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Evidence Based Guidelines to Improve Engagement and Participation for People Experiencing Depression

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Abstract

Background
Depression can have a strongly negative impact on a person's ability to engage with and participate in activities of daily living. Clinicians currently seeking guidance on best practice in this area currently need to access and critique a wide range of evidence from a number of disciplines. While some clinical practice guidelines are available, this form of evidence presentation presents several barriers to implementation.
Procedures
This article proposes a new procedure for developing guidance for clinicians, known as evidence based guidelines. The purpose of the guidelines presented here is to provide guidance on appropriate assessment and intervention strategies with people experiencing depression, who wish to improve their engagement and participation in daily activities. They were constructed using a multiple methods procedure, with five phases.
Results
Evidence based guidelines for the general population, older adults and people with co-morbid physical conditions are presented at the conclusion of this article.
Conclusion
The procedure described here produces evidence based guidelines with built in measures to promote implementation into practice. The resulting guidelines for depression will enable clinicians from all disciplines to engage in best practice, and assist people with depression participate more fully in their lives.

Keywords: depression, evidence based practice, participation, practice guidelines

Introduction

Clinical practice guidelines are designed to support clinicians use the best available evidence to direct their practice . They are ostensibly a link between research and practice, with the ultimate aim being improved outcomes for patients. However, several barriers to their implementation have been identified including a lack of accessibility, poor participation by stakeholders in their development and perceived lack of relevance to everyday practice . The uptake of such guidelines has therefore been less than hoped, despite the strong ongoing drive in health care for evidence-based practice.

The development of clinical practice guidelines has been predicated on the assumption that best practice is based on research around the safety and effectiveness of interventions . However, the discourse around evidence-based practice in allied health disciplines such as occupational therapy has evolved in recent times to acknowledge that the evidence used by clinicians encompasses far more than scientific research. The integration of knowledge with clinical practice skills involves many ways of knowing such as reflection, intuition, economic understandings, ethical behaviour, independent professional judgement and research . Current procedures for formulating clinical practice guidelines exclude all but the scientific, research-based ways of knowing.

Peer reviewed journals are the primary source of credible evidence for clinicians to use in practice. While some feel peer review journals exist to promote research , in reality they include and promote many ways of knowing . Allied health journals typically include evidence from the non-scientific genres of literature review, critical analysis, opinion, practice reports and narrative case studies. The exclusion of so much that had been judged as high quality and relevant through peer review led the researchers to ask if CPG's omit much of what clinicians used as a basis for practice (e.g. literature reviews, critical analyses etc), can they truly support evidence based practice?

A need to recognise and integrate a diverse range of evidence in a manner that was both readily useable and accessible was the main motivation behind development of the guideline that will be presented in this article. The researchers wanted to provide clinicians with guidelines that drew on the full diversity of peer review evidence, provided clear guidance on the rigour / quality of the evidence and were presented in a format which maximised their chances of being implemented. While based on the particular expertise of OT, the guidelines are designed to be applicable (at least in part) by any health profession seeking to work with people experiencing depression. They are also called evidence-based guidelines (rather than clinical practice guidelines) to acknowledge the new and different procedure used to construct them.

This article will therefore fully describe the procedure used to construct these Evidence Based Guidelines to Improve Engagement and Participation for People Experiencing Depression. The general guidelines will then be presented in full. Guidelines specific to older adults and people with co-morbid physical conditions have also been developed as part of this procedure, and will also be published. Finally, a brief discussion of the implications and implementation of the guidelines will be presented, along with areas of further development intended for the future.

Methods

The procedure for developing evidence-based guidelines had five phases; evidence gathering, guidelines construction, consultation, dissemination and evaluation. The phases ran consecutively, and ethical approval was required for some tasks in the evidence gathering, consultation and evaluation phases of the procedure.

The following will describe in detail the steps take in each phase, illustrated by the construction of these guidelines. Unlike existing methods of constructing clinical practice guidelines, this procedure was designed with implementation needs in mind. The Guideline Implementation Framework provided the basis for the design, as it includes eight domains which promote the adoption of guidelines by clinicians. These

domains were developed through a critical review of existing guidelines, which were found to contain a lot of graded evidence but few additional features that would improve their use. Following further study, Gagliardi and Brouwers recommend that guideline developers integrate content and implementation when they construct documents, and suggested this may require the development of new approaches.

