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International exchange

Prevention and management of depression in primary care in Europe: a holistic model of care and interventions – position paper of the European Forum for Primary Care

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Introduction

This position paper seeks to emphasise the importance of tackling depression and depression-related conditions, and the key role that primary care can (and does) play in the management of these common mental health problems, and in partnership with others. The paper is aimed at a wide range of individuals and organisations including: policy makers in the EU and its member states; health, social care and voluntary sector service managers and planners; as well as a range of primary and community care professionals. The paper argues for a broad definition of 'depression' which reflects the primary care experience and in doing so incorporates a range of options based around a stepped model of care, depending on levels of need, severity and disability. This paper is complementary to the European Forum for Primary Care's (EFPC's) position paper *Mental Health in Europe, the Role and Contribution of Primary Care*, which focuses on the relationship between primary care and other mental health services and issues of access, training, sustainability and quality of care across the whole range of mental health services.[1] The topic of depression in primary care can also encompass more-specialised topics such as postnatal depression, bipolar disorder and child and adolescent mental health. However, it is not within the scope of this general paper to cover these specific topics.

Depression in primary care

The importance of depression as an international and major public health problem, and the importance of primary care-based support for the majority of people with depression is now well recognised.[2] The World Health Organization (WHO) reports that depression is the leading cause of disability and the fourth leading contributor to the global burden of disease. Today, depression is already the second cause of disability-adjusted life years in the age category 15–44 years for both sexes combined. However, at present a large proportion of people with depression remain with their condition unrecognised or do not receive appropriate treatment or support.

Primary care support for mental health has been defined as 'the provision of basic preventive and curative mental health care at the first point of contact of entry into the health care system'.[3] However, this position paper recognises that general practitioners (GPs)/family physicians do not manage depression alone. People who are experiencing distress symptoms and misery seek to 'get by' or 'manage' these experiences. In doing so they may seek help and advice from a doctor but may also access other forms of support, including from within the community.

The treatment and management of common mental health problems places a very high burden on primary care; treatment options are currently largely confined

to medication (which may not be effective as a first-line response for mild to moderate depression and anxiety) and psychotherapeutic and psychosocial treatments (where demand greatly outstrips supply). This position paper seeks to offer potential ways in which the management of depression and related conditions can be enhanced within primary care. It emphasises the role of promotion and prevention, as well as care and treatment, as being within the remit of primary care. It also promotes the development of social and community links to enhance primary care management of common mental health problems.

The problem of definition

The concept of depression has long been subject to historical and cultural relativity, with psychiatric and psychological texts varying in their definitions of what constitutes depression. There are areas of ambiguity such as: whether depression is a categorical concept or exists on a continuum of normal functioning; the relationship between depression and anxiety and whether they are co-existing conditions or a single pathological condition; and the relationship between depression and physical disease or illness. Many primary care patients present with a mixture of physical, psychological/emotional and social problems, each impacting on how they experience their mental health symptoms. It is in this context of complexity that GPs make their assessment of patient needs and decide how to respond to these needs.

The issue of definition has been the foremost topic within comments received on this position paper, reflecting the professional debates and contested nature of the definition and diagnosis of depression (and depression-related conditions) within psychiatry and primary care. There is yet to be a universally agreed set of criteria for the diagnosis of depression and one that can adequately or unequivocally distinguish between severe, moderate and mild depression. Current classification systems are based on research conducted within the psychiatric care sector and are therefore based on the minority of those experiencing mental health problems seen in psychiatry, not the majority seen in primary care. GPs are most often managing subthreshold disorders which do not meet formal diagnostic criteria but which nonetheless represent significant levels of impairment.

However, the International Classification of Primary Care (ICPC-2) offers a potential way forward by including the Reason for Encounter (RFE; available as an electronic release ICPC-2-E from 2000).[4] The reason for encounter, or demand for care, given by the patient has to be clarified by the physician or other health worker before there is an attempt to interpret and assess the patient's health problem in terms of a diagnosis, or to make any decision about the process of management and care. While this offers a way forward for recording and classifying signs and symptoms based on reasons for encounter, it also supports the need for a broader conceptualisation of depression within the primary care encounter.

