

Age discrimination is a political issue which has many sides. For example, eligibility for the NHS breast screening programme has an upper age limit, which is clearly 'ageist'. On the other hand, in this issue Evans *et al*¹⁸ reported that some older people in good health regard the policy of offering people aged over 65 years the influenza vaccination as ageist. In some cases this may be because they feel healthy, and not 'at risk' or 'old', and do not wish to be perceived differently from people aged younger than 65 years; or it may be a reaction to the institutionalised ageism of health services, in which older people are cared for separately by geriatricians, and which is a specialty widely perceived to have more limited resources. In an era in which 'active ageing' and employment beyond existing retirement ages is being encouraged,¹⁹ these different perspectives raise a separate question of how to target services to the groups most at risk without appearing 'ageist'. The challenge for health services is to develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis. There is a need to explain why 'age 65 and over' is a risk factor for complications of influenza, and why vaccination is offered to this age group. There is a similar need to explain the rationale of offering screening programmes to different age groups (for example, the NHS breast screening programme age ceiling of 70 years). GPs and practice nurses are best placed to provide these explanations, but first must

be sure that their own judgments are evidence based whenever possible, and that prioritisation decisions are transparent. The Harries study¹⁰ suggests that there is some way still to go.

Ann Bowling

Professor of Health Services Research,
Department of Primary Care and Population
Sciences, University College London

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ADDRESS FOR CORRESPONDENCE

Ann Bowling

Royal Free & UCL Medical School,
Department of Primary Care and
Population Sciences, Rowland Hill Street,
London, NW3 2PF.
E-mail: a.bowling@ucl.ac.uk

We need a chronic disease management model for depression in primary care

The treatment of depression as described by steps 3 and 4 in the NICE guidelines for the management of depression are a particular challenge for primary care.¹ There is now an increasing body of

evidence that suggests depression, for a lot of people, is a chronic illness that leads to ongoing suffering and disability. Between 50 and 70% of patients with depression treated in the primary care

setting with antidepressant medication showed a response. In a recent review of treatment for depression, a meta-analysis comparing antidepressants with placebo showed a relative risk for improvement on

antidepressants over placebo of between 1.12 and 1.55, and a number needed to treat of between four and six.² This means that for every person who responds, three to five people will not. This is likely to be similar for psychological treatments such as cognitive behavioural therapy (CBT). Response in the research sense is usually defined as a 50% improvement in symptoms from baseline. This means that even in patients who respond, many patients will remain symptomatic. Remission, defined by researchers as an improvement to minimal or no symptoms, is achieved in far fewer patients. Using remission as an outcome, antidepressants perform poorly. Fawcett and Barkin found that only 30% of patients treated with an antidepressant actually achieved remission.³ Compounding this, fewer than 10% of patients will actually complete a course of antidepressants for the recommended duration.⁴

Achieving remission is important for a number of reasons. Residual symptoms of depression are associated with ongoing suffering and disability, and are also associated with a far greater likelihood of relapse. Paykel *et al* found that, over a 15-month period, 25% of patients in remission relapsed, whereas 76% of those with residual symptoms relapsed.⁵

The prognosis for many patients in primary care suffering from depression therefore appears poor. At twelve months after diagnosis nearly 45% of patients with severe depression remained depressed.⁶ Nearly 50% of patients diagnosed with a neurotic illness in primary care were found to still be a case a year later.⁷ Of those who improve, relapse is common with nearly 40% having a chronic relapsing course over more than a decade.⁸ It is unlikely that antidepressants (or psychological treatments) are going to be the whole solution to the treatment of depression in primary care.

Step 3 of the NICE depression guideline concerns the management of moderate or severe depression in primary care. The guideline recommends antidepressant medication, psychological interventions, and social support for these patients. Step 4 is the domain of specialist mental health services. Its focus is the management of treatment-resistant, recurrent, atypical,

and psychotic depression, and patients at significant risk. The guideline recommends medications, complex psychological interventions, and combination therapies. Few of these recommendations are based on evidence from randomised controlled trials. Although the guideline makes clear recommendations for patients who should be referred to secondary care for step 4 interventions, few patients make this transition.

Given the above figures for the prevalence of chronic depression and relapse rates, about 40% of patients with depression treated in primary care should be eligible for step 4 interventions. But over 90% of patients with common mental disorders, such as depression, are treated in primary care alone without recourse to secondary care services. This suggests that, as confirmed by clinical experience, primary care continues to treat a large proportion of patients who suffer with chronic or relapsing depression without the involvement of specialist services.