Table One illustrates both the phases and steps within the procedure;

Table One: Procedural Details

Phase	Steps	Guideline Implementation Framework
Evidence Gathering	Formulate explicit statement of purpose and focus Conduct systematic review of all peer review evidence Critique and grade each piece of evidence in regards to its quality Formulation of consensus statements regarding aspects of practice not addressed in current evidence. Conduct secondary systematic review of non-discipline specific literature to find any additional evidence	Relevance
Guideline Construction	Write first draft of guideline documents, including information on resources, implementation and evaluation	Adaptability Accommodation Evaluation Validity
Consultation	Full version of guideline sent to stake holders for review, with an invitation to add practice examples or other information they feel will add to the documents.	Applicability
Dissemination	Publication in multiple formats – journal articles, guidelines document, hard copy, digital, client/carer version etc.	Communicabilty Useability
Evaluation	Ongoing research into implementation of these guidelines in	Implementation

clinical settings

Phase One: Evidence Gathering

Step One: Formulate explicit statement of purpose and focus

While not a domain of the Guideline Implementation Framework , relevance is an important consideration for the development of any documents which seek to support clinicians in their practice. If the relevance of the guideline to their practice is not clear, the document will not be consulted or subsequently implemented. The relevance of guidelines largely rest on the stated focus and purpose identified at the beginning of the procedure. The purpose of these guidelines was to provide guidance on appropriate assessment and intervention strategies with people experiencing depression, who wish to improve their engagement and participation in daily activities.

The stakeholders delivering these services will mainly be occupational therapists, due to that profession's specialist knowledge and experience with functional performance and occupational engagement. However, other allied health disciplines also assist people with depression to address these issues, and can implement those recommendations which don't require occupational therapy qualifications (denoted by an * in the document) Those receiving the services are people (of all ages) experiencing depression, their carers and families.

Step Two: Conduct systematic review of all peer review evidence

This statement of purpose also guides a systematic review of current evidence published in peer review journals, which is the first step of both this procedure and traditional methods for clinical practice guidelines. The search terms 'depression' AND 'occupational therapy' were chosen to guide the initial search for evidence. While it has been suggested that such uni-professional approaches are at odds with multidisciplinary practices , current methods privilege bio-medically based understandings and disciplines at the expense of professions with alternative views. There is a case, therefore, to ground guidelines within particular specialist disciplines, so long as the guidelines are constructed with the potential role of other members of the multidisciplinary team in mind. To be included in these guidelines, evidence had to be 1) published between 1 January 2000 and 1 April 2012; 2) English language; 3) peer reviewed and 4) authored by at least one occupational therapist.

The limitations of the traditional view of what constitutes evidence became very clear during this review. Occupational therapy has maintained a strong presence in psychiatry for almost a century, and has a long tradition of working with people experiencing depression . An initial systematic review of peer review research published by occupational therapists on this topic yielded 87 articles over the past 12 years. However, only 7 of these studies used highly rigourous quantitative methods such as randomised control trials. The adoption of traditional procedures would have lead to the exclusion of over 90% of the recent peer review evidence in this case.

We then analysed each article and assigned a grading in regards to its quality and potential for guiding practice. While there are several tools available to enable this for quantitative research evidence, to date none exist which encompass all forms of evidence. The hierarchies of scientific evidence are reliable indicators of the rigour of scientific evidence, and we wanted to retain this as a guide to quality for clinicians.

Therefore, we made modifications to this structure to include the others forms of evidence. The integration of qualitative studies into a hierarchy based on quantitative standards is inherently problematic, due to the

epistemological differences between the two approaches . However, the concept of trustworthiness is universal to all qualitative approaches as a measure as to whether these studies authentically reflect the phenomenon being interrogated .

The Rosalind Franklin Qualitative Research Appraisal Instrument (RF-QRA) was chosen due to its accessibility, applicability across all qualitative approaches and its analogous scale with traditional hierarchies of quantitative evidence. This instrument evaluates the study's standards of trustworthiness, as measured through credibility, transferability, dependability and confirmability using a five point scale. The study is subjected to a series of key questions, with example strategies provided to highlight possible evidence. Level I indicates measures have been taken to address all four areas of trustworthiness, while Level V indicates the opposite. This system of ranking is vulnerable to the variability in reporting of trustworthiness in qualitative research articles , but the same could also be said of quantitative research articles which do not clearly describe their methods.

