxiety are not fleeting. For those people whose symptoms are still present, the Research Nurse will arrange a home visit for a full assessment.

At this home visit, the Research Nurse and potential study participant will discuss the study further, and the nurse will obtain written consent before inviting the participant/patient to complete baseline questionnaires. In cases where severe depression or risk of self-harm are detected by the Research Nurse, the individual will not be recruited into the study but the patient’s GP will be informed.
Eligible participants will be randomly allocated to either the ‘intervention arm’ or the ‘usual GP care’ arm and a researcher from the NOTEPAD team will inform the participant of the outcome by telephone and this will be followed up by a letter. If a participant is allocated to the ‘intervention arm’, they will be informed that a support worker will make contact with them in the next week. The participant’s contact details will be sent to Peter Bullock at Age UK by fax, and he will forward details onto the allocated support worker.

The support worker will then contact the study participant and arrange the first meeting. The support worker will work with the study participant (client/patient).

Four months after the Research Nurse’s first visit, the nurse will contact the participant again and arrange a further home visit to complete the ‘follow-up’ questionnaires.
SECTION 2

Delivering the Intervention

Session by Session guide

This section contains a step by step guide to help you in delivering the intervention. Brief details of what should be included in each session are described in the ‘session review box’. Below each review box there is a more detailed explanation of what should be covered during the sessions.

![Schedule](image-url)
Session 1  Assessment, agreeing the problem(s), making plans

Introduce self and role (eg “My name is XX and I am working with AgeUK and the NOTEPAD study. My role is to work with you over the next 6-8 weeks to work with you and help you improve how you feel.”)

Confirm the study participant’s full name, ensure they understand the purpose of the session, and explain that the session will last up to an hour.

Advise that everything they say will be confidential, unless there are any reasons that make you worried about the person’s safety, in which case you would need to discuss the person with your supervisors and the person’s GP.

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<tr>
<th>Session 1</th>
<th>Assessment, agreeing the problem(s), making plans</th>
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<td>• Introduce self and role in NOTEPAD</td>
<td></td>
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<tr>
<td>• Initiate person-centred interview, ABC, impact, other relevant information</td>
<td></td>
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<tr>
<td>• Assess risk (and respond appropriately)</td>
<td></td>
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<tr>
<td>• Use communication skills to ensure a positive interaction</td>
<td></td>
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<tr>
<td>• Introduce the patient resources and respond to questions about NOTEPAD study</td>
<td></td>
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<tr>
<td>• Agree main problem statement</td>
<td></td>
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<tr>
<td>• Set goals, including sign-posting to local group(s)</td>
<td></td>
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<tr>
<td>• Plan between session work</td>
<td></td>
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<tr>
<td>• Between session work – encourage patient to read the stories in the file</td>
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<tr>
<td>• Feedback on session – final questions – arrange next appointment (face to face or telephone)</td>
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</table>
**Person-centred interview**

Remind the study participant about NOTEPAD – that they have been included in the study because they have anxiety or depression, and that your role is to help them with this. Remind the participant that they can go and see their GP at any time.

You could use a phrase such as

“What would be helpful now is for me to understand more about you, how you are feeling, and particularly the impact that this problem is having on your life now”.

We know that many older people with depression, low mood, stress or anxiety use metaphors to describe their own experience and believe it important to incorporate this into the assessment. Try to elicit this by asking an open question such as

“In a nutshell, can you tell me, how have you been feeling?”

Ask the patient what they see as their main difficulty at the moment.

Enquire about the 4Ws:

- **What** is the problem?
- **Where** does the problem occur?
- **When** does the problem happen?
- With **whom** is the problem better or worse?
- Elicit information on both low mood or anxiety
➢ Assess risk
➢ Collaborative agreement of problem(s)

Elicit the ABC: Try to use the language of what they feel (A) what they do (B) and what they think (C).

Impact – How is their current difficulty impacting on their life – ask specifically about work, home, social, private leisure and relationships

“Tell me what’s been happening.”
“What would you say your main difficulties are?”
Triggers (current)

“Why do you think you might have problems with your mood?”

