Primary Care Services for Depression

A Guide to Best Practice
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Description: Changing the way care for depression is delivered is complex. The precise issues will vary from place to place reflecting local circumstances. The challenge remains for primary care commissioners to engage GPs and their practices in the development of mental health care. It is hoped that this guidance document and the incentives in the Quality and Outcomes Framework are mechanisms to assist in achieving this goal.

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CONTENTS

EXECUTIVE SUMMARY

CHAPTER 1: Introduction

CHAPTER 2: Depression In Primary Care – Current Issues And The Latest Evidence

CHAPTER 3: Assessment Of The Presence And Severity Of Depression

CHAPTER 4: Clinical Pathways

CHAPTER 5: Monitoring And Follow Up

CHAPTER 6: Patient Preference And Choice

CHAPTER 7: Roles For Professionals

CHAPTER 8: Interface Issues

CHAPTER 9: Case Studies

CHAPTER 10: Audit And Monitoring

APPENDICES

Appendix 1: Screening For Depression In High Risk Groups

Appendix 2: Assessing The Severity Of Depression (Icd-10 Primary Care Version)

Appendix 3: Other Scales For The Assessment Of Severity And Outcome

Appendix 4: Asking About Risk

Appendix 5: Asking About Alcohol Problems – The Cage Questionnaire

Appendix 6: Audit Questionnaire: Screening For Alcohol Misuse

Appendix 7: Relevant Patient Information Resources

Appendix 8: Treatments At Step 2

Appendix 8: Websites With Information On The Collaborative Care And Case Management Approach

Appendix 10: Phq-9 Monitoring Tool – Pfizer©

Appendix 11: Recommended Categories For Response And Monitoring With The Phq-9

REFERENCES

USEFUL RESOURCES

Books and Reports

Organisations and Websites
EXECUTIVE SUMMARY

Depression is highly prevalent in primary care, and a major cause of disease burden. The prognosis of many depressive disorders is poor, and rates of relapse and recurrence are high.

Given the burden associated with depression, it is crucial that the care provided in primary care is of the highest quality. However, management of depression in primary care is not always optimal.

There are a number of key issues that are increasingly important to the delivery of primary care services for managing depression.

Improving access to psychological therapies-
Research has indicated that psychological therapy is both effective and popular with patients, but all services have problems with access. Lord Layard has made a case for increased provision of psychological therapies (especially CBT) from an economic perspective.

Improving access to psychological therapies – minimal interventions and self help - ‘Minimal interventions’ are treatments that require less input from a professional therapist compared to traditional psychological therapy (also called self help). These interventions are usually based on books, computer programmes or websites, and often focus on teaching CBT techniques.

Stepped care - There are two key features of a stepped care system: (a) the recommended treatment should be the least intensive of those currently available, but still likely to provide significant health gain (b) the results of treatments are monitored systematically, and changes are made (so-called ‘stepping up’) if current treatments are not achieving significant health gain.

Depression as a chronic disease - Traditionally, primary care services have been structured around acute care. However, depression may be better viewed as a chronic disease, characterised by high levels of relapse and recurrence. This means that depression may be best treated through the use of specific chronic disease management models.

A population perspective on depression - Population-based care is aimed at restructuring service delivery to provide a strategy for care for all patients within a defined population with a recurrent or chronic illness.

Collaborative care and case management- Research has indicated that an effective method of improving depression outcomes is ‘collaborative care’. This involves GPs and mental health specialists working more closely to supervise the ongoing care of depressed patients.
CHAPTER 1: INTRODUCTION

Since the original version of this guidance document was published in 2004, a number of important developments have taken place in the commissioning and implementation of mental health services.

The new GP contract has had a significant impact on the way primary care services are delivered. The recent additions to the Quality and Outcomes Framework focusing on depression include two new indicators which encourage primary care to screen for depression in high risk groups, namely diabetes and coronary heart disease, and monitor the severity of depression in patients with a new diagnosis.

Implementation of NICE guidelines and the incentives in the Quality and Outcomes Framework is likely to lead to significant improvements in the management and treatment of depression in primary care.

However, challenges lie ahead for both primary care and mental health commissioners in overcoming problems with current service delivery. These challenges include improving access to a range of psychological therapies in primary care and a strengthening of the primary-secondary care interface. There are also opportunities around the redesign of existing services such as community mental health teams and counselling services, and the introduction of new workers such as the graduate primary care mental health workers and practitioners with a special interest.

So far the implementation of graduate primary care mental health workers across the country has been patchy and in some areas the opportunities have not been realised. In areas where implementation has been supported by local training programmes and management structures, services are recognising the benefits of this new workforce. These new workers are key to the delivery of the stepped care model and proper career structures for this group of workers are a matter of urgency.

Changing the way care for depression is delivered is complex. The precise issues will vary from place to place reflecting local circumstances. The challenge remains for primary care commissioners to engage GPs and their practices in the development of mental health care. It is hoped that this best practice guidance document and the incentives in the Quality and Outcomes Framework are mechanisms to assist in achieving this goal.
CHAPTER 2: DEPRESSION IN PRIMARY CARE – CURRENT ISSUES AND THE LATEST EVIDENCE

Depression is highly prevalent in primary care, and a major cause of disease burden. The prognosis of many depressive disorders is poor, and rates of relapse and recurrence are high.

Given the burden associated with depression, it is crucial that the care provided in primary care is of the highest quality. However, management of depression in primary care is not always optimal, with concerns about a failure to recognise depressive disorders, to provide medication in line with current guidelines, and an inability to provide access to psychological treatments. These problems reflect pressures on professional time, training and resources.

The original efforts to overcome these problems through initiatives such as the Defeat Depression campaign and practice-based education had some success, but the impact of these initiatives has been relatively modest. In part, this reflects the complexities associated with the management of depression, and the many factors that interact to reduce the quality of care in primary care. There are no ‘magic bullets’, and improving the quality of care for depression requires changes to the way care is provided and additional resources to develop the appropriate systems to enable primary care professionals to deliver high quality care.

Previous research on the management of depression in primary care has tended to be critical in tone. However, it is important to note that many GPs and primary care teams have developed ways of managing depression that are effective and valued by patients. The models have been developed over time and are sensitive to the particular nature of primary care and its role in patients’ lives. However, the enthusiasm of primary care professionals for mental health work varies significantly, which means that good quality care is not always available to all patients.

The models of care presented here are designed to build on present good practice in primary care and reflect the current evidence base. The main innovations relate to the standardised assessment of depression in primary care, and the systematic organisation of care that follows from that assessment.

Key issues from the latest research

There are a number of key issues that are increasingly important to the delivery of primary care services for managing depression. Some relate to issues about service structure, while others concern the particular types of interventions that should be delivered.

Improving access to psychological therapies – the Layard approach

Research has indicated that psychological therapy is both effective for depression and popular with patients. However, almost all services have problems with access, with long waiting lists resulting from limited numbers of trained therapists. This leads to frustration for patients, primary care professionals and therapists.

Lord Layard has made a case for increased provision of psychological therapies (especially CBT) from an economic perspective. He argues that employment and mental health may be linked as both cause and consequence. Mental health problems account for a significant number of days lost from work and a significant proportion of patients on incapacity benefits. If the accessibility and effectiveness of psychological therapy can be translated into increased return to work, then additional therapists can be employed on the basis that the overall costs to society can be recouped.
Improving access to psychological therapies – minimal interventions and self help

Although increases in the number of therapists will go some way towards bridging the gap between supply and demand, it is unlikely to provide a complete solution because of the high prevalence of depressive problems in the community.

An alternative approach to getting more benefit from current resources is to focus on the delivery of ‘minimal interventions’ to a proportion of depressed patients.

The term ‘minimal intervention’ refers to the fact that these treatments require less input from a professional therapist compared to traditional psychological therapy.