All remaining non-scientific evidence was categorised as 'Other Evidence' and not subjected to hierarchical rating. Converting these grades into recommendations also raised questions of equivalence, and how to capture both the diversity and strength of evidence for each guideline. We would assert guidelines that are supported by both quantitative and qualitative evidence are inherently stronger than those for which only one form of evidence exists. However, the available evidence for these guidelines had few instances of consolidation through multiple studies. Therefore, the recommendation guidelines displayed in Table Three were adopted to provide guidance for clinicians, but not to replace their individual abilities to critique the quality of evidence;

Table Two: Evidence Based Guidelines Recommendations

Level	Recommendation	Evidence Included
A	Evidence can be trusted to guide practice	I
B	Evidence can be trusted to guide practice in most situations	II
C	Evidence provides some support for recommendations, but care should be taken in its application	III
D	Evidence is weak and recommendation must be applied with caution	IV
Good Practice Point (GPP)	Practice recommended expert opinion or peer review	V Other Evidence

These grades and recommendations enhance the validity of the eventual guideline, allowing the quantity and quality of evidence to be presented clearly and concisely. A large number of potential guidelines arose from this search and the upcoming consensus statement formulation, so we decided to split the guidelines into three distinct practice areas – general guidelines, older adults and people with co-morbid physical health conditions.

Many factors influence the direction in which research evolves, and there are often aspects of practice that have not become the subject of research. There were several gaps in the evidence available around improving engagement and participation for people experiencing depression, which could be due to a lack of priority, funding or resources. Therefore, the next step in the procedure was the formulation of consensus statements to address these gaps. Both nominal group technique and Delphi technique are recommended methods for this task . The current study used a modified form of nominal group technique, conducted through a series of online questionnaires to overcome issues of distance between clinicians. A total of 16 occupational therapists began this process, however 6 dropped out after the first stage. Therefore, a group of 10 occupational therapists formed our panel and generated further recommendations for inclusion in the guidelines. This online process took several weeks. When conducted face to face, nominal group technique can be completed in a single day, which has advantages for the timeliness of guidelines.

As the procedure to this stage can take some months to complete, the final step in the evidence-gathering phase involves a secondary systematic review to capture any new research published in the intervening time. Any new guidelines arising are added to the existing list. The outcome of the first phase of this procedure is a list of draft recommendations, based on both the peer review evidence base and clinician opinion of the panel of clinicians. These guidelines in themselves would be informative and valid, and may be the end-point for some projects. However, they should be considered a largely research based starting point, with the rest of this procedure working to enhance their ability to be integrated and implemented into clinical practice.

Phase Two: Guideline Construction

Once the evidence-gathering phase is complete, a first draft of the guideline document is constructed. To formulate the information in an accessible and useable manner, the direct input of stakeholders and consideration of the documents qualities of adaptability, accommodation and evaluation are essential.

Adaptability refers to a guideline's availability in a variety of versions for different users and purposes . Phase One produces a master list of recommendations, and the first task is to consider how they may be presented in different versions. In this study, the guidelines were split into three separate documents - general guidelines, older adults and people with co-morbid physical health conditions. This reflects three distinct clinical areas in which health professionals may encounter people with depression, and also made the volume of information in the guidelines easier to digest. For professional stakeholders, the final version of the full document is freely available online, with summary versions being submitted for publication in peer review journals. There are also plans to develop a version for clients and carers uses plain language statements in the future, when resources allow.

Accommodation and evaluation are related concepts, which recommend that guidelines explicitly acknowledge and anticipate issues which may impact on their implementation . The full version has adopted a format that includes audit forms, evidence based profiles and guidance on how to organise a continuous cycle of evaluation. Table Three provides an example of the evidence based profiles, which serve to both document current practice and stimulate planning for implementation;

Table Three: Evidence Based Profile

Canadian Occupational Performance Measure (COPM) may be used to assess self perception of occupational performance over time by adults with depression	C

Focus: Adults

Resources Required:	
Technical	Canadian Occupational Performance Measure manual/form kit
Regulatory	Not applicable
Human Resources	All therapists would need to be able to administer the tool
Professional	Training required for this tool – may be provided by experienced therapists, or through DVD Self Instructional Program Introduction and explanation also required for other members of the multidisciplinary team
Workflow	Tool takes 30-45 minutes to administer
Costs	Manual / form kit - approx $55.00 Canadian plus postage Self instructional program – approx $230.00 Canadian plus postage

