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THE MANAGEMENT OF PATIENTS WITH DEPRESSION IN PRIMARY CARE: AN AUDIT REVIEW

Helen Henfrey

West Yorkshire Foundation School, UK

SUMMARY

Aims and methods: *The IAPT scheme was introduced in 2007 to implement the recommendations from NICE guidelines regarding psychological therapy for depression. This retrospective audit carried out across two General Practice Surgeries evaluates the care being given in relation to the standards of NICE guidelines.*

Results: *Initial audit found variable concordance, however after discussion of this at a local audit meeting and the displaying of posters and leaflets detailing the IAPT scheme this was improved on re-audit.*

Clinical implications: *Training should be provided to General Practitioners regarding the standards of care for patients with low mood or depression. In this training there should be an emphasis on the role of psychological therapy and details given of local resources. Posters and leaflets should be clearly displayed to allow patients to self-refer to IAPT. A close watch must be given to waiting times for the IAPT service as demands increase.*

Key words: *depression - primary care – IAPT - psychological therapy - NICE guidelines - suicidal ideation - antidepressant medication*

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INTRODUCTION

"The mental health of the nation was unlikely to be improved by treatment with psychotrophic medication alone" concluded a study of mental ill health throughout Great Britain between 1993 and 2000 (Brugha 2004). In addition they suggested that the "potential benefits of structured psychological therapies in primary care have yet to be realised" (Brugha 2004). Resonating this the NICE guidelines published in October 2009 for the "Treatment and Management of Depression in Adults" made clear recommendations that all patients presenting with depressive symptoms, regardless of severity, should be referred for psychological therapy (NICE guidelines 2009). To implement this psychological therapy in England has been co-ordinated via the 'Improving Access to Psychological Therapies' (IAPT) initiative since 2007 (Clark 2011). Data collected from nearly 20,000 patients showed that compliance with the IAPT clinical model was associated with enhanced rates of reliable recovery (Gyani 2013). Evaluation of the IAPT scheme suggests that it has been "effective in increasing access to evidence-based psychological therapies and facilitating the NICE guidelines for depression" (Gyani 2012). General Practitioners (GPs) who have read the NICE guidelines for depression (NICE guidelines 2009) are more likely to offer their patients access to psychological therapies (Gyani 2012). Furthermore, GPs are less likely to prescribe antidepressants to depressed patients if they have access to IAPT. In conclusion, it seems that GPs who have access to IAPT services were more likely to treat their patients in line with NICE guidelines (Gyani 2012).

METHOD

The standards used in this audit have been taken from the NICE guidelines "The Treatment and Management of Depression in Adults" published in October 2009 (NICE guidelines 2009).

- All patients presenting with depression should be asked directly about suicidal ideation and intent.
- All patients presenting with depression, regardless of severity, should be offered psychological interventions.
- All patients presenting with depressive symptoms and started on an antidepressant should be reviewed within two weeks.
- All patients presenting with depressive symptoms under the age of 30 and started on antidepressants should be reviewed within one week.

Setting

The audit was undertaken in two General Practice surgeries. The practices covered a population of approximately 12,030 patients at the time of audit.

Data collection

For the purpose of this audit 'system one' (general practice computerised record system) was used to identify patients. The records were examined retrospectively. Only patients over the age of 18 were included. No search criteria were specified for ethnicity, language or marital status. The initial audit data was collected from the 8th to the 12th of September 2014. The re-audit data was collected from 6th October 2014 to 10th October 2014.

Inclusion criteria

Patients were included in the audit if they fulfilled the following criteria:

- New episode of low mood / depression (defined as not having been seen in the last 6 months by a GP presenting with symptoms of low mood/depression)
- Seen by GP either in practice or at home (prescriptions without being seen were not included)

The results of the initial audit, as described in the results section, showed variable concordance with the standards set out in the NICE guidelines of 2009 (NICE guidelines 2009). Recommendations were therefore made in the following areas:

- All patients should be asked about suicidal ideation regardless of the severity of their illness.
- All patients should be offered psychological therapy regardless of the severity of their illness
- All patient started on antidepressants should be reviewed after two weeks, after one week if under the age of 30.

To enact these recommendations the following actions were taken:

- The findings and recommendations of the initial audit were presented to clinical staff at the local practice audit meeting.
- A notice was sent to clinical staff via 'intradoc' (online information platform) detailing the audit findings and recommendations.
- Posters were displayed in practice consultation rooms and patient areas at both surgeries relating to psychological therapies available locally and the ability to self-refer.
- Patient information leaflets were made available in patient areas in both surgeries and the self-help room at one of the surgeries detailing the psychological therapies available locally and the ability to self-refer.

RESULTS

In the initial audit fifty-three patients were identified. Of those fifty-three; eight patients met the inclusion criteria. The ages of the patients ranged between 19 and 77 years, the mean average was 51.4 years. Of the eight patients, seven were female and one was male. None of the patients had a previously recorded READ code for depression.

In the re-audit fifty-six patients were identified. Of those fifty-six, five patients met the inclusion criteria. The ages of the patients ranged between 41 and 81 years, the mean average was 50.8 years. Of the five patients, four were female and one was male. One of the patients had a previously recorded READ code for depression (Table 1).

On evaluation of the data an improvement in concordance with all standards was observed upon re-audit. In the re-audit a bigger proportion of patients were asked about suicidal ideation and more accordance was observed in terms of time to review of patients started on antidepressant medication. Noticeably the percentage of patients offered psychological therapy increased from 12.5 to 60%.