Much of the focus on ‘minimal interventions’ concerns ‘self help’. Self help interventions are usually based on books, computer programmes or websites, and often focus on teaching CBT techniques to patients to help them manage their symptoms. There is encouraging evidence that such approaches are effective in the management of depressive disorders.1

Because these treatments are generally not dependent on the availability of a specialist psychological therapist, they provide one method of overcoming problems with access.15

Although self-help is often based on ‘health technologies’ such as books, computer programmes and websites, the National Institute of Clinical Excellence (NICE) recommends the adoption of a ‘guided self-help’ model with some limited therapist contact. The guidance states:

For patients with mild depression, consider a guided self-help programme that consists of the provision of appropriate written materials and limited support over 6 to 9 weeks, including follow up, from a professional who typically introduces the self-help programme and reviews progress and outcome.

Although NICE has highlighted this model, other minimal interventions which may be of use are computerised cognitive behaviour therapy,16 ‘signposting’17 or group psychoeducation.18 All could provide more efficient delivery of care, meaning more patients can access effective treatment.

Stepped care

Stepped care links conventional psychological therapy with ‘minimal interventions’ in a system designed to provide the greatest amount of benefit from current resources. Stepped care is a model of healthcare delivery with its origins in the US, which has been applied to a range of disorders, particularly those of a chronic nature.19-21

There are two key features of a stepped care system.

Firstly, the recommended treatment should be the least intensive of those currently available, but still likely to provide significant health gain. In stepped care, more intensive treatments are reserved for patients who do not benefit from less intensive first line treatments.

Secondly, stepped care is self-correcting, in that the results of treatments and decisions about treatment provision are monitored systematically, and changes are made (so-called ‘stepping up’) if current treatments are not achieving significant health gain for an individual patient.

This is similar to the way many clinicians implicitly operate, but stepped care standardises systems and procedures with an explicit aim of improving effectiveness and efficiency.
Depression as a chronic disease

Traditionally, primary care services have been structured around acute care. However, studies of the natural history of depression have indicated that depression may be better viewed as a chronic disease, characterised by high levels of relapse and recurrence. This means that depression may be best treated through the use of specific chronic disease management models, similar to the models adopted in relation to other chronic diseases like asthma and diabetes.

A population perspective on depression

Taking the chronic disease management perspective on depression means that primary care organisations will have to shift their perspective on depression from the care of the individual patient, to the care of the entire population of depressed individuals. Population-based care is aimed at restructuring service delivery to provide a strategy for care for all patients within a defined population with a recurrent or chronic illness.

Collaborative care and case management

Research has indicated that an effective method of improving depression outcomes is ‘collaborative care’. This involves GPs and mental health specialists working more closely to supervise the ongoing care of depressed patients. GPs are responsible for recognition of the disorder, antidepressant prescription and overall co-ordination of care, while the mental health specialist (such as a psychiatrist) provides expert consultation, support and advice. However, the most significant difference associated with ‘collaborative care’ models is the introduction of a case manager. The case manager takes responsibility for following up patients proactively, assessing patient adherence to psychological and pharmacological treatments, monitoring progress, taking action when treatment is unsuccessful, and delivering psychological support.

Case managers may be thought of as ‘physician extenders’, who work under the supervision of the GP to improve quality of care for patients with depression. They do not work alone, but receive support from a specialist professional, and share information with the GP. A variety of professionals may be able to take up the case management role, including practice nurses, mental health nurses, and the new graduate primary care mental health workers.

Although the vast bulk of case management interventions have been tested in the United States, two recent evaluations in England have also demonstrated very positive results.

Summary

The previous section raised key issues in current models of depression care. These themes have informed the model of care highlighted in this commissioning guide, which can be discussed in terms of three key aspects of care: assessment; clinical pathways; and monitoring (Figure 1, overleaf).
Initial assessment

- Severity of depression, risk and other important factors are systematically assessed
- Treatment decision making is based on the results of that assessment and patient preferences
- All patients are provided with high quality information about depression, its treatment, and local services

Clinical pathways

- The clinical pathway consists of a number of steps. Patients enter at different steps, depending on severity and previous history
- Many patients will enter the pathway at the first or second step, and will access higher steps in order, if there is a lack of progress
- Within steps, there are choices for patients about the type of treatment that suits them best

Monitoring and follow up

- Each patient should have a planned schedule of contacts to assess progress. The exact schedule depends on severity and other factors
- Scheduled contacts use objective outcome measures as a marker of progress and an aid to clinical decision making
- Decisions may involve changes of treatments within steps, or moving patients up to new steps

CHAPTER 3: ASSESSMENT OF THE PRESENCE AND SEVERITY OF DEPRESSION

Screening

The psychological and social situation of some patients makes them very vulnerable to depression. In these cases, primary care professionals may need to proactively screen for symptoms of depression. NICE recommends primary care routinely screens certain high risk groups:

- Patients with significant physical illness
- Patients with other mental health problems, such as dementia
- Patients suffering major life events, such as childbirth, long-term or recent unemployment and bereavement
- Patients with a history of relationship difficulties and physical, sexual or emotional abuse

The new Quality and Outcomes Framework has now incentivised screening in patients on the diabetes or coronary heart disease register.

DEP1: The percentage of patients on the diabetes register and/or the coronary heart disease register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions.

Appendix 1 shows recommended questions for use in screening for possible cases of depression.

Assessment

Depression is a sensitive and stigmatised subject and there is no replacement for effective communication skills to encourage the presentation of depression within the consultation.
However, idiosyncratic and unstructured approaches to the assessment of depression may mean that patients are offered the wrong treatment. If depression is suspected, a more comprehensive assessment must be conducted. This may be most appropriately done by the GP, but could be completed by a variety of appropriately trained health professionals. This assessment should involve standardised measures of:

- Severity of depression
- Risk
- Other relevant psychosocial factors
- Ruling out of other causes (i.e. testing thyroid function)

### Severity

The new Quality and Outcomes Framework has now incentivised the assessment of depression using a validated assessment tool.

**DEP2:** In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care.

A number of different methods can be used to categorise the severity of depression. Appendix 2 details an assessment of the severity of depression according to the ICD-10 checklist. NICE recommends the categorisation of patients by mild, moderate or severe levels of depression, so as to guide clinical decision making. A categorisation tool such as the ICD-10 can help. Other instruments may be of use, and some alternatives are provided in Appendix 3.

Although the Quality and Outcomes Framework provides incentives for assessment of severity at the outset of treatment, it is recommended that measures be used to assess the outcome of treatment and assist in decisions about further management. This will be discussed later in the guide.

Such instruments are acceptable to patients if they are sensitively introduced with a clear explanation of the purpose of the task e.g. ‘Would you mind taking a couple of minutes to complete this form - it’ll help us to decide what is the best form of help for how you are feeling (or to show us how you have been progressing)’. Patients may also find the questionnaire useful for explaining to relatives how they have been feeling.

### Risk

Suicidal thoughts are very common in depression. Patients with depression should always be asked directly about suicidal thoughts and intent. Possible questions to ask when assessing risk are included in Appendix 4.

There is a training package available for primary care and mental health staff in the assessment and management of suicide risk: Skills-based Training On Risk Management (STORM). This package uses the ‘train the trainers’ format and can be commissioned by Trusts for dissemination to all staff [www.medicine.manchester.ac.uk/storm/](http://www.medicine.manchester.ac.uk/storm/)

### Other relevant factors

The assessment should also include questions relating to:

- Previous mental health problems including treatment and outcome
- Family history of mental health problems
- Associated disability
- Availability of social support
- Social problems (family disputes, financial, employment)
- Alcohol (see Appendix 5 and 6) and drug use
Patient education

The results of any assessment will need to be fed back to patients sensitively. There is still a significant stigma associated with depression, and patients may be initially unwilling to accept the diagnosis, and may not want to start or to continue treatment. This means there is a need for discussion with the patient about diagnosis and treatment options, with a view to gaining agreement about the treatment plan.

This will involve:

• Feedback to the patient on the outcome of the assessment
• Providing patient information leaflets about depression, its treatment, useful management strategies (such as lifestyle changes – diet, exercise, sleep hygiene) and local services (see Appendix 7 for relevant resources)
• Discussing treatment options. The initial focus of these discussions will concern whether an intervention is required or not. Patients who do not require or do not want an intervention will be invited back for a review with the GP in 2 weeks. Patients who do require an intervention will enter the model at an appropriate step based on their clinical need. This is explained in more detail in the next section

CHAPTER 4: CLINICAL PATHWAYS

Key messages

• The clinical pathway is represented by a number of steps. Each step defines a certain type and intensity of treatment. Patients may enter the clinical pathway at different steps depending on their initial presentation or previous history, and may be ‘stepped up’ at various points during the course of their illness, depending on progress
• Many patients will enter the pathway at the first or second step, and may access higher steps in order, depending on clinical need
• Within steps, there are some choices patients can make about the type of treatment that suits them best

As noted earlier, primary care organisations need to develop ways of managing depression that provide the greatest benefit to their population.

Although the Layard initiative has the potential to increase the number of psychological therapists, this potential may not be realised for some time. Therefore, it is likely that the introduction of self help and other minimal interventions within a stepped care system will be a key driver of increases in the abilities of services to meet demand.

The key idea underpinning stepped care is that patients receive the least intensive intervention that is still expected to provide significant benefit to their health.

Figure 2 shows the basic stepped care model, and shows how it differs from traditional services.
Figure  has the more detailed stepped care model based broadly on that proposed by NICE. There are a number of important issues to note. First, the main focus for primary care is steps 1-, with step requiring interface between primary care and specialist services. Secondly, step 1 is for patients who do not require or want a specific intervention. The other steps are for increasing levels of symptoms, distress and problem complexity. It may be appropriate for patients to bypass previous steps if their symptoms are severe enough, or if they had previously tried a step, but did not benefit. However, some patients may start at the lower steps and access higher ones only if they do not benefit from their initial treatment.

Although the model involves 5 steps, it could be argued that the main innovation is the introduction of step 2. The greatest benefit may be gained from stepped care if a significant proportion of patients are successfully managed at step 2. Therefore, some services may wish to use step 2 as a default for mild to moderate depression in primary care, with specific exceptions (e.g. severe depression, suicidal ideation or other indicators of severe problems). Other services may restrict step 2 to patients with relatively mild depression, and direct patients with moderate disorders to step 3 immediately.

The exact model adopted is likely to depend on the available resources. Nevertheless, it should be noted that one key advantage of stepped care is that patients who do not benefit from less intensive interventions at step 2 are identified and encouraged to try other treatments, because they are systematically assessed after their treatment.

Stepped care is an innovative method of organising services, and there are a number of complex issues where guidance has yet to be provided. For example, how much of the available resources should be placed at step 2? How should decisions be made about which step patients access initially? What sort of patients might miss out lower steps?

The Service Delivery and Organisation (SDO) funding body of the NHS has commissioned research on these issues which will seek to provide more specific guidance in the near future.
Treatments in the stepped care system

The main treatments which are recommended for different categories of depression severity are detailed briefly below (further details of these treatments are provided in Appendix 8). Some of these recommendations are from NICE guidance and other reviews of evidence. It is not expected that all services will necessarily have all the proposed treatments available. Rather, this list should serve as a guide to possible interventions.

Step 1

- Watchful waiting. According to NICE, watchful waiting can be used with (a) patients who do not wish to have an intervention (b) patients who the health professional thinks will recover without an intervention

Step 2

- Guided self-help. This involves a CBT-based self-help resource and limited support from a health care professional
- Computerised CBT, based on the recent recommendations from NICE
- Group psycho-education. This involves a group treatment, providing information about depression, and strategies for managing it
- Exercise on prescription. Being physically active can assist in the recovery of depression. Exercise on prescription schemes establish links with local leisure centres to allow patients to access equipment and receive regular advice and monitoring from qualified professionals

Step 3

- Brief psychological therapy. There are a number of relevant psychological therapies, including CBT and counselling. The recommended treatment is 6-8 sessions over 10-12 weeks
- Medication. According to the NICE guidelines, there is more evidence for the effectiveness of antidepressant medication in moderate to severe depression than in mild depression. In moderate depression, antidepressant medication should be routinely offered to all patients before psychological interventions. Careful monitoring of symptoms, side effects and suicide risk (particularly in those aged under 30) should be routinely undertaken, especially when initiating antidepressant medication. Patient preference and past experience of treatment, and particular patient characteristics should inform the choice of drug. It is also important to monitor patients for relapse and discontinuation/withdrawal symptoms when reducing or stopping medication. Patients should be warned about the risks of reducing or stopping medication

Antidepressants are not generally recommended for patients with mild depression because the risk/benefit ratio is poor. Medication is more commonly used with patients at steps 3 and above. Exceptions may be made when patients have failed to benefit from other interventions at lower steps, or where patients have a previous history of moderate to severe depression.
• Collaborative care and depression case management. Although the prescription of medication as recommended by NICE can be conducted by the GP alone, it is likely that the effectiveness and acceptability of the approach will be enhanced through the addition of case management through a collaborative care approach. The key facets of such an approach are as follows:

• Assigning a case manager to a patient, who is supported by a specialist mental health professional, and collaborates with the GP in the care of the patient

• Provision of medication and/or brief psychosocial interventions

• Proactive management of the patient led by the case manager, including regular follow up (face to face contact, or by phone), and monitoring of progress

• Feedback of information about treatment and progress from the case manager to the GP and mental health specialist to assist in treatment decision making in patients who fail to improve

• Most of the published studies using depression case management have involved medication, and it is expected that a significant proportion of patients at this step will be on medication. However, all patients will receive additional psychosocial support from the case manager, and it is possible for the case management approach to be used with psychosocial interventions alone, if patients do not wish to use medication. For example, a patient with a moderate depression who does not wish to take medication may receive case management, with psychosocial support offered in the form of facilitated self-help or signposting to other services, as appropriate

• Appendix 9 details a number of websites with relevant resources for use in the collaborative care approach

Step 4

• Psychological therapy. The treatment of choice is CBT of longer duration (16-20 sessions over 6-9 months), although in some cases interpersonal therapy may be used

• Medication, collaborative care and depression case management are again relevant with this group of patients
Chronic, atypical refractory, recurrent

Severe depression

Moderate depression

Mild to moderate depression

Sub-clinical and patients who choose not to have intervention

Step 1
Watchful waiting

Step 2
Guided self-help, exercise on prescription, psycho-education, signposting, or computerised CBT

Step 3
Medication, case management and collaborative care, psychological therapy

Step 4
Medication, case management and collaborative care, psychological therapy

Step 5
Specialist services
CHAPTER 5: MONITORING AND FOLLOW UP

Key messages

• All patients treated for depression should have a planned schedule of contacts in order to assess response to treatment and ongoing progress. The exact schedule will depend on the severity of depression and other relevant factors

• Scheduled contacts should include the use of objective outcome measures as a marker of progress and an aid to clinical decision making

• Decisions may involve change of treatment within steps, or moving patients up to new steps if they have failed to progress

Phases in depression treatment

At a broad level, depression can be thought of as having three phases:

• Acute phase – the aim of treatment is reducing symptoms and achieving remission (approximately 8-12 weeks if treatment is successful)

• Continuation phase – the aim is prevention of the return of symptoms during the current period (approximately 6 months from the end of the acute phase)

• Maintenance – the aim is prevention of new episodes of depression (approximately 6 months from the end of the continuation phase)

The model recommends regular, proactive contact with patients throughout these phases. The schedule will depend on the severity of the problem, and the phase. Figures 3-6 shows some suggested schedules of contacts for patients at the different steps.