Modifying factors (is there anything that makes the problem better or worse?)

“What makes things worse?”

“What makes things better?”

Onset and course

“Tell me how things have been over the past few weeks?”

“Have things been getting better or worse over the past few weeks?”

Key questions to ask patients:

“Is there anything that we have not covered in our discussion that is relevant to your difficulties?”

“Is there anything else that you would like to add?”

Summarize current difficulties:

“From what you have said to me, it seems that…… (add detail)

……does that seem right from your point of view?”

Thank them for information that they have shared so far.
Assessing risk

Risk Assessment:
- Harm to self
- Harm to others
- Harm from others (Safeguarding)
- Self-neglect

Talk about suicide:
‘Normalising’ approach
- “Sometimes when people are feeling distressed they think of harming themselves or suicide, is this something you’ve been thinking of?”

Direct approach
- “Have you been thinking of killing yourself?”
- “Do you ever want to be dead and away from it all?”

If the answer is ‘yes’
- Ask about specific plans:
  - “Have you got a plan?”
  - “How detailed is the plan?”
  - “When, where, how, and by what means?”
  - “What measures have been used to prevent detection?”
- Ask about protective factors:
  - “What stops you?”
  - “What is important to you?”

Action:
- Contact study team clinician (CC-G or deputy*); patient’s GP
- Agreeing a safety plan
- Agreeing a crisis plan

* See pages 5-6 for contact details of Carolyn Chew-graham and Heather Burroughs
Goal setting:

You may introduce goal-setting to the patient in the following ways:

“Setting goals and developing action plans is a way of helping people to achieve changes in their lives that they want to make.”

“Goals are like targets to work towards and, with an action plan, can be either what you want to achieve over a long period of time, such as by this time next year, or over a very short period of time.”

“We would suggest your goal should be something that you want to achieve over the next 3-4 months. Having goals to work towards will make it more likely that you will succeed in making changes because it will help you to be clear about what you are trying to achieve and how you will go about it.”

Explain to the client/patient that goals are things to aim for. Sometimes patients make very general goals such as “To feel better”.

Try to work with them to be more specific i.e. “Could you tell me what feeling better means to you, what things would you be doing/or doing differently if you felt better?”

Try to pick out 2-3 goals, write them down on a worksheet from the patient manual and ask the patient to rate them.

Ask them “on a scale of 0-10 - where 0 is not started and 10 is fully there - where would you put yourself right now?”
People like to feel listened to and will pick up if they are being rushed. If you are unable to do the problem statement and goals in the first session, then you could direct the client/patient to the relevant section in the NOTEPAD file and suggest that they could do them between sessions or that you can work on them together at session 2.

In agreeing goals, remember

- The decision should be made by client/patient (as opposed to being told to do something)
- Contemplating change can be difficult (you may need to ask the client/patient to discuss risks/benefits of each possible course of action)
- Goals should be realistic
- Encourage the client/patient to consider making change in small steps
- Incorporate goals into normal/routine daily life

Encourage the client/patient to identify one or two goals which they would like to achieve:

- Person-centred (developed by the client)
- Focussed on change
- Specific
- Stated positively
- Realistic and feasible (reasonable time scale)
- Measurable
Examples of specific goals

• to join a healthy living group
• to meet up with friend twice a week
• to walk briskly for 30 minutes, 4 times a week
• to go into my local charity shop and see if they need a volunteer
• to ask my neighbour in for a coffee
• to visit the library twice in the next week
• to do some relaxation three times in the next week
• to go to bed at 10pm on five occasions in the next week

Resources

Give the study participant the ‘patient resource’ file. The NOTEPAD file.

The NOTEPAD file is an A3 filo-fax style folder. It is to be given to all participants and will help to manage situations which they are finding difficult. The file is there for them to make choices about what they do rather than you/others telling them what they should do.