Further screening tools such the depression-specific Patient Health Questionnaire (PHQ-9), and the Hospital Anxiety and Depression scale (HAD) are currently being recommended within UK general practice as part of the Quality and Outcomes Framework.[5,6] Additionally, there is the relatively new Four-Dimensional Symptom Questionnaire (4DSQ) which has been designed to assess common psychological symptoms in primary care and to distinguish non-specific general distress from depression, anxiety and somatisation.[7] However, there is uncertainty as to whether screening is associated with improved outcomes in primary care.[8] In everyday practice, the usability of such scales can also be questioned. Their use should bring added value to the patient and the GP, for example: in facilitating communication between doctor and patient, particularly when patients somatise symptoms; and facilitating communication between GPs and specialist services. In managing their patients, GPs also understand the fluctuating or transient nature of their patient's emotional state (which can also be exacerbated by their current social circumstances) and the impact that symptoms are currently having on their day-to-day lives (functioning). What is required is a more holistic assessment of need that does not focus solely on diagnosis but that also takes account of functional status/disability, duration and chronicity of symptoms, and any underlying social or physical problems.

For the purposes of this paper, we do not offer any definitions of what is meant by depression. The emphasis is placed on the broader concept of 'managing common mental health problems' in primary care, of which depression and depression-related disorders (such as anxiety) constitute the majority of problems. The focus is not solely on illness and treatment but also on promotion and prevention, which necessarily encompasses general mental wellbeing and the types of interventions and activities that promote that.

A model of promotion, prevention, care and recovery

There are many arguments to support promotion and prevention activities in primary care. The persistent

and chronic nature of depression means that new cases of depression will continually add to the existing disease burden, leading to increasing numbers of individuals with poor quality of life (via the detrimental effects on their social and economic circumstances). Additionally, the widespread nature and scale of common mental health problems cannot be addressed by individual practitioners alone. What is required is a model for primary care involvement that includes promotion, prevention, care and recovery. Complementing individual therapies with promotion and prevention offers the opportunity to reduce the need for such therapies through addressing some of the underlying causes of mental health problems.

Mental health promotion and mental ill-health prevention can be targeted towards known high-risk groups, which include those: with a prior history of depression; with subthreshold depression; living with a serious physical illness; experiencing stressful life events; and with a history of abuse or neglect. The types of activities that can be incorporated into promotion and prevention activities include training in social skills, enhancing/building confidence and self-esteem, and improving parenting skills. Additional self-help and social support examples are highlighted below.

Organisational models of care

The complex nature of depression, where even mild forms of depression can have a significant impact on people's day-to-day lives and levels of functioning, requires an approach that is not solely focused on treating symptoms. Addressing patients' concerns, and improving their understanding of their condition through patient education and information is also necessary. We also know that the quality of the therapeutic relationship is very important to those experiencing mental distress, and that this can aid recovery. The future direction for the management of most chronic illnesses is based on patient involvement and active participation in their care, particularly through the encouragement of self-care/self-management mechanisms. The disease and treatment model alone is unlikely to meet the complex needs associated with, and the underlying causes of depression. A more holistic view encompassing mental, physical and social needs is required. To that end, this paper sets out some of the current organisational models of care, but extends these, essentially medical models of care, to adapted models that include social and community interventions.

Evidence from organisational models of care has demonstrated that stepped care and collaborative care models are effective in delivering integrated care, in ways that best meets the needs of individuals (see Box 1).[9] The terminology and the components of each of these models may also be combined within interventions, e.g. stepped collaborative care.[10] These approaches are also beneficial in terms of the utilisation of expensive and scarce resources. The components of these models are briefly described below with some examples of implementation projects within Europe.

Box 1 Primary care services for depression: a guide to best practice

The Care Services Improvement Partnership (www.csip.org.uk) and the National Institute for Mental Health in England (www.nimhe.csip.org.uk) have produced a guide to improving primary care services for depression as part of the *Improving Primary Care Mental Health Services: a practical guide* series. This guide reviews the current evidence base for practice and offers guidance relating to screening, assessment, clinical pathways, treatments, stepped care and collaborative care.