Unfortunately, the NICE guidelines fall short of describing a longitudinal model of care for people with chronic or relapsing depression, other than by combining medication and CBT. Often these patients fall between steps 3 and 4 in the stepped-care model, a model mainly suited to the treatment of patients in primary care with an acute episode of depression. We would argue that depression should be treated as a chronic disease. This would not replace stepped-care but we would recommend that stepped-care is placed within a chronic disease management framework. We would also suggest the addition of a step specifically for patients with chronic or relapsing depression that addresses management in 'real world' situations where these patients often do not end up being treated by specialist services.

Chronic disease management is already practiced in primary care for many chronic conditions such as diabetes and coronary heart disease. We argue that this model lends itself well to depression care. The cornerstones of chronic disease management have been documented by Wagner⁹ as changes in service delivery to ensure effective care through teams with well defined roles; support for self-management by patients; clinical case

management of more complex patients; enhancements to decision support and clinical information systems; and close links with community resources. Implicit in this is effective follow-up, review, and 'consultancy' from specialist colleagues when appropriate.

The argument that depression outcomes can be improved by the systematic reorganisation of primary care to incorporate a chronic disease management model is persuasive. Kates *et al* recently reviewed all randomised controlled trials of chronic disease management of depression in primary care.¹⁰ They concluded that most studies demonstrated not only improvements in symptoms, but also improvements in disability, reduction in relapse, improved adherence to treatment plans, and improved patient satisfaction. Chew-Graham *et al* demonstrate in this issue of the journal the feasibility of adopting such an approach for older people with depression.¹¹

Utilising new primary care workers, and existing primary care professionals in new or adapted roles may help to develop such a service model. England and Lester recently reported in this journal that primary care mental health workers are valued by patients with depression and/or anxiety, and by primary care staff.¹² Lester *et al* also found that patients assigned primary care mental health workers were more satisfied with their care than a control group, although no difference in clinical outcome was found.¹³ The primary care mental health workers in Lester *et al*'s study provided brief interventions such as anxiety management, psychoeducation, and 'sign-posting'. However, GPs were told not to alter their clinical practice. This may account for the failure to show a difference in clinical outcome. To improve patient outcomes there needs to be an organisational change in care delivery.¹⁴ 'Bolting on' extra resources to existing care strategies does not appear to be effective.

It seems sensible that a chronic disease management approach should be developed for all patients with depression. Patients who only have a single episode can still be treated within such an approach. A chronic disease management

approach is likely to include stepped-care, but should emphasise the process of care rather than individual treatment strategies at each step. Instead of focusing on particular interventions and then building a management strategy around these, the strategy should come first. Staff can then be trained accordingly to meet the requirements of that strategy.

We have reservations about the value of 'bolt-on' services, whether these are services provided by graduate mental health workers, or any other professional group, such as the psychological services recommended by Layard.¹⁵ New services need to be accompanied by a change in existing services if they are to be optimally effective. This needs careful planning and an acknowledgement that change in all parts of the system is necessary — however challenging this may be for individual professionals. Many of the components of a chronic disease model for depression are described in the 'enhanced' services for depression by the Care Services Improvement Partnership.¹⁶ However, we would argue that what is described is not an 'enhanced' service, but should be a core service for people suffering from depression.

For many people the reality of depression is that of a chronic relapsing illness, and it deserves to be treated as such. Many of these people's needs are not met by a stepped-care model alone. A chronic disease management model would help to simplify management and ensure patients have ongoing, appropriate, and timely care. We wouldn't

be satisfied with anything less than optimal care for patients with diabetes, or asthma. The same should apply to depression.

Andre Tylee

Professor Primary Care Mental Health, Health Services and Population Research Department, Institute of Psychiatry, London

Paul Walters

MRC Fellow, Health Services and Population Research Department, Institute of Psychiatry, London

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ADDRESS FOR CORRESPONDENCE

Andre Tylee

Health Services and Population Research Department, NIHR Biomedical Research Centre, David Goldberg Building, PO Box 28, Institute of Psychiatry, De Crespigny Park, London SE5 8AF.
E-mail: spjuatt@iop.kcl.ac.uk

How much monitoring?

Variations in practice can alert us that a problem exists, but do not tell us what to do. As practitioners we can be consistent but wrong (as with hormone replacement therapy), or inconsistent but without important impacts (as with choice of antipyretic to treat fever). Although inconsistencies are imperfect markers, they do demand examination in practice. In this issue, Vinker and colleagues¹ show

considerable difference in the number of tests ordered by practitioners in Israel over a single year. A fourfold difference was found between locations in the rates of some testing.¹ But are practitioners who are doing more haemoglobin A1c (HbA1c) tests, or those doing fewer tests, practising more appropriately? Those wanting to reduce costs may push for the lower rates, but this should only be

acceptable if that were also clinically appropriate. Unfortunately, for many of the common tests examined by Vinker *et al.* the poor development of our research base in diagnostics does not give a firm foundation one way or the other.

If diagnostic research is weak, monitoring research is almost non-existent. It is therefore notable that several of the 10 most frequently used