Description of current practice in this workplace

Initial audit of existing staff competence with this tool

Review cited references for this guideline

Critical appraisal of what it may add / take from current

Introduction as a pilot to evaluate work changes required

Feedback from clients and carers regarding process

*Evaluate implementation at regular intervals

Phase Three: Consultation

The first draft of the full guideline document was given to stakeholders to review, as part of a consultation process. Dissemination of the draft documents electronically has allowed clinicians from a large geographical area to participate, with each invited to add comments on the document itself and complete a short questionnaire. The questionnaire focused on the implementation of the guidelines, and uses the Guideline Implementation Framework as a basis for exploring perceptions on its usefulness and potential for application.

This consultation process aims to increase the applicability of the guideline, by ensuring the documents include information that helps clinicians interpret and implement them. Any suggested changes will be incorporated into the final version of the guideline document, which is at this point ready for publication.

Phase Four: Dissemination

These guidelines are in the process of being published across multiple formats. Three journal articles (focusing on general, older adults and co-morbid physical conditions) are currently in production. The full guideline document is freely available from Deakin University, in the form of a PDF document that can be requested by email. These guidelines have also been accepted for presentation at this year's Australian Occupational Therapy conference, and abstracts will be submitted to other professional forums over the course of the year. Electronic versions (such as a website or app) are also possible future developments for these guidelines, with future evaluations to consider whether these mediums would further enhance their applicability and implementation.

Phase Five: Evaluation

It is extremely important that these guidelines are tested under clinical conditions, to confirm that the adoption of these practices do result in better outcomes for people with depression. The project team is currently actively seeking funding for an implementation study, to take the form of a mixed methods series of case studies (including both occupational therapy and staff from other disciplines).

Results

The general evidence based guidelines to improve engagement and participation for people experiencing depression will now be presented in full. The guidelines have been arranged around the four core dimensions of occupation – doing, being, becoming and belonging – to connect them with theoretical knowledge about human occupation . All guidelines preceded by an asterix (*) are suitable for application by any discipline, while those without are relevant specifically to occupational therapists.

Being

Being is the sense of who someone is as an occupational and human being. It encompasses the meanings they invest in life, and their unique physical, mental and social capacities and abilities. Occupation may provide a focus for being, but it also exists independently of it during reflection and self-discovery. Being is expressed through consciousness, creativity and the roles people assume in life. Ideally, individuals are able to exercise agency and choice in their expression of being, but this is not always possible or even desirable. Table four and five present the best practice guidelines to promote engagement and participation through being, and the specific methods to promote engagement and participation respectively.

Table Four: Best Practice Guidelines to Promote Engagement and Participation Through Being

Guideline	Level of Evidence	References
* Screening young people with Aspergers Syndrome and hypersensitivity for depression	D	
Assessment must includes consideration of		

Quality of life	GPP
Sense of hope, self esteem, self perception and optimism	D
Cultural competence and safety	C
Awareness of gender differences in the experiences of depression	GPP
Assessment must be multidimensional	
As functional performance and quality of life do not always improve synchronously with symptom relief	D
* To capture all facets of a person's occupational being	D
* Carers of people with depression may be encouraged to focus on their caregiver and hobbyist roles	GPP

Note:
GPP = Good Practice Point
D = Evidence is weak and recommendation must be applied with caution
C = Evidence provides some support for recommendations, but care should be taken in its application
[number] = Citation for related references

Table Five: Specific Methods to Promote Engagement and Participation Through Being

Method	Level of Evidence	References
Tree Theme Method	B	
Canadian Occupational Performance Measure	C	
Assessment of Motor and Process Skills (AMPS)	C	
Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS)	D	
Time use diaries (for adolescents with depression)	GPP	
* Clinical observation and judgment	GPP	

* General mental health assessment (mental state examination)	GPP
Volitional questionnaire	GPP
* Beck Depression Index	GPP

Note:
GPP = Good Practice Point
D = Evidence is weak and recommendation must be applied with caution
C = Evidence provides some support for recommendations, but care should be taken in its application
B = Evidence can be trusted to guide practice in most situations
[number] = Citation for related references

Doing

Doing is the medium through which people engage in occupations, and the skills and abilities needed for doing accumulate across time. Doing involves engaging in occupations which are personally meaningful, but not necessarily purposeful, healthy or organized. Doing involves being actively engaged, either overtly (ie. observable, physical) or tacitly (i.e. mental, spiritual). Doing follows broadly similar patterns across the population, and humans are able to adapt their doing to greater and lesser degrees according to circumstance. Table six and seven present the best practice guidelines to promote engagement and participation through doing, and the specific methods to promote engagement and participation respectively.

