



Now we're
Talking!

Enhancing the care pathway for depression



The *Now we're Talking!* campaign has been developed in partnership with and funded by Lilly UK and Boehringer Ingelheim



Contents

■ Foreword	1
■ Introduction	2
■ Executive summary	3
■ What guides the management of depression in primary care?	5
■ The patient journey through primary care	7
■ Initial recognition of symptoms and diagnosis	7
■ Looking beyond diabetes and coronary heart disease	8
■ Informed choice of treatment	9
■ Ongoing management	9
■ How can the management of depression in primary care be further improved?	11
■ Appendix 1: Further information	12
■ References	13

Depression Alliance and SANE would like to thank the following healthcare professionals for their advice and guidance in the development of this report.

- **Professor Linda Gask:** *Professor of Primary Care Psychiatry, University of Manchester*
- **Dr Chris Manning:** *CEO Primhe (Primary care mental health and education: www.primhe.org)*
- **Mrs Carol Paton:** *Chief Pharmacist, Oxleas NHS Trust*
- **Professor David Richards:** *Professor of Mental Health, University of York*
- **Professor Andre Tylee:** *Professor of Primary Care Mental Health, Institute of Psychiatry, Kings College, London*



Foreword

Depression Alliance and SANE are two of the UK's leading mental health charities, dedicated to improving the lives of people living with mental illness.

Depression is the most common mental health problem in the UK and the majority of people with depression receive almost all their care from their GP. Depression is a recurrent condition and a substantial proportion of those who have a single episode will go on to have further episodes¹. In addition, some people with depression find it difficult to reach remission and then recovery, and may have to live with symptoms of depression for many years, with or without a diagnosis.

Anecdotal evidence from the people we support, who often have recurrent and chronic depression, has repeatedly highlighted that more healthcare support would be a welcomed improvement for those who have to live with ongoing symptoms. Now, for the first time, we have evidence directly from people with depression showing how they would like this ongoing care provided. The suggestions made in this report on how to improve care have been informed by comprehensive research among over 450 people with experience of depression, and support and advice from a multi-disciplinary advisory committee of healthcare professionals. The *Now we're Talking!* campaign has been developed in partnership with and funded by Lilly UK and Boehringer Ingelheim.

As well as providing valuable insight into patients' perceptions of their care, these findings are now even more significant because the Department of Health has called for input from patient and professional groups on where the current Quality and Outcomes Framework (QOF) of the 'GP contract' (i.e. General Medical Services [GMS] contract) could be expanded. The QOF currently contains only two depression-focused indicators and the *Now We're Talking!* survey provides a unique opportunity to share the experiences of people with depression with those who influence and provide their care.

Specifically, we are calling for those involved in the review of the QOF to develop further indicators that will provide GPs with increased knowledge and awareness focusing on three suggested areas: 1) diagnosing depression from a wide range of psychological and somatic symptoms and co-morbidities; 2) engaging better with patients to ensure informed choice of treatment; and 3) providing effective long-term care to prevent relapse, help patients achieve remission and reach recovery.

The initial inclusion of depression in the QOF is a great step forward, but much more still needs to be done. We want to ensure that this is just the first step on a journey towards providing GPs with the necessary guidance and support to improve treatment outcomes for the millions of people in the UK currently affected by this debilitating condition.

Depression Alliance and SANE

Emer O'Neill, Chief Executive
Depression Alliance

Marjorie Wallace, Chief Executive
SANE

Introduction

Depression is one of the world's most common and debilitating conditions; by 2020 the World Health Organisation (WHO) estimates it will be second only to heart disease as the biggest global health burden². Defined as a feeling of persistent sadness and often accompanied by feelings of helplessness and hopelessness³, the exact (aetiology or) cause of depression is yet to be uncovered. However, it appears to arise from a complex interaction between external and internal stressors, genetic factors and biochemical changes in the brain¹. Environmental stresses such as job loss or bereavement (social factors), anxiety or childhood rejection (psychological factors) and long-term health problems (physical factors) are believed to trigger depression. Additionally, although the exact biological cause of depression is unknown, the neurotransmitters serotonin and noradrenaline are believed to play a major role in the onset and continuation of the condition and are thought to contribute to many of the psychological and somatic symptoms experienced, such as sleep disturbance and possibly aches and pains that appear to have no physical cause⁴.

Depression is the UK's most common mental health problem⁵, affecting between 8 and 12 per cent of the population in any year⁶. For all those people who do not achieve remission or recovery, depression can become a significant long-term condition associated with considerable medical and social problems.