Monitoring response in acute phase treatment

The goal of acute phase treatment is remission of symptoms. The definition of remission will depend on the assessment instruments used. A variety of tools are available. In Appendix 10 there is a copy of a questionnaire from the United States called the PHQ-9 which can be used freely. Appendix 11 includes definitions of initial response to treatment and remission which can be used in further clinical decision making. The Clinical Outcome in Routine Evaluation outcome measure (CORE-OM) is often used in primary care in the UK, and may be another useful measure of progress. Whatever instrument is used, it is important that there are appropriate and agreed systems for defining response to treatment and remission, similar to those in Appendix 11.

Monitoring response may be undertaken by the GP (e.g. during watchful waiting) or another health professional (e.g. practice nurse, graduate primary care mental health worker, primary care mental health professional or a counsellor). In some cases, the professional providing the treatment may differ from the person monitoring progress. In all cases, information is shared with the GP.
Decision making about acute phase treatment

The result of the assessment of response to acute phase treatment feeds into decision making about further care. As the goal is remission, patients who improve, but do not remit, and those who do not improve will need their treatment reviewing. Patients who improve, but do not remit, may simply need more time on the same treatment. However, patients who fail to benefit at all may be more likely to need an alternative treatment within a step, or stepping up (see Figures -).

Periodic monitoring in the continuation and maintenance phases (Steps 3/4 only)

Patients with moderate and severe depression require longer term monitoring. Some patients who achieve remission may relapse, while others may have a recurrent episode. Following remission and during the continuation and maintenance phases, patients should be proactively followed-up in order to monitor their status.

Figures 3-6 summarise the structure of care at each of the 4 initial steps, and detail:

- The initial treatment
- The proposed schedule of contacts involved in the initial treatment, plus appropriate professionals to deliver this treatment
- The suggested point at which patient progress during the acute phase is reviewed, together with the appropriate professional to conduct the review
- The possible decisions to be made on the basis of the progress review, together with the appropriate professional to conduct the decision making
- The proposed schedule of contacts involved in the maintenance and continuation phases (where appropriate)
- The suggested point at which longer term patient progress is reviewed, together with the appropriate professional to conduct the review

The exact nature of each step, the professionals involved and the treatments provided will depend on local resources and current service structure.
Initial treatment | Sessions in acute phase | Progress review | Decision making following review | Treatment contacts in maintenance and continuation phase | Long term review

Watchful waiting | None | 2 weeks | GP | If improved or remitted | no further intervention

If not improved, step up

Guided self-help | 2-3 sessions (GW/PN) | Varies depending on program | Referral to appropriate scheme | 1-2 sessions (GW/PN) | 8 weeks | GW/PN | If improved more of initial treatment or another treatment within step, inform GP

If remitted, inform GP, discharge

If not improved, another treatment within step or step up, inform GP

Figure 3 - Clinical pathway for step 1

Figure 4 - Clinical pathway for step 2
Initial treatment | Sessions in acute phase | Progress review | Decision making following review | Treatment contacts in maintenance and continuation phase | Long term review

**Brief therapy**
- 6-8 weekly sessions (Therapist)

**Medication with case management**
- 6 fortnightly monitoring sessions (GW/PN)

**If improved**
- more of initial treatment or another treatment within step, inform GP

**If not improved**
- Discuss with GP or therapist another treatment within step, OR step up, inform GP

**If remitted**
- inform GP

**Every 2 months for 12 months**
- GW/PN

**6 and 12 months**
- GW/PN

Figure 5 - Clinical pathway for step 3

Primary Care Services for Depression

Care Services Improvement Partnership (CSIP)
Initial treatment | Sessions in acute phase | Progress review | Decision making following review | Treatment contacts in maintenance and continuation phase | Long term review
---|---|---|---|---|---
Medication and case management | CBT/IPT | 12 weekly sessions (Gateway, PwSI, CPN) | 24 weeks (Experienced GW, Gateway, PwSI, CPN) | If improved more of initial treatment or another treatment within step, inform GP | Every month for 12 months (Gateway, PwSI, CPN) | 6 and 12 months (Gateway, PwSI, CPN)

If remitted
inform GP.

If not improved
Discuss with GP or therapist another treatment within step, OR step up, inform GP

Figure 6 - Clinical pathway for step 4
One issue that is often raised about standardised systems of care is that they take little account of the preferences, needs and wishes of individual patients. Primary care has long prided itself on being focussed on exactly these issues.

However, there is room for patient choice within the proposed model.

Patients may make choices within steps. For example, when patients enter step 2, they may choose from a number of equivalent interventions, such as guided self-help, exercise on prescription, and computerised CBT, depending on what is available locally. Patients entering case management can choose whether or not to have a combination of medication and psychological interventions, or medication alone.

Patients may also be able to choose between steps, and choose to bypass lower level steps, if there is a good reason that they are inappropriate.

However, it is important that patients’ decisions are made on the basis of good information. Patients who initiate treatment for depression should be offered information on the services currently available, as discussed in the section on patient assessment. Patients’ treatment preferences should be part of the initial assessment, and patients should also be encouraged to discuss their evolving treatment preferences with the case manager or primary care professional during treatment.
CHAPTER 7: ROLES FOR PROFESSIONALS

While the clinical pathways described above identify professionals to undertake specific roles, this will depend on local availability. No professional should take on any role for which they have not received training or which they do not feel competent to undertake.

The following recommendations maybe useful:

GPs
- Initial assessment
- Patient education
- Initial medication prescription

Practice nurse, graduate primary care mental health worker
- Screening
- Patient education
- Follow up and monitoring of progress
- Guided self-help
- Signposting
- Group psycho-education
- Assisting with computerised cognitive behaviour therapy
- Case management in moderate depression

Primary care mental health professionals, counsellors
- Brief CBT
- Brief counselling

Gateway workers, practitioner with a special interest, mental health nurses
- Supervision for primary care professionals
- Training for primary care professionals in the recognition and management of depression
- Strengthening links between primary and secondary care interface
- Case management in severe depression

Mental health specialist (psychiatrist, psychological therapist, mental health nurse)
- Diagnosis where difficult in primary care
- Specialist medication advice
- Specialist longer term psychological therapy
- Consultation, support and supervision for primary care professionals and case manager
CHAPTER 8: INTERFACE ISSUES

As well as improving primary care mental health services, effective management of depression in primary care will require improvements at the primary-secondary care interface. To achieve this, professionals working in both primary and secondary care will need to work together and have agreed mechanisms for communication.

Protocols between primary and specialist mental health services can be written which enable patients who have been successfully treated by specialist services to be further treated and/or monitored in primary care. An example might be a patient who makes an almost full recovery following a short inpatient stay and may only require brief intervention or case management by a primary care professional.

The new incentives to screen patients on the diabetes and coronary heart disease registers means there is potential for increased case-finding of people with complex co-morbid problems at moderate severity and above. Dealing with these sorts of problems requires close working between primary care and mental health teams. Research examining interventions to improve outcomes for both diabetes and depression have shown mixed results, and have shown it is generally easier to impact on depression symptoms than diabetes outcomes.\(^{25}\) The same is broadly true for coronary heart disease - treating depression improves the signs and symptoms of depression in these patients, but there is less compelling evidence at present that it improves the morbidity and mortality associated with coronary heart disease.\(^{26}\)

As well as effective interface between primary and secondary care, the employment agenda highlighted by Lord Layard also suggests the need for more effective working between health and employment agencies, for example the services of Job Centre Plus and condition management programmes run by the Department of Work and Pensions (DWP).
CHAPTER 9: CASE STUDIES

Case study 1 - Mild depression

Week 0 - Initial/screening appointment (GP)

Mr Clarkson presents to the GP with a recent history of headaches and stiffness in his joints which has been affecting his sleep for the past 2 weeks. Physical examination does not indicate any physical cause. The screening questions are positive, and assessment of severity indicates that Mr Clarkson is suffering from mild depression. Treatment options in steps 1 and 2 are discussed and Mr Clarkson says that he does not feel he needs anything specific at this time. The GP gives the patient some materials on depression and suggests Mr Clarkson make another appointment in 2 weeks time to review the situation.

