

Improving access to depression care: descriptive report of a multidisciplinary primary care pilot service

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SUMMARY

Background: Research has identified a need for improved depression care in primary care, while current United Kingdom (UK) health policy outlines standards for the management of the condition, including improved access to care. Innovative ways of working are needed to address these standards and provide better care.

Aims: To pilot a multidisciplinary service for the management of depressed patients with a particular focus on facilitating access.

Design of study: Uncontrolled descriptive pilot study.

Setting: One general practice in inner London.

Methods: The service was advertised by post to all 6689 adult patients registered with the practice. It provided open access and face-to-face assessment by a specially trained primary care nurse for patients who considered themselves to be depressed. Following assessment, depressed patients received systematic telephone support from nursing staff in addition to the usual care from the general practitioners (GPs). The service was evaluated for a 6-month period.

Results: Sixty-six people, aged 19–77 years, 44 of them female, contacted the service, the majority in the first 2 months. Fifty-four patients were offered an assessment by the nurse. Thirty-five (80%) of the 44 attendees fulfilled criteria for major depression. Between them, the nurses and doctors achieved high levels of adherence to treatment and follow-up. This specialist service appears to have enabled a group of depressed patients, some of whom may not have sought or received help, to gain access to primary care. With appropriate supervision and training in depression care the nurses were able to assess and support depressed patients and this appeared to be acceptable to both patients and GPs.

Conclusion: In its present form the service would not be cost-effective. However, we believe it could be adapted to suit the needs of individual or clusters of practices incorporating key elements of the service (open access and case management, in particular), and further evaluation by a controlled trial is suggested.

Keywords: depression; health services accessibility; pilot studies; nurses; nursing assessment; case management; patient care team.

Introduction

IN Europe, around 10% of women and 6% of men suffer from depressive disorders,¹ but at least a third of them will not seek medical help.^{2,3} Predictors of healthcare seeking are complex and are thought to be influenced by various factors, including sociodemographic characteristics,³ severity of symptoms,³ and illness attribution.⁴ Many people do not consider depression amenable to medical help,^{5,6} despite available and effective treatments.

Research carried out over the past decade has identified a need for enhanced depression care in primary care, leading to recent calls for a chronic disease management approach.^{7,8} At the same time, the United Kingdom (UK) government has outlined standards for the management of depression in primary care in the *National service framework for mental health*,⁹ emphasising the need for ease and equity of access to treatment in keeping with wider healthcare reforms.¹⁰

Improving depression care, addressing both professional and political agendas, will require multidisciplinary working within primary care settings. There is now good evidence that practice nurses can support the general practitioner (GP) in the management of depression¹¹ and that they can improve adherence to antidepressant treatment and thus outcome.¹²

As an innovation in the primary care treatment of depression, we piloted a nurse-led service for patients suffering from depression, which was planned as an example of multidisciplinary enhanced care, with a particular focus on facilitating help seeking. The aim of the study, which took place over a 6-month period in 2001, was to examine the activity of the service and its acceptability to those who used and ran it, and to the primary healthcare team.

Method

Setting up the depression service

The service was advertised to all patients aged 16 years and over ($n = 6689$) registered with an inner London training practice of 5.5 full-time equivalent GPs. Four of the part-time GPs also held academic posts. None had postgraduate qualifications in psychiatry. The practice team included a part-time counsellor and a clinical psychologist.

Eligible patients received a flyer by post with a letter from their GP, outlining the purpose of the service, a description of depression and how it can respond to treatment, and guidance on how to seek help. The posting was spaced across a period of 6 weeks. Patients or their carers were invited to contact the service using a dedicated telephone line or via the practice reception. Three specially trained nurses (1.5 full-time equivalent) were available on a rota to receive tele-

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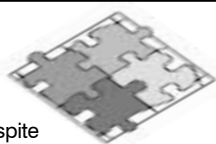
HOW THIS FITS IN

What do we know?

Depressive illness is common, but many sufferers do not access or receive help despite available and effective treatments. Research has identified a need for enhanced depression care in primary care.

What does this paper add?

A dedicated multidisciplinary depression service, based in primary care and incorporating key elements of open access and case management, appears to facilitate access to primary care for a cohort of clinically depressed patients, some of whom may otherwise not seek help. Despite the limitations identified in this pilot service, we believe our findings warrant further evaluation through randomised trials incorporating cost analyses.



phone calls during working hours, while a message on an answering machine redirected patients to out-of-hours medical help in the event of a perceived emergency at other times.

Nursing staff

The three nurses (all female) had qualified as registered nurses between 8 and 14 years previously. Two of the three, including the full-time nurse, had 3 to 5 years' experience in primary care nursing, while the third combined this post with her main role in secondary care nursing. None had specialist psychiatric experience, although all expressed a particular interest in mental health.

The nurses were trained using a programme developed for a previous study involving practice nurses.¹³ The aim of the programme was to enable the nurses to recognise, assess and support the management of patients presenting with depression. Training consisted of 9 formal study days with additional informal training sessions within the practice over a 2-month period. The programme was organised and led by a trainer with experience of community mental health nursing and nursing education. Regular individual and group clinical supervision by a nurse, a GP and a psychiatrist helped to identify and deal with further training needs after the service started.

Service protocol

Patients were offered a face-to-face assessment with a nurse if appropriate. Where a patient was already receiving treatment from primary or secondary care mental health services, the nurses judged whether to offer an assessment or to facilitate a contact with the relevant healthcare professional.

The nursing assessment, which was based around a semi-structured interview schedule¹¹ lasting up to 1 hour, was designed to elicit the presence of major depression according to recognised criteria¹⁴ and to provide additional psychological and sociodemographic data. Patients also completed the Beck depression inventory (BDI).¹⁵

The patients who scored 10 or more on the BDI and were assessed as depressed were provided with information about the condition, given an information leaflet, and discussed management options with the nurse. The nurse then arranged an appointment with a GP, taking into account patients' preferences where possible. The timing of this appointment was determined by the clinical assessment, the likely risk of self-

harm, and the BDI score. Patients who scored below 10 on the BDI and were classified as not depressed were offered routine follow-up by a GP and appropriate advice, including mental health promotion and details of voluntary agencies.

A summary of the nursing assessment and BDI score, any advice given, and recommendations made by the nurse, was made available to the GP in the patient's computerised record in the form of a template based on the assessment schedule. A similar procedure was followed after each nursing follow-up assessment.

The GPs were asked to record the presence and severity of depression for each patient and to state whether they intended to treat them for the depression. They were encouraged to offer patients 'usual care', including pharmacological and psychological treatments as necessary.

All patients seen by the GPs, and any who failed to attend, received a follow-up telephone call at 2 and 8 weeks, where possible by the nurse who performed the first assessment. The purpose of this intervention was to complete a short interview schedule¹¹ designed to allow monitoring of mental state, treatment, and GP follow-up, and to provide general support. During the course of the study, additional telephone support from the nurses was introduced at 1 week for patients starting on antidepressant medication, as this was found to be a crucial time for non-adherence to treatment. We further amended the protocol so that patients with no or mild depression (not requiring treatment) did not require nurse telephone follow-up in addition to GP care.

Evaluating the service

The nursing and GP records were audited to derive data on service activity, clinical assessment and management, and use of health services.

We sought formal and informal opinions of the service throughout. Patients who had been assessed by a nurse and who agreed to contact with a researcher were invited to take part in independent semi-structured telephone interviews. The content of the interviews was analysed to give a descriptive summary of responses. We invited all clinical members of the primary health care team ($n = 15$) to complete a questionnaire survey at the end of the evaluation period. In addition, we interviewed a purposive sample of team members, including non-clinicians and the nurses trained in depression care, to obtain informal views of the service. The interviews were audiotaped, transcribed and analysed using simple content analysis. We used a computerised statistical programme, SPSS 10, to organise and analyse quantitative data.

St Thomas' Hospital Local Research Ethics Committee granted ethical approval for the study.