Chronic disease management

Chronic disease management (CDM; also known as disease management or case management) focuses on the need to change the organisation and delivery of care, to promote adherence to evidence-based guidelines in the delivery of care, and to promote self-care in order to meet the needs of patients with a chronic illness. CDM consist of five components: identification of patients; assessment of patients' needs; treatment plan; co-ordination of care; and monitoring of outcomes and altering care if no positive changes are achieved.[11] Systematic reviews have demonstrated the positive effects of structured care for patients with depression in which the active follow-up with monitoring of depression status and psychiatric consultation may be effective elements, with the majority of the effect resulting from improved medication adherence.[9,11,12]

Several studies for improving co-ordination of depression care in primary care are currently under way in Germany. Case management for monitoring the long-term effects of care for patients with depression in family doctors' practices is currently being evaluated within the Primary Care Monitoring for Depressive Patients (PRoMPT) project whereby trained medical assistants contact patients once per month to assess the current situation and patient's needs.[13,14] The introduction of an evidence-based guideline for depression has increased detection and treatment in family doctors' practices in Germany, and strengthening the patient's role by means of 'shared decision making' has improved depression outcomes.[15,16]

Collaborative care models

Collaborative care models (CC) are also based on a chronic illness model and include patient-, provider- and system-level components (e.g. IT developments). CC can involve training of primary care professionals and consultation–liaison with specialist services, but also quasi specialists, to work with patients and liaise with primary care and mental health specialists. There are many versions of CC, which have been shown to be more effective than 'care as usual'.[17] However, the core elements of CC can be summarised as involving: evidence-based guidelines; patient and primary care practitioner education; the use of objective tools; involvement of a care manager; a stepped model of care; and supporting information systems.

Stepped care approach

In the stepped care approach (SCA), care is 'stepped' in intensity, beginning with limited professional input through to specialist care. Some models include steps at the level of the community and prior to any medical involvement (see Figure 1). Many aim to increase provision at the lower levels, as this approach has the potential to offer a cost-effective model to improve access to treatment for common mental health problems, and one that does not appear to overload mental health services.

The introduction of less-intensive interventions in higher volume, has resulted in reduced waiting times for treatment. The results of an audit by the Care Services Improvement Partnership (CSIP) in England indicate that less-intensive interventions are clinically effective in relation to improving clients' wellbeing, and in treating common mental health problems (including anxiety and depression) – with only a small number of clients experiencing deterioration in their condition during/after treatment.[18]

As an example of an innovative model, the STEPS Primary Care Mental Health Team in Glasgow, Scotland (see) uses a stepped care model that aims to offer a flexible way of working that incorporates individual therapies, community interventions and awareness, and prevention at a population level.[19] Activities include individual therapy, advice clinics, advice phone line, stress-awareness classes, support groups, information and book prescriptions. In addition the team is undertaking awareness work in local schools, developing a DVD, compiling service directories and taking part in community events and health fairs.

A further European example is the Depression and Anxiety (DEPANX) Program which is part of Cascais and Oeiras (Lisbon, Portugal) mental health care services which are based on collaborative and stepped care protocols. DEPANX encompasses the European Alliance Against Depression four-level interventions plus a fifth level: clear depression management protocols within primary and psychiatric care, and also referral/liaison protocols between care levels. For further information contact: Prof Dr Ricardo Gusmão (rgusmao.cup@fcm.unl.pt).

Step 4:	Specialist services including: specialist perinatal mental health team; eating disorders; psychoanalytical psychotherapy; inpatient services	Meeting the needs of people, and their carers and significant others, with longstanding and/or complex mental health problems requiring ongoing or intensive support, care and treatment. Meeting the needs of people, and their carers and significant others experiencing acute episodes of mental health problems or at risk of relapse in community and inpatient settings
Step 3:	Secondary care mental health services including community mental health team; community substance misuse services; community rehabilitation team	Meeting the needs of people with longstanding and/or complex mental health problems requiring ongoing or intensive support, care and treatment. Meeting the needs of people experiencing acute episodes of mental health problems or at risk of relapse in community settings
Step 2:	Primary health care: Primary care mental health including unscheduled care and out-of-hours provision	Meeting the needs of people and their carers and significant others experiencing mental distress, emotional problems and poor mental health caused by distressing life events and transitions, trauma and physical health problems
Step 1:	Communities and local neighbourhoods	Preventing the onset of mental health problems or minimising the impact of mental health problems in high-risk groups; raising communities' awareness of psychosocial aspects of mental health impacting on families and social networks
Step 0:	Education and public awareness	Raising the level of mental health literacy in the general population; education and awareness to dispel popular misconceptions and fears; creating a climate that understands the determinants of poor mental health and strategies that can address these

Figure 1 Example of a stepped care model which includes community level supports

The 'depression nurse' model in Ostrobothnia, Finland is an example of training nurses to help deliver care. It consists of combined GP and 'depression nurse' care as a way to treat mild to moderate symptoms of depression. It consists of one 60-minute session with the nurse, followed by five weekly sessions of 45 minutes, with 10- and 26-week follow-up sessions of 45 minutes. GPs maintain responsibility for prescribing, and for assessing the need for additional psychiatric input. Early results show positive benefits. For further information contact Jyrki Tuulari (jyrki.tuulari@epshp.fi).

Common to all these models of care is the importance of co-ordination and continuity of care within and across professional boundaries and care sectors. This requires primary care to work in a more collaborative and multidisciplinary way with others, and efforts to achieve this should be encouraged, such as multidisciplinary education and the development of local health, social and voluntary sector partnerships.

Co-morbidity and depression

Living with a chronic physical illness is likely to have an impact on an individual's mental health. Additionally, having a mental health problem may increase the risk of developing physical illness or add to problems associated with physical illness. For example, up to 33% of patients develop depression after a myocardial infarction, and meta-analysis has shown that depression is associated with a doubling of mortality in coronary heart disease (CHD).[20,21] It is estimated that one in three patients with heart failure and one in five patients with CHD experiences depression. Depression is also found in 30% of cases of diabetes. However, examination of the complex causal pathways between chronic physical illness and mental illness by Dowrick and co-workers introduces the concept of 'spurious association, when the same set of symptoms is used to arrive at both a psychiatric and a physical diagnosis', with the potential for over-diagnosis and mismanagement.[22,23]

Such 'co-morbidity' of physical and mental health problems is exacerbated by socio-economic deprivation. A result of this recognised prevalence is that the recently revised Quality and Outcomes Framework (QOF) of the new general medical services (GMS) contract in the UK now incorporates case finding for these groups. However, there is a lack of guidance as to how to manage these patients once a mental health issue has been identified. The following example demonstrates how a 'lifestyle' project has linked the supports offered to address both physical and mental health promotion. The East Ayrshire Community Health Improvement Project (CHIP) runs a lifestyle referral scheme which links people with a wide range of advice, support, classes and other activities or physical activity, healthy eating, smoking cessation and stress. Referral criteria include chronic physical health problems, depression and anxiety, and risk factors such as obesity. Referral is via primary care and other health professionals. Some primary care practices encourage facilitated self-referral, where the patient can complete the referral form, for signature by the GP, but without the need for an appointment.[24]

Another important area of co-morbidity is in relation to substance misuse. There is evidence for substance-induced depressive disorder as well as evidence that substance misuse leads to poorer prognosis in existing mood disorders.[25] Primary care services are in a prime position to be able to identify the occurrence of both depression and substance misuse. The close links between both, and the high possibility of self-medication with drugs or alcohol, would suggest that some assessment of alcohol and/or drug use should take place. In terms of management, the key messages stress the importance of treating the substance misuse, as this is likely to result in improved mood,[25] although, equally, treating underlying depression also improves the management of substance misuse. In alcohol misuse it is recommended that there is a one-month period of abstinence followed by a further review of mental health status before deciding a course of treatment (particularly if antidepressants are considered). The benefits of antidepressant or anxiolytic pharmacotherapy must be weighed against the increased risk of side-effects, adverse reactions, and potential complications with alcohol- or drug-induced illnesses. As for most depression-related conditions, psychological therapies are highly recommended, and in the case of substance misuse 'motivational interviewing' and 'CBT' (cognitive-behavioural therapy) are the recommended forms.[25]

Interventions at primary care level

This position paper favours the use of time-limited psychological interventions to address mild to moderate mental health problems in primary care, and mechanisms to link people to non-medical sources of support. In addition, there is a growing body of evidence in support of guided self-help approaches for common mental health problems.[26,27] Other approaches suggest multilevel interventions such as the integration of public health approaches (raising awareness) alongside professional knowledge development to increase the synergistic benefits of single interventions (see Box 2).[28]