In the UK, depression is thought to be responsible for 70 per cent of recorded suicides⁷ and is estimated to cost England and Wales in the region of £8 billion annually in terms of lost productivity⁸. Thirty five per cent of people who receive Incapacity Benefit cite mental health problems (including depression) as their core disability⁹. However, despite its prevalence and potentially serious consequences, when it comes to depression management, the majority of those who participated in the *Now We're Talking!* survey were satisfied with the care they received¹⁰. General practitioners (GPs) are at the forefront of this successful management; 80 per cent of depression is managed in primary care¹¹ and it is the third most common reason for GP visits¹².

Like many long-term conditions, the Government is keen to tackle the burden of depression and recently included two indicators within the QOF, a welcomed and important step for ensuring improved treatment for many people with risk factors for depression. However, in terms of what people with depression need, these indicators need to be expanded in several ways.

The QOF, in its current form, focuses solely on the assessment of severity of depression and screening of people with two co-morbidities, diabetes and coronary

heart disease. It does not address the bigger picture, such as the key issue of providing ongoing management and treating those who do not achieve remission or experience a recurrence of symptoms. As a result, Depression Alliance and SANE are working together to provide evidence to those reviewing the QOF to support depression being given a higher priority. People with depression often face a long road to recovery, hence it is important that GPs provide encouragement and support, and that in order to do this, they actively screen for the broad range of possible symptoms of depression, improve speed of diagnosis, provide informed treatment choice and maintain effective ongoing care.

This report presents the findings of a detailed survey, in which over 450 people with depression were asked to share their thoughts on depression management. The *Now We're Talking!* survey was undertaken to gather first-hand evidence of patients' experiences as they journey through the care pathway, and contributes to the growing evidence base supporting the case for the development of additional QOF indicators to further improve the management of depression in primary care. The *Now We're Talking!* survey was conducted among Depression Alliance's membership and posted on SANE's website with funding for the project provided by Lilly UK and Boehringer Ingelheim.



Executive summary

Depression is one of the UK's most common mental health problems⁵, affecting between 8 and 12 per cent of the population in any year⁶ and accounting for 70 per cent of recorded suicides⁷. It is estimated to cost England and Wales in the region of £8 billion annually in terms of lost productivity⁸ and is the third most common reason for GP visits¹².

The Government has recently included two indicators relating to depression within the Quality and Outcomes Framework (QOF) of the General Medical Services (GMS) contract. Although this is welcomed as an important step for improving treatment for people with depression, in terms of what is needed, these new indicators do not go far enough to provide effective ongoing care.

Until now, people with depression have had little or no involvement in the development of QOF indicators. For the first time, the QOF Expert Panel is inviting patient and professional groups to submit evidence on potential areas that they feel should be included within the QOF. The evidence presented in this report is from a survey developed by Depression Alliance and SANE, in partnership with Lilly and Boehringer Ingelheim. The *Now We're Talking!* survey was posted on SANE's website and mailed out to Depression Alliance's membership in

December 2006. After a period of four weeks, 473 responses were analysed by the independent market research company IPSOS Mori.

Now We're Talking! provides first-hand evidence of the experiences of people with depression in primary care and explores where in the primary care pathway people with depression feel their care could be improved. The results from this survey support the following call to action.

Call to action

From the evidence collected, Depression Alliance and SANE believe that more could be done to improve the experiences patients have of the management of depression within primary care. Reflecting the typical journey a patient takes through primary care (the 'patient care pathway'), there are three areas where it is considered the QOF could be expanded:

1. Initial recognition of symptoms and diagnosis

The *Now We're Talking!* survey showed that there are a wide range of long-term conditions commonly associated with depression. People with depression are likely to suffer from other health conditions such as high blood pressure (14 per cent), chronic painful conditions (12 per cent) and arthritis (11 per cent)¹⁰. However, the QOF is currently limited to recommending that GPs identify how many patients on their diabetes and coronary heart disease registers have been screened for depression. Although it would be difficult to look for depression in all associated conditions, there is scope to expand the QOF and encourage the identification of depression in other disease areas.

Depression Alliance and SANE recommend... the development of a QOF indicator that encourages GPs to:

- Look for depression in a wider range of disease areas, in addition to diabetes and coronary heart disease.
- Take into account the broad range of psychological and somatic symptoms associated with depression when considering an initial diagnosis.

As a GP you can... actively check for all symptoms associated with depression in patients presenting with other long-term conditions and consider their relevance when making your initial diagnosis.

As a patient you can... improve your awareness of the many and varied symptoms of depression and proactively highlight these to your GP to help them i) with their initial diagnosis or ii) identify relapse.

2. Informed choice of treatment

The *Now We're Talking!* survey showed that when it comes to depression, some patients currently feel their opinions on treatment are not adequately considered or discussed and they would welcome more ongoing advice and support from their GP¹⁰.

Depression Alliance and SANE recommend... *the development of a QOF indicator that supports the increased involvement of patients in their treatment decisions.*

As a GP you can... *provide patients with additional information on alternative and/or available treatments with reference to the NICE stepped care model¹¹. If time does not allow, you can refer patients to an appropriate support group or third party patient organisation.*

As a patient you can... *make yourself aware of available treatments through your own research or through contact with a suitable support group or third party patient organisation. Having done this, you will be in a better position to ask your GP about the suitability of particular treatments for you.*

3. Ongoing management

Over half of respondents (58 per cent) in the *Now We're Talking!* survey felt more ongoing support from GPs would lead to an improvement in care¹⁰. The results showed that over half of respondents (57 per cent) first started to experience depression over ten years ago¹⁰, yet a significant proportion of people who have had several episodes of depression or who suffer from chronic depression (39 and 48 per cent, respectively) reported not being advised how long to stay on treatment¹⁰. The fact that over half of survey participants treated with antidepressants (55 per cent) had at some point terminated their treatment early may reflect this lack of adequate guidance¹⁰.

Depression Alliance and SANE recommend... *the development of a QOF indicator that supports GPs in the identification, management and ongoing care of those with depression.*

As a GP you can... *keep in regular contact with patients with a known history of depression and, if and when prescribing antidepressants, provide an 'information prescription' to inform patients about the medication and possible side-effects, and also provide support for treatment adherence.*

As a patient you can... *be vigilant for signs of relapse and seek regular treatment reviews with your GP.*

It is hoped that as a result of providing a forum to highlight the opinions of people with depression and by acknowledging the patient perspective, future revisions to the QOF will be wider in scope and enable those working in general practice to meet the needs of people with depression and ultimately enhance treatment outcomes.



What guides the management of depression in primary care?

An increased Government focus on long-term conditions

An increased focus on improved management of long-term conditions is a major aspect of the current health agenda. The NHS improvement plan, *Putting People at the Heart of Public Service*¹³, sets out the Government's four year strategy for improving the NHS. Central to this strategy is the development of a health service focused on the individual. For people with long-term conditions such as depression, it is hoped to bring about closer personalised care which will enable people to have greater control of their treatment and spend more time with their families and friends¹³. The 2005 White Paper *Our Health, Our Care, Our Say*¹⁴ developed similar goals, supporting the provision of community-centred care and the empowerment of patients to act as partners in their care, hence also encouraging increased control over their treatment.

An increasingly greater emphasis is being placed on managing chronic conditions such as depression within primary care. One key tool to help healthcare professionals deliver these proposals is the *Long-term (Neurological) Conditions National Service Framework (NSF)*, launched in March 2005 and developed to support the provision of care tailored to the needs and choices of the individual¹⁵.

One way in which primary care teams are responding to increased responsibility for managing common chronic conditions, such as depression or diabetes, is through collaborative care. This typically involves the introduction of a case manager who facilitates improved liaison between primary care clinicians and secondary health specialists, delivers low-intensity psychological treatment, and aims to improve treatment adherence and implement mechanisms to collect and share information on individual patients. Case managers often support patients using the telephone.

Guidelines for treating depression

Advice on the effective management of depression was developed by the National Institute for Health and Clinical Excellence (NICE)¹¹ in 2004 and is designed to achieve the following goals:

- Identify people with depression
- Treat depression effectively (to improve mood, social and occupational functioning and quality of life)
- Reduce the chance of relapse or recurrence

As well as suggesting a system for the diagnosis and categorisation of people with depression, NICE also offers a stepped-care model for the management of clinical depression. The stepped-care model provides guidance on the most effective treatment or intervention, depending on whether the individual is experiencing mild, moderate or severe depression. (*See figure A for details of the NICE stepped-care approach to treatment*)

Figure A: The stepped-care approach to the management of depression. Adapted from NICE 2004¹¹

Level of care	Stage of depression	Intervention
Step 1: GP, practice nurse	Recognition	Assessment
Step 2: Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 3: Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, combined treatments
Step 4: Mental health specialists, including crisis team	Treatment-resistant, recurrent, atypical, and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 5: In-patient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT

CBT, cognitive behavioural therapy; ECT, electroconvulsive therapy.

Quality and Outcomes Framework (GMS contract)

The Government's NSF, NICE guidelines and guidance on long-term conditions demonstrate a positive commitment to tackling depression. However, there is concern that health delivery systems do not go far enough to encourage the best and most effective care. The recent addition of depression to the QOF is a case in point. Although the inclusion of depression is a useful

starting point, there are just two indicators, focusing on aspects of depression management for only a small percentage of people who have or may be at risk of depression. In its present state, the QOF will not necessarily encourage GPs to ask the right questions to reach diagnosis and, beyond diagnosis, it does not offer the most effective holistic care for all people with depression. (See figure B below)

Figure B: Current QOF indicators on depression¹⁶

- The percentage of patients on the diabetes register and/or the CHD (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. (8 points)
- In those patients with a new diagnosis of depression, recorded between the preceding April 1 to March 31, 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. (25 points)





The patient journey through primary care

Although every person's experience of depression is unique and some may only experience a single episode, the majority of people in the *Now We're Talking!* survey found depression to be a long-term or recurrent condition. As with many chronic conditions, there is a typical pathway of care that people with depression will follow through primary care.

The first step of this pathway is usually presentation of symptoms which leads to diagnosis. At present, the QOF calls for GPs to screen for depression in two common co-morbidities – diabetes and coronary heart disease. It also recommends the use of one of three depression rating scales – the Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HADS) or the less frequently used Beck Depression Inventory Second Edition (BDI-II) – to assist with the detection and severity assessment of the condition. For high-risk groups, NICE recommends the use of two screening questions to identify those potentially at risk¹¹. However, it is important to recognise depression not as a single entity but as the name given to a cluster of symptoms. As people with depression can experience a broad spectrum of psychological and somatic symptoms, it is not surprising the scales do not provide an exhaustive list. Consequently, it is important that GPs are conscious of and respond to the broad range of symptoms potentially associated with depression.

Although the early identification of depression is a crucial first step and worthy goal, it is important to recognise it as the beginning of a more thorough appraisal of the patient. Following diagnosis, the pathway of care typically leads to initiating the most appropriate treatment, depending on the characteristics and severity of the individual's depression. After treating the initial episode, the focus moves to ongoing management of the individual's depression, with the aim of preventing relapse or a recurrence of symptoms, achieving remission and reaching recovery.

Initial recognition of symptoms and diagnosis

Results from the *Now We're Talking!* survey suggest that GPs are at the forefront of identifying depression. As is the case with many long-term conditions, 78 per cent of those who sought help from their GP during their most recent episode were diagnosed by their GP; while 10 per cent were diagnosed after referral to a mental health specialist¹⁰. However, as this survey highlights, depression is not always simple to diagnose.

Although the vast majority of people (75 per cent) who took part in the *Now We're Talking!* survey reported having been aware of early symptoms of depression prior to full onset of the condition¹⁰, evidence suggests that many of those with depression do not present to their GP and, of those who do, not all admit to having psychological symptoms¹¹. It is thought that up to 69 per cent of people present exclusively with somatic symptoms that may not always be perceived immediately as symptoms of depression, including headache, constipation, weakness and musculoskeletal pain in the lower back, joints and neck¹⁷.

According to the *Now We're Talking!* survey, one in four of those who went to their GP with symptoms of depression were not diagnosed on their first visit¹⁰. For these unidentified patients, the road to diagnosis can be a complicated and lengthy process:

- Of those who were not diagnosed at the first visit, 7 per cent of people didn't go back to their GP and a

quarter only made another appointment because they felt it appropriate, rather than being encouraged to do so by their GP¹⁰.

- Of those who had further appointments with their GP, one in four waited between one and three months before receiving a diagnosis of depression and 12 per cent waited more than a year to be diagnosed¹⁰.
- When asked about potential areas where depression management could be improved, 38 per cent of those surveyed rated a more rapid diagnosis as an important potential improvement¹⁰.

Recognising the broad range of symptoms of depression is a key step in ensuring early diagnosis. Results from the *Now We're Talking!* survey highlight that these delays may be as a result of people with depression not reporting all potential symptoms to their GP. However, the survey results also suggest that GPs are not questioning patients to identify all possible

symptoms of depression, which may hinder rapid diagnosis and, where applicable, the initiation of suitable treatment¹⁰.

- Loss of confidence and self-esteem were the most commonly recognised symptoms of depression; 79 per cent of those who were able to tell they were becoming ill reported this symptom¹⁰. However, at the first visit to the GP, loss of confidence and self-esteem ranked only seventh in symptoms mentioned by the patient to the GP and tenth in symptoms which the GP asked their patient about (43 per cent and 17 per cent, respectively)¹⁰.
- Although suicidal thoughts were a common early symptom (60 per cent who were able to tell they were becoming ill reported this symptom¹⁰), only 42 per cent of those who sought help from their GP mentioned it during their first consultation¹⁰.
- Feelings of self-harm were reported by 21 per cent of those who were able to tell they were entering an episode of depression¹⁰. However, only one in ten who approached their GP proactively discussed this symptom with their GP during their first visit¹⁰.
- A third (33 per cent) of those who recognised early symptoms of depression felt physical aches and pains. When asked which symptoms they mentioned to their GP at their first visit, only 23 per cent of those who sought their GP's help talked about physical aches and pains and only 9 per cent reported their GPs asking about it¹⁰.

Although our survey reveals that a wider recognition of all the symptoms of depression is needed, patients do not equate this with a lack of knowledge or professionalism from their GP. In fact, the majority of people with depression (80 per cent) stated their GP was interested in seeing them and hearing about their symptoms¹⁰ and 78 per cent felt that their GP was 'knowledgeable' about depression¹⁰.

Looking beyond diabetes and coronary heart disease

It is widely acknowledged that many people with an established physical illness become depressed during the course of their condition^{18,19}. The link between depression and other conditions is also acknowledged in the NICE guideline which advises screening for depression in patients with dementia¹¹ and within the QOF, which encourages GPs to screen for depression in patients who suffer from diabetes and / or coronary heart disease.

However, a higher incidence of depression and its associated risks is not limited to diabetes and coronary heart disease. For example, recent research into the incidence and impact of depression among patients with chronic obstructive pulmonary disease (COPD) found that almost half of those hospitalised with COPD (44 per cent) also suffered from depression. Moreover, those with depression were at an increased risk of death, underwent longer hospital stays and experienced between 12 and 37 per cent worse COPD symptoms²⁰. Depression is also commonly seen among people who have suffered a stroke, affecting over a third of these patients²¹.

The *Now We're Talking!* survey provides further evidence to illustrate the wide range of long-term conditions commonly associated with depression. From our survey, anxiety and migraine were the most commonly reported health conditions before a diagnosis of depression was made, followed by high blood pressure, high cholesterol and angina¹⁰. However, it is important to recognise that the symptoms of depression and anxiety overlap considerably and that these two conditions often exist together. Out of the 345 respondents who had other health conditions besides depression, only 6 reported having diabetes and 1 reported having heart disease before being diagnosed with depression¹⁰.

These results support the development of a QOF indicator that encourages GPs to take into account a broader range of psychological and somatic symptoms when considering an initial diagnosis of depression

The survey findings support the development of a QOF indicator encouraging GPs to screen for depression in other disease areas, in addition to diabetes and coronary heart disease



Informed choice of treatment

Among health professionals, GPs still have the greatest degree of contact with people with depression beyond diagnosis. 50 per cent of people in the *Now We're Talking!* survey reported that a GP was the healthcare professional they visited most often, compared with 10 per cent whose main healthcare provider was a community psychiatric nurse, 16 per cent who saw their counsellor most often and 11 per cent who had most contact with their psychiatrist¹⁰. However, despite GPs being heavily involved in depression management, many people with depression feel that there could be a better partnership between doctors and patients. When asked to consider which factors were important in improving the management of depression, respondents thought a better understanding from their GP on how depression makes you feel (61 per cent) would lead to an important improvement in the provision of care¹⁰.

A better understanding of what support patients would like from their GP would help to further improve the patient-doctor partnership. When asked about what they expected from their GP on their first visit to discuss symptoms of depression, the most common responses from survey participants were 'advice' or prescription medication (55 per cent each)¹⁰. However, when it comes to learning about depression, people in the survey were as likely to turn to the internet for information as they were to approach their GP¹⁰.

A study [conducted by Loh and colleagues] suggests that engaging in a dialogue with patients about their treatment and acknowledging their wishes may help improve treatment outcomes by improving adherence rates²². NICE recommends that patients' preferences and their experiences and outcomes with previous treatments should be taken into account when deciding the most appropriate treatment¹¹.