Week 2 - Review appointment (GP)

Two weeks later, the assessment indicates no symptoms, and it is agreed that no further action is required.

Case study 2 - Mild depression

Week 0 - Initial/screening appointment (GP)

Mrs Jones is a 34 year-old teacher who presents to her GP complaining of poor sleep and appetite and tearfulness for the past four or five weeks. A physical examination indicates no abnormalities. The GP asks the patient the two screening questions and following a positive response asks specific questions about symptoms, impact and risk and completes the ICD-10. The patient is asked to complete the screening tool (PHQ-9). Both scores are indicative of mild depression and this is discussed with the patient. The patient agrees she has been feeling a little fed-up and drinking slightly more alcohol than normal but isn’t at risk and has no previous history. The patient shows some interest in psychological therapy, and the GP gives the patient an information leaflet on available therapies, and suggests the patient might wish to use some self help materials in the first instance. An appointment is made to see the graduate worker to discuss some guided self-help in more detail.

Week 2 - Guided self-help session 1 (graduate primary care mental health worker)

The graduate primary care mental health worker briefly discusses the nature of the patients’ problems and possible materials that may be of use. They decide on a depression self-help book, and the graduate primary care mental health worker suggests scheduling pleasant activities more regularly, and shows the patient how the manual can help with this. They make an appointment for 2 weeks. This information is fed back to the GP by addition in the medical records.

Week 4 - Guided self-help session 2 (graduate primary care mental health worker)

The patient and worker discuss the patient’s use of the manual and any difficulties that have arisen. Other activities are also discussed. The patient continues to be concerned about her alcohol consumption so the worker gives her contact details for the local voluntary alcohol support service. This information is added to the medical records.

Week 6 - Guided self-help session 3 (graduate primary care mental health worker)

The patient and worker continue to discuss the patient’s use of the manual. The patient did contact the voluntary alcohol service and has signed up for a support group.

Week 8 – Monitoring session (graduate primary care mental health worker)

The worker gets the patient to complete the PHQ-9. Scoring the questionnaire indicates that the patient’s
problems have remitted. The patient is happy to continue using the manual and attending the voluntary support group. The results of the assessment are fed back to the GP and entered onto the medical record. The patient is removed from the workers’ caseload.

Case study 3 - Moderate to severe depression

Week 0 - Initial/screening appointment (GP)
Mr Allen attends surgery complaining of ‘not feeling right’ since being made redundant 6 months ago. Unable to establish any specific physical complaints the GP asks Mr Allen what he is doing with his time and discovers that the patient is spending most of his time in the house ‘just watching TV’. He has stopped going to his darts matches as ‘it all seems like too much effort’. Completion and scoring of the ICD-10 and PHQ-9 indicates a moderate level of depression. The patient also discloses that he had a similar depression when his wife left him 4 years ago. He has never posed a risk to himself or others but on this occasion has thought his family would be ‘better off without him’. The GP probes into this further and using the recommended risk questions asks if the patient has made any plans to act on his thoughts. Having established that Mr Allen has no plans to harm himself because he would leave too much debt for his daughter, the GP discusses the treatment options with the patient. The GP and the patient agree to try medication. The GP prescribes an anti-depressant which has minimal risk in overdose and explains side-effects, the time required for medication to work and any possibility of increasing the dose in the future to therapeutic levels. The GP explains to the patient that he will be assigned a practice nurse to manage his case and support and assist him over the next few months, who will contact him by telephone in the next week to discuss the medication. The patient is given a patient information leaflet on depression and an appointment to be seen in the clinic at the practice held by the local Citizens Advice Bureau regarding his debt problems.

Week 1 – Initial follow up (Practice nurse)
One week later the practice nurse contacts Mr Allen to discuss his medication, answer any queries he has, and to give support. The nurse establishes that he forgot about his CAB appointment and reschedules him another one and agrees to remind him by telephone the afternoon before the appointment.

Weeks 3, 5, 7, 9 Follow up (Practice nurse)
The practice nurse continues to contact Mr Allen to discuss his medication, answer any queries he has, and to give support. Mr Allen did attend his appointment and is being supported by the CAB worker to deal with his debts.

Week 12 Progress review session (Practice nurse)
The PN sees Mr Allen to conduct a review of his progress with the PHQ-9. Scoring the questionnaire indicates that Mr Allen has had a partial response to the medication. Further discussion indicates some problems with loneliness Mr Allen is assisted to increase his social support through activity scheduling/behavioural activation and using local support groups. Mr Allen is happy with this and does not wish to change his medication at present. This information is discussed with the GP and added to the medical records.

Months 2, 4, 8, 10 post acute phase (Practice Nurse)
The PN conducts telephone follow-up, checks progress is maintained and discusses medication.

Months 6 and 12 (Practice Nurse)
The patient is invited for an appointment with the Practice Nurse to review progress and the PHQ9 is completed.
CHAPTER 10: AUDIT AND MONITORING

Patients on a practice list with depression will need to be identifiable through the clinical record keeping system (often referred to as ‘registers’). For audit purposes it would also be beneficial to classify the depression (i.e. mild, severe, atypical etc).

It is recommended that this identification record should be separate from any Severe Mental Illness (SMI) registers.

It is recommended that audit involves checking the following are being undertaken:

- Primary care has protocols in place for the screening of high-risk groups and that these protocols are adhered to
- Screening tools are used to aid diagnosis
- Standard questionnaires are used to monitor progress
- Patients are offered the appropriate number of monitoring and review appointments
- Medication is prescribed appropriately and monitored regularly:
  - Not used for mild depression
  - Information is given to the patient
  - Prescribed in accordance with NICE guidelines
  - Maintenance prescribing is monitored regularly
- Appropriate psychological therapies are available and offered to the patient
- Patient satisfaction is monitored (using a standard patient satisfaction questionnaire)

APPENDICES

Appendix 1: Screening for Depression in High Risk Groups

‘During the last month, have you often been bothered by feeling down, depressed or hopeless?’

and

‘During the last month, have you often been bothered by having little interest or pleasure in doing things?’

If the patient’s response to BOTH questions is ‘no’, the screen is negative.

If the patient responds ‘yes’ to EITHER question, use a recommended screening tool (Appendix 2 and 3).
Appendix 2: Assessing the severity of depression (ICD-10 Primary Care Version)

**KEY SYMPTOMS**
Have any of the following occurred most of the time for two weeks or more:

A. Persistent sadness or low mood
B. Loss of interest or pleasure
C. Fatigue or low energy

**ASSOCIATED SYMPTOMS**

1. Sleep disturbance
   - Difficulty falling asleep
   - Early morning wakening
2. Appetite disturbance
   - Appetite loss
   - Appetite increase
3. Poor concentration or indecisiveness
4. Agitation or slowing of movement
5. Decreased libido
6. Low self confidence
7. Suicidal thoughts or acts
8. Guilt or self-blame

*If YES to any of the above, continue below*

**Conclusion:**
Positive to A, B or C and:
- 4 of the associated symptoms above = MILD
- 5-6 of the associated symptoms = MODERATE
- 7 or more of the associated symptoms = SEVERE
Appendix 3: Other scales for the assessment of severity and outcome

Patient Health Questionnaire (PHQ-9). Developed specifically for primary care and used widely in the US. Items relate closely to the criteria for depression in the DSM-IV. Copyright Pfizer Inc. Details are provided in Appendix 9 and 10. Can be downloaded free from:
www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/

General Health Questionnaire (GHQ) (12 items). Easy to complete and well validated. Available in several languages. Available from NFER-Nelson Publishing Co Ltd Tel: 08456 021937.