Box 2 A 4 level approach for depression and suicide

The European Alliance Against Depression (EAAD) is a European Commission-funded project with 18 European regions working together to improve the care of people with depression and the prevention of suicide across Europe. The alliance aims to share information and resources to improve the diagnosis and treatment of people with depression and to reduce stigma. The EAAD approach is to implement community-based intervention programmes on four different levels: working with GPs, public relations activities, training community facilitators in recognising and helping people with depression, and working with high-risk groups.[26]

Guided self-help involves the role of a 'therapist' in delivering the self-help module to the patient, and normally involves monitoring the progress of the patient in using the self-help module. There are many variations of this model, depending on the type and level of qualifications of the 'therapists' delivering the self-help materials, which may include the use of non-qualified self-help workers through to clinical psychologists supporting the delivery of CBT-based self-help approaches. In the national Doing Well by People with Depression Programme established in Scotland, many sites found it was possible to deliver evidence-based psychological interventions through non-traditional roles, such as self-help workers, lifestyle coaches, primary care mental health workers and lay support people.[29] Assuming that these roles are well supported and appropriately supervised, this can be one way to maximise capacity and capability. These roles retain the use of the therapeutic relationship, which was highly valued by those who used these types of services.

The role of self-help and self-care

There are many different conceptualisations of self-help, and across both professional and public perceptions the boundaries between self-help, guided self-help and psychological therapies often merge or differ, depending on the context in which they are being delivered. Nonetheless, there is a growing body of evidence (particularly in the field of CBT-based approaches and including computerised/online CBT) in support of self-help approaches for common mental health problems. The internet is proving a new way to increase access to guided self-help interventions. There are examples of free online self-help resources: devised to help people develop key life skills to help them tackle common life problems, such as low mood, anxiety, disrupted sleep and unhelpful thought patterns. Courses are typically based on CBT approaches. These include Living Life to the Full,[30] and Mood Gym.[31]

Bibliotherapy or reading therapy is a therapy in which a person suffering from depression reads self-help books and other motivational books to speed up their recovery and also to maintain recovery. Bibliotherapy works best on mild to moderate symptoms, and is not regarded as a replacement for conventional treatments. A review of the published research on bibliotherapy concluded that it could successfully treat depression, mild alcohol abuse and anxiety disorders.[32] In a small but significant percentage of cases, bibliotherapy reduces symptoms sufficiently that the sufferers no longer seek additional treatment. Most research suggests that bibliotherapy is most effective when used in conjunction with conventional therapy or while waiting for conventional therapy to begin. Bibliotherapy can be administered by being 'prescribed' by a therapist to read alongside therapy sessions, or individuals suffering from depression or anxiety can be given a self-help book to read as a self-administered treatment without any other drug therapy or psychotherapy (as stand-alone therapy). In the UK, where the wait for professional treatment can be as long as 6 months, the National Health Service (NHS) has embraced bibliotherapy as the first line of treatment for non-emergency cases. The programme varies, but in most parts of the country, health officials have approved a list of about 35 books that have been stocked at local libraries. Seekers of non-emergency mental-health services receive a prescription enabling them to check out a book without a library card and for 12 weeks, four times longer than other books.

The role of social support

It is now widely understood that social, economic and environmental factors have a significant influence on the mental health and wellbeing of people. Social prescribing aims to strengthen the provision of, and access to, socio-economic solutions to mental health problems. This can involve linking people (usually, but not exclusively, via primary care) with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self-help, as well as support with, for example, benefits, housing, debt, employment, legal advice or parenting. Cultural differences between medical and community development models may be a potential barrier to promoting social prescribing. At the same time, social prescribing fits well with a commitment to increasing patient choice and to address the social and economic determinants of health.

'SPLASH' (Social Prescribing, Learning And Self Help) is an initiative in Greenwich, linking residents of the region with organisations and activities that work

to improve health and wellbeing, including physical activity, learning and volunteering, mutual aid, advice, befriending and self-help. SPLASH is aimed at GPs and primary healthcare professionals in Greenwich, as well as the public in general. A website has been developed to enable both primary healthcare professionals and the public to make referrals. GPs and primary healthcare professionals can refer patients to a specific organisation by downloading and completing a referral form from an organisation's listings page. Health professionals can also track the patient's progress by way of a feedback form which will be completed and returned to the GP or other professional by the organisation. Patients and the public in Greenwich can self-refer by following the instructions given by organisations on their SPLASH webpages.

Research by the National Institute of Adult Continuing Education (NIACE) in 2000 revealed that 87% of people felt physically better as a result of taking part in adult learning, and 89% reported positive emotional or mental health benefits. In response NIACE established a Prescriptions for Learning Project, in sites located across England and Wales. The project placed learning advisors in GP surgeries, where GPs or other primary care staff could refer patients to discuss potential learning opportunities.[33]

Building healthy communities is an approach that takes account of the roles that other public services (e.g. schools, higher education establishments, housing and employment agencies) and voluntary agencies can play in alleviating mental distress. It is based on the notion that 'mental health is everybody's business', but also requires building the capacity of other public and voluntary services to promote mental health and support recovery. The involvement of community development workers and joint arrangements across health and local government organisations can help to achieve some of these aims.[34]

An example of this is the Building Healthy Communities project in Dumfries and Galloway, Scotland, which aims to build individual, organisational and community capacity to take action to tackle the root causes of inequalities, and to strengthen the infrastructure for health regionally, with an emphasis on building healthy communities from the bottom up. The project offers outreach and social support for people dealing with anxiety, stress, depression, isolation, lack of self-esteem, and addiction. Activities include: recruitment, training and development of volunteers, to support people who would not otherwise have become volunteers; befriending and peer support groups; arts for health; physical activity groups to improve mental health and develop intergenerational relationships through exercise; and access to complementary therapies for different age groups.[35]

To facilitate the role of self-help and to increase the availability and use of social supports for the management of depression, it is essential to improve GP and patient access to information and resources. The NHS Borders in Scotland developed a toolkit of key contacts across health, social care and the voluntary sector. This toolkit has been used to help signpost people to local sources of help and support. Provided alongside guided self-help and multimedia self-help materials, the process of building the toolkit has also helped local agencies to network together and build stronger relationships.[36]

The role of pharmacological interventions

Evidence reviewed within the National Institute for Health and Clinical Excellence in England (NICE) does not generally support the use of pharmacological treatments for people suffering from mild to moderate depression.[26] This should be balanced by more appropriate prescribing for those with moderate to severe depression which would require an assessment of the level of severity, such as via the PHQ or HADS. Medication management support, such as in the chronic disease model, might also be appropriate for those with moderate to severe depression in receipt of antidepressant medication. There is also emerging evidence surrounding the substantial placebo effects of antidepressant medication and that neither new nor older antidepressants are consistently distinguishable from placebo, and the superiority sometimes observed may be attributable to non-specific effects or other methodological artefacts.[37–39] As debates surrounding the efficacy of antidepressants continue, efforts to include alternative management strategies should be increased.

Support for older people

Mental health in later life is a much neglected area, with fewer resources and often age barriers in accessing services. It is also compounded by attitudes that mental health problems are inevitable in older people and that little can be done. However, mental health problems in later life can be prevented, particularly through recognition of social isolation as a key risk factor. Strengthening social support for older people, and enabling older people to help themselves and each other, is important.[40] Collaboration between housing, health and social care services can also help older people maintain independence and wellbeing. The following are examples of innovative projects.

In the 'Being down, being up (coping with depression for older people)' initiative in the Netherlands, there are 10 weekly meetings which discuss topics such as depression, mood, stress, relaxation, assertiveness and changing thinking patterns. The aim of the

programme is to address depression, reducing symptoms and increasing coping by offering skills training, relaxation exercises, education, encouraging pleasant activities, positive thinking, assertiveness training, and home work. It is an outreach project where volunteers visit the older person's home.[41]

The Centres for Elderly in Norway aims to increase social activity and participation, and decrease social isolation by participation in cultural activities, physical training, special groups for information on nutrition, special groups for people with dementia, and their families. Volunteers participate in running the centre, and most volunteers are also participants, so a mutual exchange of helping is set up with a focus on empowerment. Contact: Odd Steffen Dalgard, Thomas Heftyes gt. 29, 0264 Oslo, Norway Tel: +47 22 850634; fax: +47 22 850590; email: o.s.dalgard@samfunnsmed.uio.no.