The *Now We're Talking!* survey suggests that, in reality, patient preference has a limited influence on treatment choice. Only just over half (59 per cent) felt that their preferred treatment option was adequately discussed or considered¹⁰ and 58 per cent thought it was important that people with depression be given greater freedom around treatment options¹⁰. For example, 59 per cent of respondents expressed a preference for antidepressants,

46 per cent for counselling and 30 per cent for CBT as their treatment of choice¹⁰. Whilst this is reflected in the way antidepressant medication is prescribed – 67 per cent of people were given antidepressants for their most recent episode of depression – counselling was offered to 23 per cent and CBT to only 12 per cent of respondents¹⁰. This is indicative of the limited availability of psychological support throughout the UK, despite being recommended by NICE as a front-line treatment for depression¹¹. Increased access to CBT and talking therapies is acknowledged by both patients and healthcare providers as a potential area where care for people with depression could be significantly improved. (This view is supported by the Government which introduced pilot schemes in 2006 to evaluate the best means of providing increased access to counselling and talking therapies.) In the *Now We're Talking!* survey, 75 per cent of people agreed better access to counselling and other talking therapies would amount to an important improvement for depression management¹⁰.

These results support the development of a QOF indicator that encourages the increased involvement of patients in their treatment decisions

Ongoing management

Although it is possible to experience a single episode of depression and then make a full recovery, this is unfortunately only the case for up to 50 per cent of people. It is thought at least half of those affected by a first episode of clinical depression will have at least one more episode¹. Of those surveyed by Depression Alliance and SANE, 45 per cent have chronic depression (where the symptoms are present continuously)¹⁰ and almost half of those who have experienced several episodes (46 per cent), have experienced three to five¹⁰. (However, those surveyed by Depression Alliance and SANE may be more likely to have chronic or recurrent depression, which would account for the high incidence of long-term depression in the findings.) Relapse is a significant barrier to remission; after experiencing a second episode of depression, the risk of further recurrence rises to 70 per cent and people who have a third episode are at a 90 per cent risk of relapsing again¹.

Preventing relapse is therefore a key component of successful depression management. Providing regular health checks, keeping in contact with patients with a known history of depression and proactively contacting patients to discuss their treatment progress are key steps healthcare professionals can take to provide ongoing care and prevent relapse. Results from the *Now We're Talking!* survey highlight areas where improvements could be made.

- 32 per cent of respondents were given no advice about making further appointments during their most recent visit to the GP
- Over half of respondents (58 per cent) called for more ongoing support from GPs and 68 per cent felt that a proactive, ongoing support programme would lead to an important improvement in the provision of care¹⁰

A study [by Paykel] suggests that ineffective treatment of the symptoms of depression is also a major contributor to relapse, making patients three times more likely to experience another episode of depression²³. Identification and treatment of somatic symptoms such as change in appetite, sleep disturbance and physical aches and pains may be of particular importance because it is thought that treating all the symptoms of depression - both psychological and somatic - may lead to a greater number of people reaching remission²⁴. In addition to directly targeting symptom relief, effective depression management should involve the implementation of management techniques, including psychological therapies such as CBT or counselling, that improve the quality of life and social functioning of people with depression.

The *Now We're Talking!* survey also revealed that people with depression often demonstrate a lack of knowledge about their medication, in terms of how long to take it for, the side-effects they may experience and when it may be appropriate to stop¹⁰.

Although NICE recommends all people prescribed an antidepressant should be informed of the possibility of discontinuation symptoms¹¹, a number of survey participants reported not being given information on the following¹⁰:

- How long to take their treatment for (36 per cent)
- How to stop taking it (43 per cent)
- What to do if the medication did not appear to be working (45 per cent)
- Possible side-effects (37 per cent)

Furthermore, while it is recommended that patients who have experienced two or more serious episodes of depression be considered for long-term antidepressant

treatment (continued treatment for two years after remission) and that after remission, treatment be continued for a further six months¹¹, a significant proportion of survey participants taking antidepressants who have had several episodes of depression or who suffer from chronic depression, reported not being advised how long to stay on treatment (39 and 48 per cent, respectively)¹⁰. Encouraging wider use of the depression severity assessment tools may lead to more people having their depression characteristics accurately assessed which would support the provision of suitable treatment and, where appropriate, monitoring of patients' progress over time.

The fact that over half of those in the survey treated with antidepressants (55 per cent) had at some point terminated their treatment early may reflect this lack of adequate guidance¹⁰. More significantly, 57 per cent who stopped taking their medication did so without informing their doctor or nurse¹⁰. Over a quarter of participants who had discontinued a course of medication (27 per cent) reported having done so because they didn't feel the medication was working and 30 per cent because they felt better and thought they didn't need to continue taking it¹⁰. The most common reason for interrupting a course of medication was side-effects (46 per cent), highlighting the need for open and early discussion on the subject between the GP and the patient.

WHO stresses the implications of patients abandoning treatment too quickly are potentially very serious, highlighting the fact that those who stop their medication because their symptoms disappear often relapse within a short space of time, resulting in loss of ability to work, reduced quality of life and leading, in some cases, to suicide²⁵. There is also evidence that people who remain on treatment for at least six months incur significantly reduced medical service costs, reducing the overall burden placed on health services²⁶.

The results from the Depression Alliance and SANE survey indicate there is a clear need for improved communication between doctors and people with depression, a critical factor for optimal adherence and, as a result, improved treatment outcomes.

These results point to the development of a QOF indicator that supports GPs in the identification, management and ongoing care of those with depression



How can the management of depression in primary care be further improved?

The *Now We're Talking!* survey suggests there are three areas within the pathway of care where depression management can be further improved in primary care:

- Initial recognition of symptoms and diagnosis of depression
- Informed choice of treatment
- Ongoing management

1. Initial recognition of symptoms and diagnosis

When identifying depression, look at other co-morbidities in addition to diabetes and coronary heart disease

The present QOF recommends the screening of certain groups of patients for depression, specifically asking GPs to identify how many patients on their diabetes and coronary heart disease registers have this condition. However, the *Now We're Talking!* survey indicates that people with depression are likely to suffer from other health conditions such as high blood pressure (14 per cent), chronic painful conditions (12 per cent) and arthritis (11 per cent)¹⁰. Notwithstanding the fact that the range of health conditions which can be associated with depression is high, and acknowledging that it is not feasible to screen for depression in every GP consultation, these findings indicate there is scope to expand the QOF beyond those patients diagnosed with diabetes and coronary heart disease¹⁰.

Take into account a broader range of symptoms when considering an initial diagnosis of depression

The *Now We're Talking!* survey highlights the importance of recognising all the possible symptoms associated with depression when seeking a diagnosis:

- A quarter of people with depression do not receive a diagnosis on their first visit to their GP¹⁰
- It is thought up to 69 per cent of people present exclusively with somatic symptoms that may not always immediately be perceived as symptoms of depression¹⁷

Updating the QOF to encourage GPs to be conscious of and respond to the broad range of psychological and somatic symptoms potentially associated with depression would facilitate diagnosis and inform appropriate treatment.

2. Informed choice of treatment

Encourage the increased involvement of patients in their treatment decisions

The NHS has committed itself to ensuring individuals are more involved in treatment choice and made active partners in their overall care. However, when it comes to depression, in many cases patients feel their opinions on treatment are not adequately considered or discussed and they would welcome more ongoing advice and support from their GP¹⁰. An example of this, highlighted in the *Now We're Talking!* survey, is that many people with depression would like better access to counselling and other talking therapies¹⁰.

3. Ongoing management

Support GPs in the management and ongoing care of those with depression

The *Now We're Talking!* survey highlights the long-term nature of depression; over half of those surveyed (57 per cent) first started to experience depression more than ten years ago¹⁰. As is the case with many long-term conditions, chronic or recurrent depression may require ongoing treatment and support. Indeed, over half of respondents (58 per cent) called for more ongoing support from GPs and 68 per cent felt an a proactive, ongoing support programme would lead to an important improvement in the provision of care. The survey reveals that 55 per cent of survey participants had at some time discontinued their treatment before the end of the course¹⁰. Case managers can support GPs by keeping in regular contact with patients, getting feedback about their experience of the treatment prescribed and where appropriate, by encouraging patients to stay on treatment ('adherence'). GPs themselves can provide detailed information to their patients, educating them about their condition, medication and the importance of adherence which should help to address this issue.

Appendix 1: *Further information*



Depression Alliance is the leading UK charity for people with depression, working to relieve and to prevent this treatable condition by providing information, support and understanding to those who are affected by it.

Depression Alliance
212 Spitfire Studios
63 - 71 Collier Street
London N1 9BE

0845 123 2320

information@depressionalliance.org

www.depressionalliance.org



SANE is a UK-wide charity established in 1986 to improve the quality and care for people affected by mental illness. SANE has three objectives:

- To raise awareness and respect for people with mental illness and their families, improve education and training, and secure better services
- To undertake research into the causes of serious mental illness through The Prince of Wales International Centre for SANE Research
- To provide information and emotional support to those experiencing mental health problems, their families and carers through SANEline and SANEmail

SANE

1st Floor Cityside House
40 Adler Street
London, E1 1EE

020 7375 1002 / SANEline: 0845 767 8000

info@sane.org.uk



References

1. Prodigy Guidance. Depression. Available from: <http://www.prodigy.nhs.uk/depression> [cited January 2007].
2. Murray CJ. and Lopez AD. Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. *Lancet* 1997; 349(9064); 1498-1504.
3. Depression Alliance. Help and information. Available from: <http://www.depressionalliance.org/docs/help/help.html> [cited January 2007].
4. Ressler K and Nemeroff CB. Role of serotonergic and noradrenergic systems in the pathophysiology of depression and anxiety disorders. *Depression and Anxiety* 2000; 12 (Supplement 1); 2-19.
5. SANE. About mental illness: depression. Available from: http://www.sane.org.uk/public_html/index.shtml [cited January 2007].
6. Singleton N, Bumpstead R, O'Brien M *et al.* Office for National Statistics: psychiatric morbidity among adults living in private households 2000. London: The Stationery Office 2001.
7. Faulkner A. Suicide and deliberate self-harm. Mental Health Foundation 1997. Briefing paper 1.
8. Thomas CM and Morris S. Cost of depression in England in 2000. *British Journal of Psychiatry* 2003;183; 514-9.
9. Office of the Deputy Prime Minister. Mental Health and Social Exclusion: Social Exclusion Unit Report. Crown Copyright. June 2004. Available from: www.socialexclusionunit.gov.uk/downloaddoc.asp?id=134. [cited January 2007].
10. Depression Alliance and SANE, with IPSOS Mori. *Now We're Talking!* survey. November – December 2007. Sponsored by Eli Lilly and Boehringer Ingelheim.
11. National Institute for Health and Clinical Excellence (NICE). Depression: management of depression in primary and secondary care. Clinical Guideline 23. December 2004.
12. NHS Centre for Reviews and Dissemination (CRD). Improving the recognition and management of depression in primary care. *Effective Health Care Bulletin* 2002; 7(5); 1-12.
13. Department of Health. The NHS improvement plan: Putting people at heart of public services. June 2004.
14. Department of Health. Policy and guidance: About our health, our care, our say. Available from: <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/fs/en> [cited January 2007].
15. Department of Health. National Service Framework for long-term conditions. March 2005.
16. NHS Employers. Revisions to the GMS contract 2006/7: delivering investment in general practice.
17. Simon GE, Vonkorff M, Piccinelli M *et al.* An international study of the relation between somatic symptoms and depression. *The New England Journal of Medicine* 1999; 341; 1329-1335.
18. Anderson IM, Nutt DJ and Deakin JFW. Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 1993 British Association for Psychopharmacology guidelines. *Journal of Psychopharmacology* 2000; 14(1); 3-20.
19. Wells K B, Golding J M, and Burnham M A. Psychiatric disorder in a sample of the general population with and without chronic medical conditions. *American Journal of Psychiatry* 1988; 145; 976-981.
20. Ng T-P, Niti M, Tan W-C *et al.* Depressive Symptoms and Chronic Obstructive Pulmonary Disease: Effect on mortality, hospital readmission, symptom burden, functional status, and quality of life. *Archives of Internal Medicine* 2007; 167; 60-67.
21. Carod-Artal J, Antonio-Egido J, Luis-Gonzalez J *et al.* Quality of life among stroke survivors evaluated 1 year after stroke: Experience of a stroke unit. *Stroke* 2000; 31; 2995-3000.
22. Loh A, Leonhart R, Wills CE *et al.* The impact of patient participation on adherence and clinical outcome in primary care of depression. *Patient Education and Counselling*. 2007; 65(1); 69-78.
23. Paykel ES, Ramana R, Cooper Z *et al.* Residual symptoms after partial remission: An important outcome in depression. *Psychological Medicine* 1995; 25; 1171-1180.
24. Fava M. Depression with physical symptoms: Treating remission. *Journal of Clinical Psychiatry* 2003; 64 (Suppl 7); 24-28.
25. World Health Organisation. Mastering depression in primary care. Available at: <http://www.gp-training.net/protocol/psychiatry/who/whodep.htm> [cited in January 2007].
26. Katzelnick DJ, Koback KA, Greist JW *et al.* Effect of primary care treatment of depression on service use by patients with high medical expenditures. *Psychiatric Services* 1997; 48; 59-64.



Now we're
Talking!

Enhancing the care pathway for depression