Table Six: Best Practice Guidelines to Promote Engagement and Participation Through Doing

Guideline	Level of Evidence	References
Intervention must include consideration of * Cultural competence and safety	C	
* Interventions aimed at improving physical fitness must be habituated in to the clients daily routine	D	
* Clients should be advised to consider consulting their doctor about pharmacological treatments if they wish to improve their motor and/or processing skills	D	
* Improvement in neurological functioning related to depression may be supported by activities that induce flow and utilize the left hemisphere	GPP	

* Carers of people with long term depression may be encouraged to focus on small pleasures and significant activities	D

Note:
GPP = Good Practice Point
D = Evidence is weak and recommendation must be applied with caution
C = Evidence provides some support for recommendations, but care should be taken in its application
[number] = Citation for related references

Table Seven: Specific Methods to Promote Engagement and Participation Through Doing

Method	Level of Evidence	References
Group Interventions		
* Outpatients groups	B	
* Clubhouse attendance	C	
* Adult Education	D	
* Day Treatment Services	D	
* Writing groups	D	
* Short term anxiety management courses	D	
* Companion dog therapy	D	
* Living skills	GPP	
* Relapse prevention	GPP	
* Leisure activities	GPP	
* Mindfulness therapy	GPP	
* Stress management	GPP	
* Relaxation	GPP	
* Walking	GPP	
* Symptoms management / psycho-education	GPP	
* Discussion groups	GPP	
* Art therapy	GPP	
Individual Interventions		

Tree Theme Method	B
Remotivation process	C
* Stress management techniques training	D
Client centred occupational therapy	D
* Cognitive behavioural therapy	GPP GPP
* Work / life balance approach	GPP
* Pennebakers writing method	GPP
Re-establishment of client roles and routines	GPP
* Self management	GPP
* Community integration activities	GPP
* Psycho-education	GPP
* Calming techniques	GPP
* Problem solving	GPP
* Lifestyle counselling	GPP
* Skills training	GPP
* Relaxation	GPP
* Relapse prevention	GPP
Vocational Interventions	
Individualised occupational therapy focusing on work	B GPP
* Workplace mental health literacy interventions	B
Carer Interventions	
* Linkage to community agency support	GPP
* Psycho-education regarding depression and carer fatigue	GPP

Note:
GPP = Good Practice Point
D = Evidence is weak and recommendation must be applied with caution
C = Evidence provides some support for recommendations, but care should be taken in its application
B = Evidence can be trusted to guide practice in most situations
[number] = Citation for related references

Becoming

Becoming is the perpetual process of growth, development and change which reside within a person throughout their life. It is directed by goals and aspirations, which can arise through choice or necessity, from the individual or from groups. Regular modifications and revisions of goals and aspirations help to maintain momentum in becoming, as does the opportunity to experience new or novel situations and challenges. Table eight and nine present the best practice guidelines to promote engagement and participation through becoming, and the specific methods to promote engagement and participation respectively.

Table Eight: Best Practice Guidelines to Promote Engagement and Participation Through Becoming

Guideline	Level of Evidence	References
* Improvement in the performance of meaningful occupations may be supported by initially engaging in small achievable tasks, then building	GPP	

Note:
GPP = Good Practice Point
[number] = Citation for related references

Table Nine: Specific Methods to Promote Engagement and Participation Through Becoming

Method	Level of Evidence
Structured and balanced routine activities	GPP
* Assistance to access community programs	GPP
* Stress management	GPP
* Goal setting	GPP
* Psychoeducation	GPP
* Sleep education and training	GPP

Note:
GPP = Good Practice Point
[number] = Citation for related references

Belonging

Belonging is a sense of connectedness to other people, places, cultures, communities and times. It is the context within which occupations occur, and a person may experience multiple belongings at the same time. Relationships are essential to belonging, whether they be with a person, place, group or other factor. A sense of reciprocity, mutuality and sharing characterise belonging relationships, whether they are positive or negative. Table ten presents the best practice guidelines to promote engagement and participation through belonging.