Hospital Anxiety and Depression Scale (HADS) (14 items). Used frequently in primary care, especially useful with patients who also have physical illness. Available from NFER-Nelson Publishing Co Ltd Tel: 08456 021937.

Beck Depression Inventory (BDI–II) (21 items) Copyright belongs to the Psychological Corporation and can be purchased at www.fpnotebook.com

Geriatric Depression Scale (GDS) is used for screening with the elderly. Not subject to copyright. Can be downloaded from www.miahonline.org

Edinburgh Postnatal Depression Scale (EPDS) is commonly used by health visitors to screen for postnatal depression. Not subject to copyright and can be downloaded from www.priory.com/psych.htm


The CORE-OM is a patient completed outcome measure and part of the CORE System. It is a 34-item questionnaire designed to measure clients’ global distress, including subjective well-being, commonly experienced problems, functioning, and risk. Although protected by copyright, no charge is made for the CORE-OM and practitioners who are interested in using it can photocopy materials if their content is not changed in any way. Further information on training, support systems and software are available at www.coreims.co.uk/index.php

These questionnaires can be used to assess severity and monitor progress.

Most scales can be completed by patients whilst in the waiting area. Patients who have difficulty reading or are non-English speakers may require additional help. Minimal staff input is required for the scoring of responses.

Appendix 4: Asking About Risk

Intention - thoughts
Do things ever feel that bad that you think about harming or killing yourself?
Do you ever feel that life is not worth living?

Plans
Have you made plans to end you life?
Do you know how you would kill yourself?

Actions
Have you made any actual preparations to kill yourself?
Have you ever attempted suicide in the past?

Prevention
How likely is it that you will act on such thoughts and plans?
What is stopping you killing or harming yourself at the moment?
Risk Factors for Suicide:

- Recent marital conflict
- Currently untreated severe mental illness
- Alcohol abuse
- Previous suicide attempts

It is also important to ask about risk to others, especially where patients are not known to the primary care practice. An example question might be “Have you ever been in trouble with the police?”

Categorising risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>No current thoughts, or infrequent thoughts</td>
<td>Continue follow-up visits and monitor. Normalise thoughts and differentiate between thoughts and actions.</td>
</tr>
<tr>
<td>Intermediate risk</td>
<td>Frequent current thoughts but no plans or intent</td>
<td>Assess risk carefully at each visit. Liaise with specialist mental health service. Ensure patient knows how to access services.</td>
</tr>
<tr>
<td>High risk</td>
<td>Current thoughts with plans and preparations</td>
<td>Refer to specialist mental health service and engage in collaborative approach to treatment and monitoring.</td>
</tr>
</tbody>
</table>

Appendix 5: Asking About Alcohol Problems – the CAGE Questionnaire

Have you ever felt you ought to Cut down on your drinking?

Have people Annoyed you by criticising your drinking?

Have you ever felt bad or Guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?

Two or more “Yes” responses yield a positive screen test for alcohol.
Appendix 6: AUDIT Questionnaire: Screen For Alcohol Misuse

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?
   - Never
   - Monthly or less
   - 2–4 times a month
   - 2–3 times a week
   - 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7 to 9
   - 10 or more

3. How often do you have six or more drinks on one occasion?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   • No
   • Yes, but not in the past year
   • Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
    • No
    • Yes, but not in the past year
    • Yes, during the past year

**Scoring the audit**

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4.

A score of 8 or more is associated with harmful or hazardous drinking. A score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.
APPENDIX 7: RELEVANT PATIENT INFORMATION RESOURCES

Many GPs have the variety of leaflets available at www.patient.co.uk on their computers for printing for individual patient use.

Below are some of the other web-sites and organisations from where patient information leaflets can be accessed or purchased.

MIND produces a variety of leaflets, some of which are available in languages other than English. They can be printed by individuals or ordered on-line for a cost to organisations www.mind.org.uk

The Royal College of Psychiatrists produce leaflets on depression, anti-depressants and psychotherapy in a variety of languages which can be printed from www.rcpsych.ac.uk

The British Association of Behavioural and Cognitive Psychotherapies (BABCP) have leaflets on depression, self-help which are printable or available to order at a cost www.babcp.com

Depression Alliance have a number of on-line patient information leaflets on depression and available treatments www.depressionalliance.org/

The Mental Health Foundation have leaflets available to order at cost and can be printed from the web-site by individual patients www.mentalhealth.org.uk

The Department of Health has produced a free leaflet with information on different psychological therapies www.doh.gov.uk and search for talking therapies.

APPENDIX 8: TREATMENTS AT STEP 2

Guided self-help

Self-help involves providing patients with both information about a condition and skills and techniques to overcome symptoms and assist with problems. These skills and techniques are often based on cognitive-behaviour therapy (CBT). Guided self-help is appropriate for mild depression.

There is some evidence from the UK that ‘pure self-help’ through written materials improves outcomes for patients in primary care, and that guided self-help can be conducted by non-mental health specialists such as practice nurses.

A comprehensive self-help booklet for depression can be ordered from the Oxford Cognitive Therapy Centre at www.octc.co.uk/html/self-help.html

Overcoming Depression is written by Chris Williams, and two of the chapters on Problem Solving and Being Assertive are available free of charge at www.calipso.co.uk

Newcastle, North Tyneside and Northumberland Mental Health Trust self-help booklets are available free to download at www.nnt.nhs.uk/mh/

Computerised CBT

Computerised packages may be designed to function with very little guidance, although monitoring of outcome is still recommended. There is evidence from the UK that computerised CBT (with brief guidance) is clinically and cost-effective in primary care.

The National Institute of Clinical Excellence has reviewed the evidence for computerised packages and provided guidance. www.nice.org.uk/page.aspx?o=ta097
Referral facilitation (‘signposting’)

Referral facilitation involves assessing a patient and helping them find appropriate local or national voluntary organisations. On occasion, statutory organisations may be suggested or new support groups established. Referral facilitation is based on the availability of local groups, up to date information on their scope, and agreement from these groups concerning referral. It is recommended that a professional such as a graduate worker visits groups in order to gather information on a pro-forma concerning each group, which allows easy and rapid sharing of information about available resources.

Referral facilitation is appropriate for mental health problems of mild to moderate severity, and may be relevant for patients with depressive symptoms who are facing particular psychosocial difficulties for which there are relevant groups available.

There is one study in the UK that suggests that referral facilitation improves patient outcome. There is one ongoing UK trial that is examining the effects of referral facilitation specifically by graduate primary care mental health workers.

Group psycho-education

Group psycho-education for depression is group treatment which involves providing information about depression, issues that affect mood, how to identify and change thoughts, activities and interactions that affect mood, relaxation training, and goal planning. Groups of 6-10 people are formed on a locality basis and each group meets for 8, 2 hour sessions.

Because of the educational nature of the intervention, it can be used in a variety of settings, including those outside health such as adult education. The intervention can be used in a preventive capacity (i.e. in patients at risk of developing depression) or with patients with specific depressive problems.

Group psychoeducation is appropriate for mild depression. There is evidence from UK primary care that group psychoeducation is effective.

Exercise on Prescription

Exercise on Prescription (EoP) can be used as a non-drug treatment in the treatment of depression and aims to help people increase their physical activity.

Being physically active can assist in the recovery of depression and can also prevent against re-occurrence. However, seven in ten adults are not active enough to get the health benefits. The EoP Government schemes aim to tackle health inequalities by improving access to sport and exercise.

Many of the schemes already in operation have established links with local leisure centres and patients can access the equipment and receive regular advice and monitoring from qualified registered fitness professionals. National standards for EoP have been published by the Department of Health which encourage the development of new and effective high quality projects nationwide.