Results

Activity

Service use. Sixty-six (44 female, 22 male) people contacted the service over 6 months, 56 (85%) doing so in the first 2 months after receipt of the flyer. Most (56 [85%]) used the dedicated telephone line. Six calls were made on behalf of a patient by a relative, friend, or family member. Only two messages were left outside practice opening hours. Twenty-nine follow-up calls were received from patients already assessed

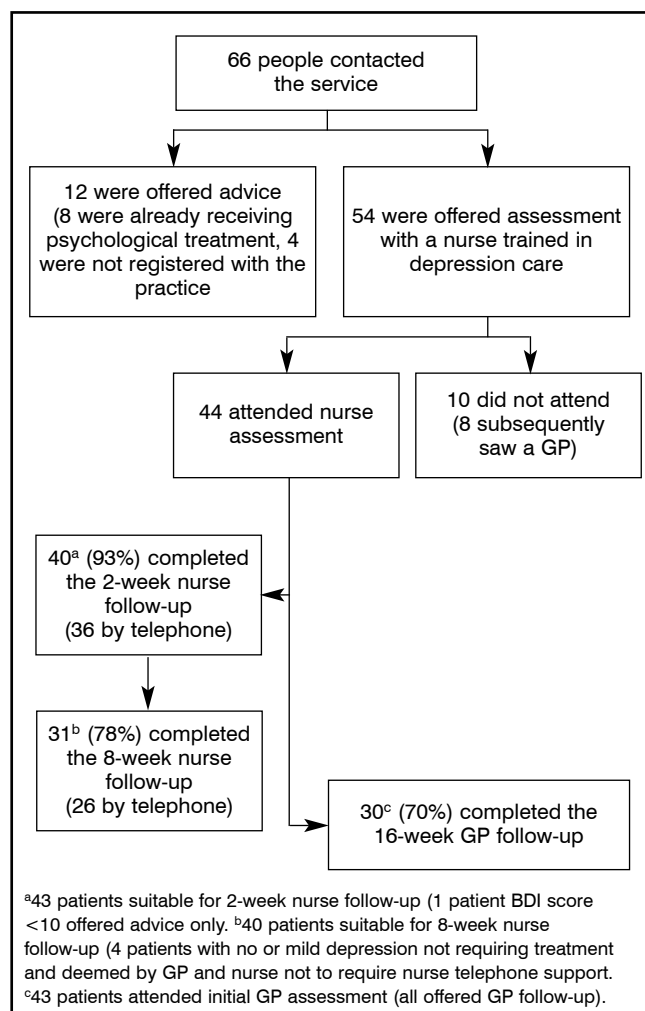


Figure 1. Flow of patients through the service.

by a nurse. Of these, 21 calls were for administrative reasons and eight of them were to obtain support.

The majority of patients, both female (27 [63%]) and male (10 [50%]), were aged between 25 and 44 years. Fifty-eight (94%) patients had consulted a GP in the previous year. Of these, 31 had presented with physical complaints, 11 of whom had consulted six or more times. The remaining 27 patients had been diagnosed with depression or another psychological complaint, 15 of whom were receiving psychological treatment at the time of contacting the service and 11 of whom had defaulted from follow-up for depression.

The flow of patients through the service is shown in Figure 1. Forty-four patients were assessed by a nurse trained in depression care. Thirty-seven reported having had a low mood for at least 4 weeks before this assessment, although 24 had not sought medical help in this period. The nurses were unable to make contact with nine patients at 8-week follow-up, although two were attending their GP for depression care over a 16-week period. This group had an initial BDI score of 28 and six were being treated for depression.

Clinical assessment and management. The clinical status of the assessed patients is shown in Table 1. The majority of patients were at least moderately depressed by self-reported

Table 1. Presence and severity of depression using self-reporting and clinical criteria in patients attending nurse assessment.

Presence or severity of depression	Number of patients (%)
Self-reported BDI score ^a (n = 42)	
None	1 (2)
Mild (10–15)	5 (12)
Mild to moderate (16–19)	5 (12)
Moderate to severe (20–29)	15 (36)
Severe (30 to 63)	16 (38)
Nurse assessment inventory (n = 44)	
DSM-IV R ¹⁴ criteria for major depression fulfilled	35 (80)
GP clinical assessment (n = 43)	
None	4 (9)
Mild	8 (19)
Moderate	26 (60)
Severe	5 (12)

^aBaseline BDI score median = 26, interquartile range = 19–32. BDI = Beck depression inventory; DSM-IV R = Diagnostic and statistical manual of mental disorders, 4th edn.

criteria. The GPs stated that they intended to treat 37 (86%) patients for depression. Antidepressant medication was initiated in 19 patients, and continued in a further four, while five patients elected to start St John's wort as an alternative. At 4 months, only four of the patients prescribed antidepressant medication had discontinued it. At the 8-week assessments, all patients self-medicating with St John's wort reported that they were still taking it.

Use of other health services. Twenty-four of the 43 patients assessed by a GP were referred for non-pharmacological therapies (counselling, clinical psychology or psychodynamic psychotherapy), while five were referred to the community mental health team.

Acceptability

The patients' perspective. Twenty-nine of the patients assessed by a nurse were happy to be contacted by a researcher and these patients were invited to take part in a telephone interview to gather their views of the service. Seventeen patients agreed to an interview. These patients appeared to be no more depressed at the outset than those who declined an interview (BDI scores = 21 versus 26, respectively, $P = 0.17$, difference = 4.8, 95% confidence interval [CI] = -2.3 to 11.9), although they were twice as likely to have participated in the 8-week follow-up by a nurse (100% versus 59%, $P = 0.003$, relative risk 2, 95% CI = 1.14 to 3.52).

The flyer had acted as a prompt for 10 patients, who said they had delayed seeking help for their low mood. Particular features that had attracted them to the service were the dedicated telephone line operated by nurses who were trained to listen (cited by 11 patients), and the 'specialist' nature of the service (14 patients). These elements were discussed in the context of perceived difficulties for depressed patients in accessing help via a practice reception. Reasons for contacting the service included previous experiences (positive for two patients and negative for 11) of seeking professional help for depression, and expectations that the service might offer a

new approach (14 patients).

The service offered an alternative route to seeing a GP. Thirteen patients perceived that the GP would not be able to offer them enough time to deal with their problem, while 10 wanted to confirm the validity of their problem, i.e. whether or not they were depressed, before seeing a GP in order to avoid 'wasting his time'. Nurses were seen as approachable and able to provide time. Both these attributes were thought to be important when dealing with depressed patients. Some patients thought they might have reacted less favourably to the service had the initial contact been with a doctor rather than a nurse. Others stated they would be more likely to talk openly to a woman. Despite these sentiments, once assessed and counselled by a nurse, all patients reported that they had found it acceptable to be referred on to a GP, with all but one stating that they felt they had been given enough choice in this decision. Nine patients thought they might have been able to continue with exclusive nurse management of their depression, although it was understood that medical help was needed to prescribe antidepressants or arrange referral to a therapist. All of the patients expected the nurse to have reported her findings to the GP in preparation for their follow-up consultation.

Patients reported positively about the (usually) hour-long initial assessment with the nurse, all of them stating that they had had time to give their history without feeling hurried. Completing the BDI before seeing the nurse appeared to have been acceptable to most patients. All viewed the process of nurse follow-up as supportive and described the importance of someone assessing their progress and monitoring their medication. One patient had expected counselling. Although most patients received telephone follow-ups, nine said they would have preferred face-to-face contact. When offered a choice between exclusive follow-up with a GP and the addition of the nurse telephone support, 12 interviewees opted for the latter.

Impact on the primary health care team. Fourteen questionnaires were returned (response rate 93%). All but one health professional deemed the service useful for patients. Most (75%) of the GPs thought it had proved useful to them, but its relevance to the remaining members of the primary health care team was less clear. The GPs reported that they were happy, to varying degrees, to share the care of depressed patients with suitably trained and trusted primary care nurses, most preferring this option to that of a community psychiatric nurse fulfilling the role.

Almost all of the primary healthcare team favoured the initiative, as it dealt with a clinically important area and widened patient choice. Some GPs had anticipated that the service would attract dependent patients, whereas in reality they noted that it had uncovered both unrecognised need as well as some chronically depressed patients. They noted the implications in terms of workload, resources and funding for GPs and psychological therapists in particular. The GPs were asked to consider several models for developing the depression service. The majority agreed that the service should extend across a cluster of practices, staffed by nurses from those practices who would receive shared training and supervision.

The views of the nurses trained in depression care. The nurses

saw their role as that of a 'facilitator' within the practice, acting as a patient advocate and supporting the GPs, and considered the role suitable for a nurse with a primary care background and an interest in mental health. They highlighted the importance of adequate preparatory and ongoing training, and regular clinical supervision. The nurses acknowledged the potential impact on their own mental health of dealing with depressed patients, and favoured working part time in this specialist capacity.

Discussion

Principal findings

Key elements of the service may have been successful in facilitating access, both practically and by encouraging or permitting help seeking.

The posted material acted as a prompt and a source of information about depression. Initial contact with the service was made using the dedicated telephone line in the majority of cases, attracting calls from a wide age range of males and females, predominantly aged between 25 and 44 years. The service identified a group of patients for whom it was agreed on all counts that they were suffering from clinical depression and in need of treatment. With appropriate training, clinical support, and regular supervision, the nurses were able to assess and support these depressed patients, and this appeared to be acceptable to patients and GPs alike.

The 'specialist' nature of the service may have provided a different route to primary care for a particular group of depressed patients, such as those with frequent attendance at the practice presenting with physical symptoms and possible unrecognised depression,¹⁹ and those who had previously defaulted from follow-up for depression care from their GP, who may not otherwise have sought help at this time or have had their depression acknowledged in routine consultations.

Strengths and weaknesses of the study

We suspect this novel approach to accessing depression care may have reduced some of the perceived or actual barriers to seeking help that may be experienced by depressed patients. The arrival of the posted flyer may have 'permitted' these patients to seek appropriate help, challenging lay views that depression is not amenable to treatment.^{5,6}

Telephone access was important. Patients' experiences of the reception process in general practice are not always favourable,²⁰ a sentiment expressed by some of the patients in this study. Depressed patients often have low motivation and may be low in confidence and self-esteem, and they may be more likely to favour a system that allows them to seek help using a dedicated line in the knowledge that their call will be answered by a health professional. Ease of access may also have encouraged younger males to make contact. This is traditionally a group that is poorly represented in general practice attendance¹⁶ and more likely to seek medical help using walk-in centres.¹⁷ Further work is needed to explore the hypothesis that additional elements of the service reduced some of the sociocultural barriers known to prevent men from seeking help for psychological problems.¹⁸

In view of its novelty, we were unable to anticipate the response to the posting and it became clear that our nurses

were under-employed. Repeating postings within a practice every few months would prove costly and may yield fewer cases. These issues could be addressed by operating the service across a cluster of practices with nurses integrating this specialist role with general practice, thus providing a more cost-effective model and maintaining the responsiveness and flexibility of the service. We estimate 2 nursing hours would be needed per thousand patients per week.

Whereas the additional workload created by these patients appeared to be acceptable to most participating GPs in the context of the time-limited pilot study, the availability of in-house therapists and the skills and attitudes of the GPs in this setting may not be replicated in all practices.

Comparison with other studies

We believe that the overall approach to depression management outlined in this study is unique. However, aspects of the service were developed with previous work in mind.

The nursing interventions were designed to enhance the therapeutic relationship between patients and the practice team, including supporting patients in the vulnerable early stages of taking antidepressants. We found the nurses and GPs worked well together in managing depressed patients, as has previously been demonstrated,¹¹ and between them they achieved high levels of adherence to treatment and follow-up. Although we cannot draw any firm conclusions on the significance of these findings from what is an uncontrolled pilot study, the service featured aspects of active case management of depressed patients (such as systematic follow-up) and antidepressant drug counselling that have been shown to improve depression outcomes in other settings.^{12,21} That case management was carried out by nurses may also have been important. Patients attributed skills and attitudes to them that they perceived to be helpful when dealing with depressed patients, in keeping with lay and nursing views expressed elsewhere.^{22,23}

Implications for clinical practice and policy

This service appears to have facilitated access to primary care for a group of depressed patients who might not otherwise have sought help. In its present form, costs would prohibit this service from being provided by an individual practice. However, there are some pointers for future primary care initiatives. Reform of primary care has created many competing demands on the primary care team, but, with adequate support and training, the majority of practice nurses would like to expand their role in dealing with mental health problems,²² and practices may be in a better position to provide multidisciplinary depression care as an 'enhanced service' within the new general practice contract.²⁴

Individual practices could retain certain elements of the service and manage them more cheaply; for example, by targeting smaller patient groups at risk of depression using mailings or by recruitment via the wider primary health care team or practice website; or by inviting patients to a longer appointment with a nurse in which the BDI is used as a screening tool, and offering telephone follow-up by nurses, all of which could be integrated into clinical sessions.

Alternatively, there is potential for this service to operate across a number of practices, with shared staff and facilities funded by the umbrella primary care organisation, maintaining

the key elements of open access and case management. We believe that this service is worth further development and evaluation through a controlled trial with accompanying cost analyses.

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