Community psychiatric nursing and health promotion in the elderly in Sweden has been developed through partnerships between primary care and municipal old age care. The project consists of co-operation with district nurses, GPs, other staff in outpatient psychiatric care, and staff in municipal old age care. The project entails home visits, health promotion group meetings with a cognitive approach, education and instruction of the participants, structured routine for information to patients and relatives, counselling and guidance. Contact: Gunilla Köhler, Psykiatriska kliniken, Länssjukhuset, S-301 85 Halmstad 40, Sweden Tel: +46 35 131779; fax: +46 35 131722; email: gunilla.kohler@lthalland.se.

Training for primary care professionals

The evidence for training primary care professionals, and GPs in particular, is fairly equivocal and within systematic reviews most types of education/training alone are not shown to be effective in improving outcomes for patients.[9] Guideline implementation strategies aiming to improve the recognition and management of depression were only effective when education and organisational interventions, including nurse management, collaborative care, or intensive quality improvement, were combined.[9] That said, there are many available training programmes within Europe which can be utilised and adapted. The Health Promotion Agency for Northern Ireland, in partnership with representatives from the Health and Social Care Trust, primary care and public health and the voluntary sector has developed a training programme for GPs. This programme, which is being organised in each health and social services board (HSSB) area, includes a half-day training session, supported by supplementary literature and an interactive CD ROM. To date 161 GPs have attended the training which is currently being evaluated.[42] Additionally, the EAAD is also working with GPs to improve ability and knowledge concerning the processes of detection, diagnosis and treatment of depressive disorders; advanced training courses for GPs are being conducted in EAAD intervention regions using highly interactive training packages including role plays and group discussions. Furthermore, information material and decision aids (e.g. video tapes for GPs and patients, patient files, screening tools) are being distributed among primary care doctors to support the decision making concerning individual cases of depressive patients in their practice. The EAAD training is also provided as part of a multilevel approach (see Box 2).

Capacity and composition of primary care teams

This paper has outlined some of the current organisational models for the delivery of care for those with depression, as well as offering a range of interventions (particularly self-help and social interventions) for tackling common mental health problems and for mental health promotion and prevention. Delivering these requires co-ordination and co-operation with others outwith the primary care team. The availability of surrounding mental health and community resources may determine the scope, scale and variety of initiatives available. Those with access to psychiatrists, mental health nurses or clinical psychologists will be better placed to deliver on stepped collaborative care models for those with chronic and moderate to severe depression. In some countries, primary care mental health teams have been established to support GPs in their care of patients – these are well placed to deliver a range of interventions within a stepped care model. Countries without access to such resources may be better served by enhancing the skills of existing primary care nurses (through training and support from psychiatry) to support GPs in managed care for patients. Many self-help (including guided self help) initiatives can be delivered within primary care, either through existing nurse or health visitor roles or through the use of lay self-help workers (valued for their life experience). The use of (free) internet-based self-help programmes can also increase the options available to GPs. These latter options may help increase the availability of supports in countries with fewer healthcare resources and little access to clinical psychologists for the delivery of CBT. The development of links with social and voluntary care sectors can also increase

capacity in access to resources and enhance the composition of primary care teams (for example, the co-location of housing or debt counselling staff).

Summary

This position paper emphasises a more holistic approach to the management of depression and depression-related conditions (as reflecting the majority of common mental health problems) in primary care. This approach takes account of the physical, psychological/emotional and social needs of patients and the position that attention to more than the diagnosis and treatment of symptoms is required. This also includes the role for primary care in engaging with promotion and prevention activities and working in partnership with other public services and voluntary agencies to address the needs of patients and enhance their general wellbeing. We leave our wide target audience for this paper with a fairly typical scenario of a patient presenting in primary care: George is a divorced single male in his 50s. He lives in an area of high deprivation and is unemployed. He quit his low-income job after becoming concerned it was aggravating his heart condition, and subsequently went into debt while waiting to become eligible for state support. During this time he was briefly homeless. He currently lives in state housing on a low income (from state benefits) and struggles to meet debt repayments. He has come to his GP as he feels his heart condition is deteriorating and he is becoming more depressed. He is already on an antidepressant. What would be the current pattern of care for George and how might this be changed to better meet such needs in the future?

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