There is some evidence that exercise is effective in improving depression. Guidance is available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthyLiving/en
APPENDIX 9: WEBSITES WITH INFORMATION ON THE COLLABORATIVE CARE AND CASE MANAGEMENT APPROACH

Helping the Chronically Ill through Quality Improvement and Research (a national program of the Robert Wood Johnson Foundation)
www.improvingchroniccare.org

The MacArthur Initiative on Depression in Primary Care
www.depression-primarycare.org

The Health Disparities Collaborative
www.healthdisparities.net

APPENDIX 10: PHQ-9 MONITORING TOOL (COPYRIGHT PFIZER)

The Patient Health Questionnaire (PHQ-9) is a brief 9-item patient self-report questionnaire specifically developed for use in primary care and used extensively in the United States. The PHQ-9 has acceptable reliability, validity, sensitivity and specificity as an assessment tool for the diagnosis of depression in primary care. The questionnaire can also be used to monitor progress with possible scores ranging from 0 to 27 with higher scores indicative of increasing severity.
www.depression-primarycare.org
1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
   Read each item carefully, and circle your response.
   a. Little interest or pleasure in doing things
      Not at all       Several days       More than half the days       Nearly every day
   b. Feeling down, depressed, or hopeless
      Not at all       Several days       More than half the days       Nearly every day
   c. Trouble falling asleep, staying asleep, or sleeping too much
      Not at all       Several days       More than half the days       Nearly every day
   d. Feeling tired or having little energy
      Not at all       Several days       More than half the days       Nearly every day
   e. Poor appetite or overeating
      Not at all       Several days       More than half the days       Nearly every day
   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
      Not at all       Several days       More than half the days       Nearly every day
   g. Trouble concentrating on things such as reading the newspaper or watching television
      Not at all       Several days       More than half the days       Nearly every day
   h. Moving or speaking so slowly that other people could have noticed.
      Or being so fidgety or restless that you have been moving around a lot more than usual
      Not at all       Several days       More than half the days       Nearly every day
   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
      Not at all       Several days       More than half the days       Nearly every day

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
   Not Difficult at All       Somewhat Difficult       Very Difficult       Extremely Difficult

Scoring the PHQ-9 when used to measure severity involves counting one point for each of the 9 items in question 1 ticked ‘several days’, two points for each ticked ‘half the days’ and three points for those ticked ‘nearly every day’. Sum the total for a severity score.
APPENDIX 11: RECOMMENDED CATEGORIES FOR RESPONSE AND MONITORING WITH THE PHQ-9

<table>
<thead>
<tr>
<th>SCORE</th>
<th>SEVERITY</th>
<th>CLINICAL PATHWAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
<td>Mild depression</td>
<td>Step 1 or 2</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
<td>Step 2 or 3</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderate to severe depression</td>
<td>Step 3 or 4</td>
</tr>
<tr>
<td>&gt;20</td>
<td>Severe depression</td>
<td>Step 4 or 5</td>
</tr>
</tbody>
</table>

**Definition of improvement**

- **Improved**: A reduction of 2 or more points on the baseline score
- **Not improved**: Drop of 1 point or no change or increase

**Definition of remission**

A PHQ-9 score of less than 5 is the eventual goal of acute phase treatment. When this goal is achieved, patients enter the continuation phase of treatment. Changes of treatments within steps and stepping up are considered for patients who do not meet this goal.
REFERENCES


22 ANDREWS G. Should depression be managed as a chronic disease? BMJ 2001;322:419-421.
USEFUL RESOURCES

Books & Reports
www.dh.gov.uk/assetRoot/0/0/9/9/0099pdf
National service framework for mental health: modern standards and service models.
www.dh.gov.uk/assetRoot/0/07/7/09/007709.pdf
Executive Summary: Saving lives: Our Healthier Nation is an action plan to tackle poor health.
www.dh.gov.uk/assetRoot/0/0/5/5/005583.pdf
www.dh.gov.uk/assetRoot/0/0/89/60/008960.pdf
This policy guidance supports the delivery of adult mental health policy locally.
www.dh.gov.uk/assetRoot/0/0/82/45/008245.pdf
Department of Health (2003) Fast Forwarding Primary Care Mental Health Graduate primary care mental health workers Best Practice Guidance. London,
www.dh.gov.uk/assetRoot/0/0/11/13/001113.pdf
Guidelines for the appointment of general practitioners with special interests in the delivery of clinical services: mental health
www.dh.gov.uk/assetRoot/0/0/8/28/65/0082865.pdf
General Medical Services (GMS)
www.dh.gov.uk/PolicyAndGuidance
OrganisationPolicy/PrimaryCare/
www.dh.gov.uk/assetRoot/0/0/7/86/59/0078659.pdf
www.dh.gov.uk/assetRoot/0/0/7/88/98/0078898.pdf
NICE CCBT
www.nice.org.uk/page.aspx?o=ta097
www.nice.org.uk/pdf/BestPracticeClinicalAudit.pdf

Introduction
http://kc.nimhe.org.uk/upload/nimhe/1CaseForChange.pdf

Policy context

Primary Care
http://kc.nimhe.org.uk/upload/nimhe/3PrimaryCare.pdf

Community Services

Hospital Services
http://kc.nimhe.org.uk/upload/nimhe/5HospitalServices.pdf

Forensic Mental Health Services
http://kc.nimhe.org.uk/upload/nimhe/6ForensicMentalHealth.pdf

Partnership working across Health and Social Care

User Involvement

Anti-discriminatory practice

Emerging areas of Service Provision

http://kc.nimhe.org.uk/upload/nimhe/conn00_strat.pdf

NHS Modernisation Agency (00-00). Improvement Leaders’ Guides London, Department of Health.

These guides are for people involved in improving patient care and experience:

Series 1
Process mapping, analysis and redesign

Matching capacity and demand

Measurement for improvement

Series 2
Involving patients and carers
www.modern.nhs.uk/improvementguides/reading/Involving_patients.pdf

Managing the human dimensions of change

Spread and sustainability

Series 3
Building and nurturing an improvement culture

Working in groups
www.modern.nhs.uk/improvementguides/reading/workingInGroups_final.pdf

Redesigning roles

Working with systems

Setting up a collaborative programme

Workforce Action Team (2001)
Primary Care Key Group Report to the Workforce Action Team Mental health national service framework workforce planning, educational and training underpinning programme. London, Department of Health.
http://www.dh.gov.uk/assetRoot/04/01/47/92/04014792.pdf

Increasingly, interventions such as ‘Art on Prescription’ and ‘Prescription for Learning’ are being evidence-based and recommended.
www.socialexclusionunit.gov.uk
Organisations & Websites

**A/B**
The British Association of Medical Managers  
www.bamm.co.uk
Dedicated to the promotion of quality healthcare by improving and supporting the contribution of doctors to management.
The British Medical Association  
www.bma.org.uk
A professional association of doctors, representing their interests and providing services for its 126,000 plus members.

**C**
Centre for Evidence Based Mental Health (CEBMH)  
www.cebmh.com
The broad aim of the CEBMH is to promote evidence-based health care and provide support and resources to anyone who wants to make use of them.

**D**
Database of Abstracts of Reviews of Effectiveness (DARE)  
www.york.ac.uk
DARE contains summaries of systematic reviews which have met strict quality criteria. Included reviews have to be about the effects of interventions.

**H**
Health Development Agency  
www.hda.nhs.uk
Set up by government to play a central part in implementing the public health strategy Saving Lives: Our Healthier Nation.

**E/F/G**
Electronic Library for Social Care (eLSC)  
www.scie-socialcareonline.org.uk
eLSC is a free online resource owned and managed by the Social Care Institute for Excellence (SCIE). It provides a single point of access to an extensive range of social care knowledge, including practice information, skills tutorials, and around 70,000 abstracts of books, reports, research papers, journals, official publications and articles.