The resources within each file can be split into two categories (see below). These are: resources which are in all files (listed below) and resources which are specific for the individual. It is up to you to tailor the specific resources to match the situation and interests of each particular participant.
**In all files:**

Age UK worker details  
Session Record Sheets  
Mood thermometers  
Weekly Activity Log  
Blank note pages  
Information about anxiety and depression  
Staying well and mood monitoring  
Relaxation  
Patient stories  
Useful contacts

**Inserts tailored to individual**

Diet, alcohol, exercise and sleep hygiene  
Local groups and services

**Ending the session**

Tell the patient/client when there is 5-10 minutes of the session left.  
Ask the person when they would like their next contact – i.e. 1 week or 2 weeks – and would they like this to be face to face or by telephone.  
Ask the patient/client for their views on the session, and any final questions that they may have. Ensure that the person knows when they will next see/hear from you, and what to expect from the next session. If you have arranged for the next session to be at a group, ensure that the person understands arrangements.  
Remind them that they can refer to their own NOTEPAD file in between sessions.
Session 2  Reviewing mood, progress, reviewing diary
OR
Accompanying person to a group – arranged at session 1

Session 2  Reviewing mood, progress, reviewing diary

Orientation to the session

• Engaging older person

• Use of mood thermometers (as a means of reviewing progress, stimulating discussion, not to ‘measure’)

• Reviewing diaries/progress

• Sign-posting

• Set goals, including sign-posting to local group(s)

• Plan between session work

• Between session work – encourage patient to read the stories in the file

• Feedback on session – final questions – arrange next appointment (face to face or telephone)
Reviewing mood

To start off the session, ask the client/patient to reflect on how they feel using a ‘mood thermometer’, and encourage the person to explain why.
**Sessions 3, 4 and 5**  Reviewing mood, progress, reviewing diary; Staying well; Preparing to end contact

<table>
<thead>
<tr>
<th>Sessions 3-5*  Review</th>
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<tbody>
<tr>
<td>Orientation to the session</td>
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<tr>
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</tr>
<tr>
<td>• Reviewing diaries/progress</td>
</tr>
<tr>
<td>• Attendance at groups – Yes - how it felt; any problems? No – why? What could encourage them to attend?</td>
</tr>
<tr>
<td>• Sign-posting</td>
</tr>
<tr>
<td>• Set goals, including sign-posting to local group(s)</td>
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<tr>
<td>• Staying well</td>
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<tr>
<td>• Planning between session work</td>
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<tr>
<td>• Feedback on session – final questions – arrange next appointment (face to face or telephone)</td>
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<tr>
<td>• Preparing to end contact</td>
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*depends on client/patient wishing to continue.

Welcome patient and orientate them to the purpose and duration of session (15-20 minutes). Review progress against set goals. Identify any barriers, ‘stuck points’ with the intervention and progress. Use the patient/client’s own experience to work with them - i.e. "you must have experienced these kind of difficulties in your life before – what has worked for you to overcome them". Perceived or actual barriers are crucial to identify – use careful questioning in a conversational style to elicit and collaboratively
problem solve.

The aim is for the patient/client to incorporate changes into their current lifestyle – so if someone has started walking twice a week, then the key is to discuss how this can be sustained and incorporated into their routines.

‘Staying well’

Start to introduce the concept of ‘staying well’ in session 3 onwards. It is important that you are honest with people – depression can and does recur but looking at relapse prevention is important. You should review with the patient their overall progress. As with the intervention, this should be a collaborative process and directed by the patient. Introduce this to them by saying that this part of the session is focused on staying well – what things they need to do (you will have already discussed with the patient the importance of incorporating positive changes in their daily routine to ensure gains are maintained).

Keeping well: Action plan – how to introduce this to the client/participant:

“Ensure you keep doing the things you find rewarding and enjoyable.”
“Try to schedule a variety of routine, pleasurable and necessary activities into your daily routine.”

“Try to identify what you get out of the enjoyable activities, so that if you can’t do something, for example, because the weather is bad, you can do something else instead, that will still give you pleasure.”