Table Ten: Best Practice Guidelines to Promote Engagement and Participation Through Belonging

Guideline	Level of Evidence	References
* Client's social networks, perceived social supports, engagement in social activities and risk of loneliness should be considered as part of therapy	C	
* Time spent with parents and the quality of that relationship may be considered when working with children and adolescents	GPP	
*Clients experiencing homelessness may consider vocational, emotional, social participation and educational interventions	GPP	

Note:
GPP = Good Practice Point
C = Evidence provides some support for recommendations, but care should be taken in its application
[number] = Citation for related references

Discussion

This project has taken approximately twelve months to construct using this procedure, and provides a comprehensive and detailed set of guidelines for health professionals to use with people experiencing depression. This level of time investment precludes clinicians from writing such guidelines alone, and the development of further evidence based practice guidelines will require partnerships between clinicians and academics to get the best combination of theoretical, evidentiary and practical ways of knowing. While evidence-based practice literature currently focuses on the role of clinicians in finding and using evidence, the use of knowledge brokerage (Dobbins et al., 2009) may best enable more of these guidelines to be produced. Knowledge brokers can also assist in navigating differences between workplaces and organisational cultures, which must be considered when implementing evidence.

Designing guidelines documents with implementation in mind appears to be an effective way of enhancing their changes of being applied by clinicians. Traditional methods for developing clinical practice guidelines are not always directly applicable to the non-biomedical disciplines that engage in multidisciplinary teams. Hence, the decision to construct these guidelines in a way that is inclusive of the entire range of evidence used by clinicians. By closing research-practice gap, evidence based guidelines provide an alternative to documents based solely on one way of knowing.

A potential criticism of this approach is that it lacks the rigour of guidelines based solely on scientific evidence. While this is correct, scientifically rigourous findings do not always translate into the real world of clinical practice. There is also the assumption that clinicians should only be exposed to the highest quality scientific evidence, as these studies are the epitome of best practice. All health professionals now receive undergraduate training in the critique of scientific evidence, and the skills of critical analysis required to weigh up the value of other evidence. They are therefore able to make judgements about the quality of a diverse range of evidence, without the need for selective presentation.

Another advantage of evidence-based guidelines are their role in highlighting gaps in the current evidence base. The authors were surprised about the overall lack of research around functional performance and occupational engagement for people experiencing depression, and there remain many areas that would benefit from further exploration. Highlighting these gaps will enable researchers to target them, leading to ever more comprehensive and rigourous guidelines in the future. Evidence-based guidelines could therefore play a significant role in improving the standards of evidence available to clinicians, and enable them to play a role in setting the research agenda through their feedback and experiences of using the document.

Another limitation of this study is the relatively small sample of clinicians used in the nominal technique phase. This method if often completed with similar sample sizes, but it would have been better to draw from the experience of a larger group of therapists. The nominal group technique phase will need to be re-visited in the future when the guidelines are updated, and the authors will make every effort to increase the sample size at that point.

There are many ways in which these guidelines could be developed further into the future. There is a clear need for implementation studies across a range of settings and disciplines, to assess how they are applied in practice and whether they make a meaningful contribution to client outcomes. Clinicians could also benefit from the development of further resources to accompany the guidelines, and support implementation. For example; case studies or suggested approaches could be collected from those using the guidelines and published as an attachment. The authors intend to update the evidence in the guidelines on a yearly basis, and re-run the nominal group technique consensus building activities every few years.

Conclusions

This article has described the development of evidence-based guidelines for improving engagement and participation for people experiencing depression, and reported the general guidelines produced as a result. The procedure used is complex and required significant time investment. However, the practice of constructing guidelines with implementation in mind appears to have produced a document that clinicians can more easily engage with and apply. By presenting all peer review evidence, they have a broader selection of evidence on which to base their practice and can use their existing skills in critical analysis to make sound choice.

Construction of these guidelines have clearly highlighted how little evidence there is around this topic, and that what is know is often not consolidated by follow up studies. It appears there has been a prevalent assumption that improvement in symptoms automatically leads to an improvement in engagement and participation. However, the social model of disability and recovery model highlights that there is far more to overcoming depression than symptom relief. It is hoped the publication of these guidelines will act as a spur for greater research and investigation in this area, lifting the overall standard of evidence over time.

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