**I/J**
The Institute of Health Management  
www.ihm.org.uk
The largest UK professional body for managers

circulars are quasi-legislative and include a direction or requirement to take specific action. Letters are used to provide key communication between DH and its NHS and social care audiences.

Department of Health Primary Care section  
www.dh.gov.uk/PolicyAndGuidance/ OrganisationPolicy/PrimaryCare/fs/en
This section of the Department of Health website includes policies, initiatives and standing arrangements in primary care.

Department of Health Publications on the Internet  
www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en
This resource provides a library of all Department of Health publications, to browse and locate required documents by a fully functioning search facility.
working in health. The IHM was formed by the coming together of two major organisations, the Institute of Health Services Management and the Association of Managers in General Practice.

Integrated Care Network
www.integratedcarenetwork.gov.uk
The Integrated Care Network aims to help frontline organisations to work together to deliver flexible services that help people to remain in control and live independent lives. If you work with services in the health, local government or independent sectors then this website is for you.

Internet-gp.com
www.gpwebsites.net
A list of over 600 General Practitioners’ web sites in the UK.

The Institute for Public Policy Research
www.ippr.org.uk
Britain’s leading centre-left think tank. Their purpose is to contribute to a greater public understanding of social, economic and political questions through research, discussion and publication.

K/M
The Kings Fund
www.kingsfund.org.uk
The main focus for is to improve the health of Londoners by making change happen in health and social care. They work nationally and internationally; give grants to individuals and; carry out research and development work to bring about better health policies and services and develop people and encourage new ideas.

Manchester Centre for Healthcare Management
www.orgs.man.ac.uk/mchm
Established in 1956 and part of Manchester Business School at the University Manchester, they offer a wide range of postgraduate and professional development courses and undertake research in the NHS and other public sector organisations.

Mental Health Service Provision for Working Age Adults in England 2002
www.durham.ac.uk/service.mapping/amh
Mental Health Service Mapping exercise is undertaken by the Centre for Public Mental Health at the University of Durham every year. It draws together information about both health and social care mental health services provided in the statutory and independent sectors and organised by a range of administrative areas (eg LIT, StHA, PCT).

N
National Association of Primary Care
www.primarycare.co.uk
A non-political, non-profit making membership organisation which represents and supports the interests of all primary health care professionals and organisations.

National Audit Office
www.nao.gov.uk
Independent organisation which scrutinises public spending on behalf of Parliament.

National Confidential Inquiry
www.national-confidential-inquiry.ac.uk
The National Confidential Inquiry is a research project based at the Centre for Suicide Prevention, University of Manchester and funded largely by the National Institute for Clinical Excellence (NICE). It examines all incidences of suicide and homicide that occur under mental health services in the UK.

National Database for Primary Care Groups and Trusts
www.primary-care-db.org.uk
A substantial stand-alone dataset to provide linked information on population characteristics, health service provision and health status for all PCTs in England. The data is accessible through the internet and a dynamic map interface which allows you to download the data onto your PC.

National Electronic Library for Health Programme
www.nelh.nhs.uk
This programme is working with NHS Libraries to develop a digital library for NHS staff, patients and the public.

National Electronic Library for Mental Health (NeLMH)
www.neimh.org
This specialist library sits within the National electronic Library for Health and aims to provide access to the best available evidence to answer mental health questions.

National Institute for Clinical Excellence
www.nice.org.uk
Appraises health care interventions and then provides guidance on which treatments work best for patients.

National Institute for Mental Health for England (NIMHE)
The National Institute for Mental Health aims to improve the quality of life for people of all ages who experience mental distress. They work with and beyond the NHS to implement positive change, provide a gateway to learning and development, offer new opportunities to share experiences and a place to find information.
Now part of the Care Services Improvement Partnership (ESIP).

National Institute for Mental Health for England Development Centres
East
www.nimheeastern.org.uk

East Midlands
www.nimhe-em.org.uk
London
www.londondevelopmentcentre.org
North East
www.nimhe.org.uk/development/northeast/index.asp
North West
www.nimhenorthwest.org.uk
South East
www.sedc.org.uk
South West
www.nimhesw.org.uk
West Midlands
www.nimhewm.org.uk

NHS Direct
www.nhsdirect.nhs.uk
This website provides links to information about health conditions and a telephone helpline service for people with concerns about their own health or that of others.

National Pharmaceutical Association
http://npa.co.uk The national body for Britain’s community pharmacists.

National Primary and Care Trust Development Programme
www.natpact.nhs.uk
NatPaCT aims to help Primary Care Trusts grow by sharing information, experiences, and achievements.

National Primary Care Development Team
www.npdt.org
This website contains practical information and resources to support those people participating in our programmes and those who are interested in the application of improvement science.
The National Primary Care Research and Development Centre is a multi-disciplinary and academically independent centre, established by the Department of Health in 1995 to undertake a programme of policy related research in primary care. It is a collaboration between the Universities of Manchester and York with our main base at the University of Manchester.

National Research Register (NRR)
www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment
A register of ongoing and recently completed research projects funded by, or of interest to, the UK NHS. Information is held on over 80,000 research projects and is expected to grow further, as well as entries from the Medical Research Council’s Clinical Trials Register, and details on reviews in progress collected by the NHS Centre for Reviews and Dissemination.

New Health Network
www.newhealthnetwork.co.uk
An independent health organisation committed to a safe, successful and efficient health system.

NHS Alliance
www.nhsalliance.org
Represents well over three-quarters of Primary Care Trusts.

NHS Confederation
www.nhsconfed.org
Informs, advises, campaigns and publishes on ways in which the NHS can improve the management of its services.

NHS.uk
www.nhs.uk
The official gateway to National Health Service organisations on the Internet.

Nuffield Institute
www.leeds.ac.uk/nuffield/index.htm
Carries out research which spans management, medicine, health and social sciences. It aims to bridge evidence, policy and practice throughout its programmes.

Office of National Statistics
www.statistics.gov.uk
This website includes statistics reflecting Britain’s economy, population and society at national and local level.

Public Health electronic Library (PHeL)
www.phel.gov.uk
The Public Health electronic Library (PHeL) aims to provide knowledge and know how to promote health, prevent disease and reduce health inequalities.

PubMed
PubMed is an American website which includes links to many articles and sites providing full text articles and other related resources from a range of International sources.

Royal College of Nursing
www.rcn.org.uk
The RCN is the worlds largest professional union of nurses. It represents nurses and nursing, promotes excellence in practice and shapes health policies.

Royal College of General Practitioners (RCGP)
www.rcgp.org.uk
An academic organisation for UK general practitioners. Its aim is to encourage and maintain the highest
standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and standards issues.

Royal College of Psychiatrists
www.rcpsych.ac.uk
The professional and educational body for psychiatrists in the UK and the Republic of Ireland.

Royal Society of Medicine
www.roysocmed.ac.uk
An independent, apolitical organisation. Its activities include the provision of postgraduate education for health professionals.

School of Health and Related Research (ScHARR)
Sheffield University.
www.shef.ac.uk/scharr
ScHARR carries out a wide range of health services research relating to the NHS in the UK.

Society for Academic Primary Care
www.sapc.ac.uk
Aims to promote excellence in research, education and policy development in general practice and primary health care.

Social Care Institute for Excellence (SCIE)
www.scie.org.uk
SCIE promotes good practice in social care.

Turning Research Into Practice (TRIP) Database
www.tripdatabase.com
The TRIP Database allows users to rapidly and easily identify high quality medical literature from a wide range of sources. It is part of the Centre for Research Support at the University of Wales.

UK Health for all Network
http://independent.livjm.ac.uk/healthforall
This network is an internationally recognised structure which enables those working to improve the health of local communities and apply Health for All principles, to meet and share information, research and experiences.

World Health Organization: Mental Health Section
www.who.int/mental_health/en
The World Health Organization is the United Nations specialized agency for health. This section deals specifically with mental health.