You should introduce the idea to the client/patient, that low mood can recur and that they should be alert to this:

“Be aware of early warning signs of low mood such as: physical symptoms, negative thoughts, things you avoid or stop doing.”

“Identify situations which might make you feel vulnerable to feeling low, or stressed, in the future including times of the year, anniversaries.”

Write down with the client/patient, in the NOTEPAD file, a specific ‘keeping well’ plan which might include:

- What I will do to keep myself well.
- Situations that might trigger a low mood or stress.
- How I will spot my mood dipping.
- What I will do if I begin to lose interest in things, feel down or stressed.
You should ask the patient what aspects they think are important to monitor to help them stay well (for example this may be advising the person to use the mood thermometers on a monthly basis; a patient may have decided to do regular exercise, join a club or group). One of the key messages here is that to stay well we need some form of self-monitoring system to alert us to any early warning signs that things may not be going so well – this allows us to make changes and try to nip the problem in the bud.

Where people have previously not monitored either their mood or behaviours try to encourage them to do so – using the mood thermometer, discussing when to act and what action to take.

**Ending the session**

Recap the session, particularly highlighting staying well plan. Thank client/patient for their time.
Final session (may be session 6, but this may be earlier in the client/patient wishes to end sooner, or you feel that ending is appropriate)

Final Session
Orientation to this final session

• Engaging older person

• Use of mood thermometers to review progress and stimulate discussion

• Review diaries/progress

• Attendance at groups – Yes - how it felt; any problems?
  No – why? What could encourage them to attend?

• Sign-posting

• Set goals, including sign-posting to local group(s)

• Staying well

• Feedback on session – final questions

• Advising about staying well

• Advising about when to seek help
Monitoring and Supervision

You will receive supervision in groups, from Peter Bullock and Carolyn Chew-Graham. We will encourage you briefly present each new study participant – problem statement and goals, impact (including the impact of their depression on their self-care), and any risk issues. We would also like to discuss progress of all participants in the study, as well as any patients who have ‘dropped out’. There will be an opportunity for you to discuss any other problems. Individual supervision may be also conducted over the phone depending on support worker and supervisor preference and availability.

Preparing for supervision

In preparation for your supervision session, please make a note of study participants in the following categories:

- Total number of clients in NOTEPAD
- Number of new participants
- Number of participants who have had four sessions
- Number of participants who are approaching six sessions (and contact ending)
- Number of participants who seem to have dropped out
- ID of clients who do not seem to be improving
- ID of clients you wish to discuss

Remember: If you have any worries about a study participant (risk or safeguarding issues), between supervision sessions, contact Peter Bullock and/or Carolyn Chew-Graham – contact details are on pages 5-6.
Participant contact sheets

You will be keeping your own notes for the people you are seeing as per usual AgeUK protocol.

We will also ask you to keep a monitoring sheet for each study participant. This information is very important to us as it will tell us on average how many sessions study participants attended, the delivery mode in which they received follow-up (face to face or telephone) and what was done in each session.
Participant diary sheet

In the participant’s NOTEPAD file are diary sheets (see below) for the participant to fill in if they wish to keep a record of their sessions.

<table>
<thead>
<tr>
<th>Session 1</th>
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<tbody>
<tr>
<td><strong>Date:</strong></td>
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<tr>
<td><strong>Time:</strong></td>
</tr>
<tr>
<td><strong>Review of previous session:</strong></td>
</tr>
<tr>
<td><strong>Things discussed at this session:</strong></td>
</tr>
<tr>
<td><strong>Things to do for next session:</strong></td>
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<tr>
<td><strong>Notes:</strong> Review of previous session:</td>
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Below is a supervision sheet for you to fill in prior to supervision sessions.

**Supervision Sheet**

Date

Carolyn Chew-Graham: c.a.chew-graham@keele.ac.uk 01782 734 717
Peter Bullock: peter.bullock@ageuknorthstaffs.org.uk 01782 206720

Supervisor

Mode of supervision (circle)  telephone/face to face/group

Time start

Time end

<table>
<thead>
<tr>
<th>Number</th>
<th>Comments</th>
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</table>