Table 1. Comparison of initial audit and re-audit in terms of a summary of the percentage of patients treated in accordance to standards

Standard	Initial audit (%)	Re-audit (%)
All patients presenting with depression should be asked directly about suicidal ideation	50.0	60
All patients presenting with depression regardless of severity should be offered psychological interventions	12.5	60
All patients presenting with depressive symptoms and started on an antidepressant should be reviewed after 2 weeks	57.1	75
All patients presenting with depressive symptoms under the age of 30 and started on antidepressants should be reviewed after one week	0.0	n/a

DISCUSSION

The NICE guidelines for the management of adults with depression (NICE guidelines 2009) set out the gold standards of care. It is the author's opinion that the improvements seen in terms of concordance with those standards were in part due to increasing the awareness of the clinical staff of these standards. Other factors are discussed below.

Perhaps the most striking difference between the NICE standards and clinical practice as found in the initial audit was the numbers of patients being offered psychological interventions. According to NICE guidelines all patients presenting with depressive symptoms, regardless of severity of symptoms, should be offered psychological interventions (NICE guidelines 2009). The concept and inception of the IAPT initiative were discussed in the introduction. Further investigation into the IAPT service showed that higher recovery rates occurred with higher average numbers of therapy sessions, larger services and larger proportions of experienced staff within the IAPT service (Gyani 2013). The key question therefore is why IAPT was not being accessed by some patients in the initial audit. Access to treatment has traditionally been cited as a barrier to the implementation of NICE guidelines in primary care in terms of psychological therapy (Gyani 2012). The Annual Report on the use of IAPT services in England 2013-2014 showed 3,395 patients accessing services in the CCG local to the audit location (Psychological therapies 2013/2014).

Table 2. Percentage of patients waiting time for IAPT in England as a whole and the local CCG 2013-2014 (Psychological therapies 2013/2014)

Waiting time	England (% of patients)	Local CCG (% of patients)
28 days or less	64.9	63.8
28-56 days	18.9	29.9
57-90 days	7.0	5.2
>90 days	9.2	1.3

As seen in table 2 data from the local CCG is broadly in line with that of England in terms waiting times (Psychological therapies 2013/2014). Despite this it may be that the perceived potential lengthy wait for treatment was a deterrent to referral. A commonly cited problem with the data relating to waiting times is that this refers only to the initial contact with IAPT (usually a telephone call assessing the situation) and not, in reality, the start of treatment.

The variable concordance with the other standards as seen in the initial audit can, in part, be explained by a broad number of factors. The variability in discussion of suicidal ideation may relate to barriers to discussing suicidal intent in primary care found in a survey of 103 GPs in 2008 (Bajaj 2008). Significantly 35.9% of the GPs surveyed thought that discussion of suicidal ideation could induce thoughts of self-harm, and 25.2% thought it could trigger suicidal behaviour (Bajaj 2008). This is contrary to randomised controlled trials, which show that screening for suicidal ideation in primary care in patients with depressive symptoms "does not induce feelings that life is not worth living" (Bajaj 2008). In addition evidence shows that asking high-risk patients about suicidal intent leads to "better outcomes, and does not increase the risk of suicide" (Norris 2012). In the re-audit the proportion of patients asked about suicidal ideation increased, thus suggesting that GPs are willing to discuss this with their patients. The variation in follow-up timings seen in the initial audit can perhaps be explained by findings from the US. In America it has been suggested that GPs view each consultation with patients suffering from chronic conditions (depression included within this) as "separate episodes with ourselves (the GP) as the only significant resource" (Leif 2005). This evidently does not apply to all practitioners but may go some way to explain the lack of scheduled follow up.

THOUGHTS FOR THE FUTURE

In terms of a broad view of the management of depression in primary care across England the results of this audit can be extrapolated. The discussion of suicidal intent should be part of any consultation with patients presenting with depressive symptoms, this should be emphasised within general practice training and revalidation. Again, practices of follow-up of patients started on antidepressants can be addressed through training for GPs and included in their revalidation procedures.

The IAPT initiative continues to grow in size and stature within the NHS and has certainly made improvements in the referral structure for psychological therapy from primary care. In the future it is important to emphasise the role of psychological therapy to GPs in their training and to ensure they are aware of local resources. It has been shown that self-referral to IAPT is a more equitable in terms of age, gender, ethnicity and benefit status (Brown 2014) and so more should be done to educate patients and encourage them to refer themselves. A sobering thought is that if the initial audit is representative of other practitioners clinical work then there could potentially be 7 times more people requiring IAPT services than are currently being referred. If the NICE guidelines are to be followed and standards met then only time would tell the effects of the true burden on IAPT services.

RECOMMENDATIONS

In light of this the final recommendations from this audit are as follows:

- During a consultation with patients relating to depression/low mood all patients should be asked about suicidal ideation, offered psychological therapy and reviewed within two weeks (one week if less than 30 years of age) if started on antidepressant medication. All these actions should be undertaken regardless of the severity of their illness.
- Clinical staff should have teaching on a regular basis about the gold standard recommendations for the management of patients with depression.
- Posters and patient information leaflets should be displayed in clinical areas relating to local sources of help such as the IAPT service.

Limitations

Both the initial audit and the re-audit have significant limitations in terms of its small sample size (only 13 patients in total meeting the inclusion criteria). In addition it is possible that discussions took place, for example relating to psychological therapy, but these were not documented on the System one computer record. In addition the short time from initial to re-audit may artificially enhance the results, it would be useful to re-audit again after 6 months to ensure the improvement was lasting.

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Correspondence:
Helen Henfrey, MD
West Yorkshire Foundation School
UK
E-mail: