NHS FORTH VALLEY
Integrated Care Pathway
For
Depression

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This document can, on request, be made available in alternative formats
NHS Forth Valley
Consultation and Change Record

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Change Record

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NHS FV Depression Integrated Care Pathway

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1. Introduction

This document provides guidelines to the care and treatment of service users in the identification of and diagnosis of depression through the means of an integrated care pathway (ICP) for the delivery of care in Primary Care, Adult Mental Health, Older Peoples and Learning Disabilities settings.

Please note that this ICP is for the treatment of depression and there is an ICP available for the treatment of Bipolar Disorder which addresses Bipolar Depression.

This document has been produced in accordance with NHS Forth Valley Policy on Developing Guidance. ¹

The term of service user will be used throughout the document to represent those referred to and receiving care and treatment from Primary Care and Secondary Care Mental Health Services unless referring to inpatient care.

Please note: The blue highlighted text within the document provides access to web-linked appropriate documentation; when read online.
Please “control and click “to open the link if required.

These ICP guidelines will be used in conjunction with the Generic ICP guidelines according to each Care Group (AMH, OPS, LDS,) when the service user is receiving care and treatment in a secondary care setting through the means of the ICP.

These ICP guidelines can be found on the Quality Improvement web pages (Mental Health section) of the NHS Forth Valley website.
Click link below http://www.gifv.scot.nhs.uk/CE_Guidance.asp?topic=Mental Health

The guidelines for this local Depression ICP are underpinned by the:

- NHS Quality Improvement Scotland Standards for Integrated care pathways in mental health depression care standards ²
- Scottish Intercollegiate Guidelines Network (SIGN) 114 non-pharmaceutical management of depression in adults ³
- National Institute for Health and Clinical Excellence (NICE) clinical guideline 90 on depression ⁴
- NHS Forth Valley Guidance for the Management of Depression ⁵

¹ http://intranet.fv.scot.nhs.uk/home/PoliciesProcedures/PP_Non-Clinical/PP_General.asp
³ http://www.sign.ac.uk/guidelines/fulltext/114/index.html
⁴ http://guidance.nice.org.uk/CG90
This ICP contains recommendations based on the best available clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (product licence). Where a medicine is prescribed outwith the product licence, the prescriber needs to be aware that they are responsible for this decision and must document the clinical need.

Where classes of medicines are recommended, e.g. atypical antipsychotics, prescribers must acquaint themselves with which medicines are licensed and have Scottish Medicines Consortium (SMC) approval for the prescribed indication.

See links to:

The electronic Medicines Compendium (eMC) which contains information about UK licensed medicines.
http://www.medicines.org.uk/EMC/default.aspx

Scottish Medicines Consortium (SMC): http://www.scottishmedicines.org.uk/Home

NHS Forth Valley procedures should be followed for the prescribing of unlicensed and non-SMC approved medicines.

Please see link to NHS Forth Valley Individual Patient Treatment Request Process Policy.
http://intranet.fv.scot.nhs.uk/home/Depts/PrimaryPharmacy/Pharm_Primary_Intro.asp

It is important to discuss contraception and risk of pregnancy with women of childbearing age and encourage women to discuss pregnancy plans with their doctor.

Please see link: NICE guidelines on Antenatal and Postnatal Mental Health
and Forth Valley Perinatal Mental Health

The UK Teratology Information Service (UKTIS), is commissioned by the Health Protection Agency to provide an enquiry answering service (0844 892 0909) on all aspects of the toxicity of drugs and chemicals during pregnancy to healthcare professionals. UKTIS produce summaries of drug and chemical safety in pregnancy.

5 http://intranet.fv.scot.nhs.uk/web/FILES/Pharmacyfiles/Guidance_for_the_Management_of_Dep_post_ADTC_agree%5B1%5D.pdf
6 http://guidance.nice.org.uk/CG91/QuickRefGuide/pdf/English
7 http://www.nice.org.uk/CG45
2. Consent to Treatment and Decision Making.

Treatment and care should take into account the person’s needs and preferences. People with depression should have the opportunity to make informed decisions about their care and treatment, in partnership with their practitioners. (NICE).

The Mental Welfare Commission have produced a guidance document named “Consent to treatment: a guide for mental health practitioners” that is available from: http://www.mwcscot.org.uk/web/FILES/Publications/Consent_to_Treatment.pdf

- Always seek valid consent from people with depression, explain options and check that the person understands, has not been coerced and continues to consent over time.

- Encourage the use of advocacy services and voluntary support. These services should be available to people with depression and carers separately if required.

- For carer/s of an adult who is unable to make decisions about their health care and treatment without help. Please click link to further information for carers. http://www.hris.org.uk/patient-information/information-for-carers/caring-and-consent/

- If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

3. What is an Integrated Care Pathway (ICP)?

- It is an explicit agreement by a local group of staff and workers, both multidisciplinary and multi-agency, to provide a comprehensive service to a clinical or care group on the basis of current views of good practice and any available evidence or guideline.

- It is important that the group agree on communication, record keeping and audit.

- There should be a mechanism to pick up when a patient has not received any care input specified by the pathway so that the omission can be remedied.

- The local group should be committed to continuous improvement of the integrated care pathway on the basis of new evidence, of service developments or of problems in implementation.

(Definition extracted from Standards for Integrated care pathways for mental health)

4. Whole System and Recovery Approach

Mental health services provide support, assistance and treatment for those with a mental illness and support to their informal carers. Mental illness is a general term for a wide range of disorders where mental functioning such as perception, memory, emotion or thought is affected.

Care is provided by a range of services within NHS Primary Care, NHS Secondary Care,
Local Authority, Voluntary Organisations and the Independent Sector.

This ICP was developed using a whole systems approach by ensuring the involvement and consultation of a wide range of services, organisations and individuals who would be affected by the delivery of; or be in receipt of care by way of this ICP.

This ICP offers a framework that ensures all efforts are made to support the principles of prevention, self management and recovery.

The Depression ICP is based on:

- a tiered model of provision.
- a whole systems approach to care.
- the need to work in partnership.
- the clarity of service roles and remits.
- the service user at the centre of care.

This ICP includes stakeholder input from service users, carers, and members of staff from the healthcare, local authority, voluntary and independent sector organisations within the Forth Valley area.

ICPs must capture the ethos and values of recovery and deliver recovery-orientated services.

The Scottish Recovery Network describes recovery as:

“Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness is a unique and deeply personal process.”

(Scottish Recovery Network)

For further information on recovery and mental health please click link below.

http://www.scottishrecovery.net/What-is-Recovery/what-is-recovery.html

5. Standard Documentation

The Depression ICP documentation will be used in conjunction with the documentation used for the Generic ICP for those with a diagnosis of depression receiving treatment in secondary are settings.

5.1 Assessment Tools

The following standard from the ICP standards on depression indicates that:

A validated measure of depression is used at initial assessment and repeated at regular intervals to monitor progress and outcome.

- General Practitioners (GPs) have a requirement in accordance with the Quality Outcome Framework to use a recognised assessment tool for depression. NHS Forth Valley advocates the use of HADs or PHQ-9 tools in Primary Care.
The Geriatric Depression Scale (GDS) is designed specifically for older patients. The GDS loses specificity in Severe Dementia but the Cornell Scale for Depression in Dementia addresses this difficult area.

Assessment tools used in General Practice have not been validated for use in people with a learning disability.

Please note:

“Health care professionals should not rely on the interpretation of a score alone when assessing an individual who may have depression but should also consider other factors including degree of impairment, length of episode, history of depression, family history, other co-morbid disorders and specific circumstances pertaining to individuals”. (NHS QIS 2011).

Although standardised questionnaires may capture whether symptoms are mild, moderate or severe they may not capture complexity. It is therefore important that the above factors are taken into account.

The Depression ICP Development Group examined a range of tools and the following assessment tools are recommended for use in the appropriate care group setting.

<table>
<thead>
<tr>
<th>Assessment Tools (Depression)</th>
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<tbody>
<tr>
<td>PHQ9</td>
<td>Patient Health Questionnaire 9</td>
</tr>
<tr>
<td>HADs</td>
<td>Hospital Anxiety and Depression Scale</td>
</tr>
<tr>
<td>GDS</td>
<td>Geriatric Depression Scale</td>
</tr>
<tr>
<td>CSD</td>
<td>Cornell Scale for Depression in Dementia</td>
</tr>
<tr>
<td>MADRS</td>
<td>Montgomery Asberg Depression Rating Scale</td>
</tr>
<tr>
<td>GDS-LD</td>
<td>Glasgow Depression Scale for People with a Learning Disability</td>
</tr>
<tr>
<td>GDS-CS</td>
<td>Carer Supplement to the Glasgow Depression Scale for People with a Learning Disability</td>
</tr>
<tr>
<td>PAS-ADD</td>
<td>The Psychiatric Assessment Schedules for Adults with Developmental Disabilities</td>
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See appendix 1 for description of these tools.

6. Depression

Depression is a common mental health condition. For some this will present as a single episode, for others it may be recurrent or persistent.

Depression can have a significant impact on an individual’s psychological, social and occupational functioning. Around one in five of the population of Scotland will experience depression at some point in their lives. It can range in severity from a mild disturbance to a severe illness. The most common diagnostic category in Britain is Mixed Anxiety and Depression with almost 9% of people meeting criteria for diagnosis.  


The Office for National Statistics Psychiatric Morbidity report 2001
The majority of people with depression will be diagnosed and treated within Primary Care Services with Secondary Care Services supporting complex cases or those with enduring difficulties.

6.1 Potential Triggers for Depression

- Bereavement.
- Acute physical illness.
- Having to move into an institution.
- Declining health and mobility.
- Dependence on others.
- Sensory loss.
- Trauma.
- Cognitive decline.
- Housing issues.
- Retirement.
- Caring for a chronically ill or dependant family member.
- Unemployment/Redundancy.
- Relationship problems.
- Financial problems.
- Alcohol/Substance Misuse.
- Development of a long term condition. (Symptoms persisting more than 12 months).

6.2 Mild to Moderate Depression

In a mild to moderate depressive episode the individual usually suffers from lowering of mood, reduction of energy and decrease in activity.

Loss of interest, enjoyment, and concentration are common, together with marked tiredness even after minimal effort.

Sleep is often disturbed and appetite diminished. Self confidence and self esteem are almost always reduced and ideas of worthlessness are common.

"Somatic" symptoms may also occur, these include:

- loss of interest or pleasure in activities that are normally enjoyable.
- lack of emotional reactivity to normally pleasurable surroundings and events.
- waking in the morning 2 hours or more before the usual time.
- depression being worse in the morning.
- objective evidence of definite psychomotor retardation or agitation.
- marked loss of appetite.
- weight loss (defined as 5% or more of body weight in the past month.
- marked loss of libido.
A duration of at least 2 weeks is usually required for diagnosis.

- Both mild and moderate depressive episodes may be accompanied by "somatic syndrome" characterised by the presence of four or more of the following symptoms: loss of interest or pleasure in activities that are normally enjoyable
- lack of emotional reactivity to normally pleasurable surroundings and events
- waking in the morning 2 hours or more before the usual time
- depression worse in the morning
- objective evidence of definite psychomotor retardation or agitation
- marked loss of appetite
- weight loss (defined as 5% or more of body weight in the past month
- marked loss of libido.

The differentiation between mild and moderate depressive episodes rests upon clinical judgement involving the number, type, and severity of symptoms present, also the extent of ordinary social and work activities is a general guide to the degree of severity of the episode.

In individuals with a mild depressive episode, two of the following symptoms should be present:

- Depressed mood to a degree that is abnormal for the individual, occurring for most of the day, almost every day, and largely uninfluenced by circumstances.
- Loss of interest and enjoyment.
- Reduced energy or increased fatigability.

An additional symptom or symptoms from the following list should also be present giving a total of at least four. However, the individual will probably remain able to continue with most activities.

- reduced concentration and attention
- loss of self-esteem and self-confidence
- unreasonable feelings of guilt and unworthiness
- bleak and pessimistic views of the future
- recurrent ideas or acts of self-harm or suicide
- disturbed sleep
- changes in appetite

In a moderate depressive episode, as in a mild depressive episode, two of the following symptoms should be present:

- Depressed mood to a degree that is abnormal for the individual, occurring for most of the day almost every day, and largely uninfluenced by circumstances.
- Loss of interest and enjoyment.
- Reduced energy or increased fatigability.

In addition, there must be other symptoms from the previous list giving at least six in total and the individual usually has great difficulty continuing with ordinary activities.
6.3 Moderate to Severe Depression

In a moderate–severe depressive episode the individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to impairment of activity. The lowered mood varies little from day to day, and is often unresponsive to circumstances. "Somatic" symptoms are common, these include:

- loss of interest or pleasure in activities that are normally enjoyable.
- lack of emotional reactivity to normally pleasurable surroundings and events.
- waking in the morning 2 hours or more before the usual time.
- depression being worse in the morning.
- objective evidence of definite psychomotor retardation or agitation.
- marked loss of appetite.
- weight loss (defined as 5% or more of body weight in the past month.
- marked loss of libido.

A duration of at least 2 weeks is usually required for diagnosis, but shorter periods may be reasonable if symptoms are unusually severe and of rapid onset.

The differentiation between moderate and severe depressive episodes rests upon clinical judgement involving the number, type, and severity of symptoms present.

The extent of ordinary social and work activities is a general guide to the degree of severity of the episode.

In individuals with a moderate depressive episode, at least two of the three most typical symptoms (depressed mood, loss of interest and enjoyment, and reduced energy) should be present, plus additional symptoms (see below) to make a total in excess of 6.

An individual with a moderately severe depressive episode will usually have considerable difficulty in continuing with social, work or domestic activities.

The following symptoms may be evident:

- reduced concentration and attention.
- loss of self-esteem and self-confidence.
- unreasonable feelings of guilt and unworthiness.
- unreasonable feelings of guilt and unworthiness.
- bleak and pessimistic views of the future.
- recurrent ideas or acts of self-harm or suicide.
- disturbed sleep.
- changes in appetite.
In a severe depressive episode, the individual usually shows:

- considerable distress or agitation, unless retardation is a marked feature.
- all three of the typical symptoms (low mood; anergia and anhedonia), plus at least four other symptoms, some of which should be of severe intensity.

During a severe depressive episode it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent.

A severe depressive episode with psychotic symptoms meets the above diagnostic criteria and the individual can experience:

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</table>

During a severe depressive episode it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent.

A severe depressive episode with psychotic symptoms meets the above diagnostic criteria and the individual can experience:

- delusions, in which the delusions usually involve ideas of sin, poverty, or imminent disasters, responsibility for which may be assumed by the patient (mood congruent).
- auditory or olfactory hallucinations which are usually defamatory or accusatory in nature.
- severe psychomotor retardation which may progress to stupor.

### 6.4 Co morbidities

In some cases, anxiety, distress, and motor agitation may be more prominent, and the mood change may also be masked by added features such as irritability, excessive consumption of alcohol, histrionic behaviour, and exacerbation of pre-existing phobic or obsessional symptoms, or by hypochondriacal preoccupations.

The presence of dementia or learning disabilities does not rule out the diagnosis of a treatable depressive episode, but communication difficulties are likely to make it necessary to rely more than usual for the diagnosis upon objectively observed somatic symptoms, such as psychomotor retardation, loss of appetite and weight, and sleep disturbance.

### 6.5 Exclusion Criteria

There must have been no hypomanic or manic symptoms sufficient to meet the criteria for a hypomanic or manic episode (F30) at any time in the individual's life, and the episode must not be attributable to psychoactive drug use or to any organic mental disorder.

### 7. People with Learning Disabilities and Depression

*Learning disability is a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities (ICD-10).*

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1. Having a significant impairment in intellectual functioning; and
2. Having a significant impairment in adaptive functioning; and
3. The onset of both of these should be before adulthood.

Presentation may be similar to the general population in those who have a mild learning disability, but like other mental illnesses, it becomes more difficult to assess, the more severe the learning disability. In general, diagnosis of mental illness can be difficult due to

factors such as complex care needs, severity of the learning disability as well as communication challenges.

It is important to get a normal (baseline) measure of the person from a reliable informant in order to compare the current to the usual premorbid state.

At least one of these below must be present and prominent

| Depressed or irritable (onset/increase in physical aggression/verbal aggression/reduced level of tolerance) mood |
| Loss of interest in activities or social withdrawal or reduction in self care skills or reduction in communication |

Some of the following symptoms must be present so that there are a total of 4 symptoms from table above and below

- Loss of energy; increased lethargy
- Loss of confidence or increase in reassurance seeking behaviour/ onset of or increase in anxiety or fearfulness
- Increased tearfulness
- Onset of or increase in somatic symptoms/physical health concerns
- Reduced ability to concentrate/distractibility or increased decisiveness
- Increase in a problem specific behaviour
- Increase in motor agitation or increased motor retardation
- Onset of or increase in appetite disturbance or significant weight change
- Onset of or increase in sleep disturbance

(Taken from Diagnostic criteria for psychiatric disorders for use with adults with learning disabilities/mental retardation (DC-LD)

The majority of people with learning disabilities who are depressed are assessed and treated by their general practitioner, as in the general population.

- Like the general population, the GP will exclude other medical conditions, such as hypothyroidism.
- The GP will inform the patient about the assessment and obtain consent. Where the patient refuses consent and/or unable to consent, these are documented and use of appropriate legislation is considered and used appropriately.
- Assessment tools used in general practice have not been validated for use in people with learning disabilities.
- Guidelines for treatment should be similar to the general population but there may be challenges in making the diagnosis.
- If there are ongoing concerns about diagnosis or management, refer to Community Learning Disability Team.

The reason for referral to the specialist learning disability team is often changes in behaviour or apparent mental health problems, including depression.

The referral will be discussed at the team meeting and allocated to the appropriate discipline. This may be nursing, psychology or psychiatry. If urgent, contact with patient/carer will be made within 3 days.
• As people with a learning disability often have changes in mood or behaviour that are related to physical ill-health, the learning disability nursing staff will complete a holistic health assessment.

• Depending on the outcome, further assessment is done in consultation with the person, their family and care staff. Changes in the environment or staff changes can precipitate and perpetuate depression.

• Where there is suspicion of depression, appropriate staff will use the Glasgow Depression scale for people with a learning disability (GDS-LD) and/or the Carer Supplement to the Glasgow Depression Scale for People with a Learning Disability (GDS-LD/CS).

• The team member assessing the patient will liaise with the relevant professionals for further information and feedback. This includes communicating the management plan to the GP.

• There is limited evidence base for psychological therapies in those with learning disability and depression. If psychological therapy may be of benefit, a referral should be made to the appropriate service for an assessment.

• With regard to pharmacological interventions, please refer to NHS Forth Valley Guidance for the Management of Depression.

• Many people with a learning disability are cared for by their family. There is evidence that the prevalence of depression among female family carers of people with a learning disability is 3 times that of the general population. This has implications for the care of the person with a learning disability and service providers.

8. Older People with Depression

Depression is the most common mental health condition of later life but can be difficult to diagnosis. Older adults do not always fit the typical picture of depression. Indeed, many with serious depression do not have symptoms that fit current classifications of mood disorders which have been generated to reflect symptoms in younger people. Many don’t claim to feel sad or recognise themselves as being depressed at all.

In Primary Care, screening for depression should be considered for elderly patients presenting with persistent, multiple physical symptoms of unclear aetiology.

Signs to look out for:

• Unexplained or aggravated aches and pains
• Hopelessness
• Anxiety and irritability
• Memory problems
• Loss of feeling of pleasure
• Slowed movement
• Lack of interest in personal care (skipping meals, forgetting medication, neglecting personal hygiene)

Antidepressant Treatment

- Antidepressant prescribing guidelines for the over 65 age group is available within [NHS Forth Valley Guidance for the Management of Depression](http://guidance.nice.org.uk/CG16/QuickRefGuide/pdf/English).

- Antidepressants may help ease symptoms however if the depression is due to loneliness, poor health or other lifestyle issues, then antidepressant medication may not be indicated.

- Antidepressant use in older adults also comes with safety concerns that are important to be aware of such as increased risk of hyponatraemia with SSRI antidepressants.

- Older people may be more sensitive to the adverse effects of medicines due to declining liver and renal function. Furthermore this group of patients are likely to have other co-morbidities and be prescribed other medicines leading to drug interactions and other adverse effects.

- Older people may forget to take their medication leading to non-compliance and poor outcomes with antidepressant treatment.

Suicide

- Feelings of hopelessness are common in older people. The desire of death in older people is as would be expected, strongly associated with depression but also with physical disability, pain, sensory impairment and institutionalisation.

- Indirect self destructive behaviour such as refusing food and “turning face to the wall” are common in residential/nursing homes.

- Most acts of deliberate self harm in older people are carried out with high suicidal intent and are at greater risk of completing suicide with 1 in 5 elderly people who self harm going on to end their life.13 (NICE 16).

- Older people attempting suicide are more likely to have a psychiatric illness than younger adults and over half will have a depressive disorder. Grief especially after a spousal bereavement is noted to be consistently associated with self harm in elderly people. According to the World Health Organisation (WHO) data suicide rates remain highest in older people in most countries. When an elderly person attempts suicide his/her gesture must be taken seriously as it is likely that any attempt will result in death as studies show a ratio of 2:1.

Depression and Dementia

Individuals are often referred to specialist mental health services when there is dubiety about diagnosis. It can never be assumed that a loss of mental “sharpness” is just a normal sign of old age. It could be a sign of depression or dementia.

- Since both conditions share many similar symptoms, including memory problems, sluggish speech and movements and low motivation it can be difficult to clarify diagnosis without thorough investigation and assessment. Further investigations may include CT brain scans to exclude brain pathology and neuropsychological testing.

- The premorbid state of the patient is important to know as in the case of dementia there tends to be a history of declining cognitive function whereas in the case of a major depressive disorder patients tend to exhibit a more abrupt decline associated

with other features of depression. Many elderly depressed people however worry that they have dementia and this may put them off seeking help.

- Cognitive impairment is associated with high rates of depression particularly in vascular and in the prodromal phases and early stages of Alzheimer’s Dementia when the patient is aware that something is wrong. A major challenge of diagnosis in late life depression is when there is a co morbidity with dementia

9. Stepped Model of Care

A stepped model of care enables care and treatment to be matched and delivered to meet the needs of the individual following assessment and to ensure that this occurs at the right time in the right place by the right team in the most appropriate care setting.
Due to the large number of service users presenting with depression and the demand for psychological services, it is important that a stepped care model of service delivery is applied.

Stepped care is a tiered approach to service provision, best described as pyramidal in structure, with high-volume low intensity interventions being provided at the base of the pyramid to service users with the least severe difficulties.

Subsequent ‘steps’ or tiers are usually defined by increasing levels of case complexity and increasingly intensive forms of psychological treatment.
It is important to note that this model is flexible. For instance, some service users with complex needs may still require low-intensity interventions such as stress/depression management and should not be excluded from accessing the lower tiers of the service.

Tier One

In this tier services users will tend to have mild to moderate difficulties and are able to benefit from one of the high volume low-intensity psychological services.

- **A self-help guide for depression** is available to promote the importance of applying self-management techniques to manage mood related difficulties. GPs and other health professionals can access the depression guide from the Forth Valley website. [SID](#)

- Book prescriptions for depression are also available and accessible from GPs. If service-users require further help than this they can be offered one of the low-intensity interventions detailed below.

- Individual guided self-help based on written materials (or alternative media) should be supported by a trained practitioner who reviews progress.

Service users who are able to apply self-management techniques with minimal clinical support can be referred to Beating the Blues or Stress Control.

- **Beating the Blues** is a computerised evidenced-based Cognitive Behavioural Therapy (CBT) for service users with mild/moderate depression.\(^ {14} \) Beating the Blues is the most widely used and evidenced based CCBT for the treatment of depression. This service is available Forth Valley wide and GPs can directly refer to it. Service users are usually sent an appointment within 28 days. Service users should be supported where necessary, explaining the CBT model and encouraged to complete tasks between sessions, by a trained practitioner who reviews progress and outcome. This typically takes place over 9–12 weeks, including follow-up.

- **Stress Control** is a 6 week evidence-based CBT stress/anxiety and mood management course for service users and their relatives.\(^ {15} \) This will be made available to service users across most areas in Forth Valley. Service users who require more emotional support can access depression management groups from both the NHS and Third Sector.

- **Therapeutic groups** for those with a diagnosis of depression are available and are provided by both NHS and Third Sector agencies. The Third Sector agencies are: Action in Mind in Stirling, the Falkirk and District Association for Mental Health and The Scottish Association for Mental Health in Clackmannanshire. Group-based CBT should be based on a model such as ‘Coping with depression’

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be delivered by two trained and competent practitioners, consist of 10–12 meetings of 8–10 participants and typically take place over 12–16 weeks, including follow-up. (NICE)

Tier Two

In this tier service users may not have complex difficulties but do require high intensity time-limited psychological interventions such as CBT.

- This treatment is available within community integrated mental health services.
- CBT can also be accessed from Primary Care Adult Psychology which is an area wide service.
- Service users with complex family histories can access other high intensity psychological interventions at this level from Primary Care Adult Psychology and Dynamic Psychotherapy.
- CBT for mild-moderate depression can usually take up to 16 sessions. (More sessions may be required for those with more severe and complex needs accessing secondary care)

Tier Three

This tier of the service can overlap between primary and secondary care. This tier is for service users who require more specialist interventions but who do not require the support of a CMHT.

Service users who have not responded to time-limited high intensity interventions can be referred to the following services for specialist psychological assessments and interventions. (These may be service users with a history of trauma, co-morbid problems or personality difficulties that impact on their ability to engage with the more protocol driven psychological interventions.)

- Primary Care Adult Psychology Service.
- Dynamic Psychotherapy Service
- NHS Forth Valley Area Wide Trauma Service (Service users diagnosed with depression with primary or secondary trauma.)

Referral information about the above services can be accessed via this web link to SID

9.3 Secondary Care Psychological Interventions

Tiers Three and Four.

Specialist psychological assessment and treatment is available for service users with treatment-resistant, recurrent and chronic depression.

- For all service users whose depression appears to be resistant to treatment, who have complex needs, chronic and/or recurrent depression, psychological assessment and/or therapy should be considered as an option.
• This will usually be on a longer term basis than for service users with less complex needs and who have responded to medication and/or more short term psychological interventions. The decision to refer on for psychological assessment may be made at various times in the service user’s journey and in discussion with the service user and other professionals.

• Due to the fact that depression often co-occurs with anxiety and other mental health problems and previous trauma/abuse, a comprehensive assessment and psychological formulation needs to be carried out to choose the best approach.

• Options for people with chronic depression include cognitive-behaviour therapy, interpersonal therapy, behaviour activation, problem solving therapy, psychodynamic therapy and for relapse prevention, mindfulness based approaches are indicated.

• Other options where indicated by the assessment/formulation include psychological approaches for complex trauma and couples therapy.

• It is likely that service users with a more severe and/or complex depression are seen within a community mental health team setting where their care might involve a number of professionals and be a coordinated team approach.

• However some service users with a more complex or chronic depression do see their psychologist/psychological therapist within a primary care setting.

• When making the decision with consideration to the most appropriate referral, various factors should be considered. These include any previous psychological therapies and response to this, the service users own preferences and choices about interventions, environment/space for psychological work and readiness for psychological work.

• Psychological therapies and interventions will be available depending upon the training in psychological therapies and skill/experience within the team and different levels/intervention thought to be needed. It is important that there is high quality ongoing supervision, that people have been trained to appropriate levels of competency and continuing professional development is available.

• The role of clinical psychologists within the team can be indirect work supporting others, joint work and direct work with service users.

• Clinical psychologists can offer support, advice, supervision and consultation to other staff within the team who are involved in psychological interventions with people with depression as well as teaching and training in relevant issues. As well as this, clinical psychologists within teams offer individual psychological therapy to service users.

• Arts Therapists are accredited and HPC regulated practitioners who provide evidence based psychodynamic psychological therapies. The evidence for Arts Therapies is growing and includes some RCT evidence supporting Art
Psychotherapy as a treatment for depression. The Arts Therapies can provide appropriate treatment interventions for individuals where verbal therapies might be contraindicated or rejected.

- As well as providing direct treatment, the psychodynamic psychotherapy service can also offer consultations and reflective practice groups to teams. These can be helpful to staff working with more complex cases.

9.4 Description of Evidence based Psychological Therapies

Cognitive behaviourial Therapy (CBT)

A structured and collaborative therapeutic approach requiring appropriate training and ongoing supervision. CBT aims to make explicit connections between thinking, emotions, physiology and behaviour, primarily through behavioural experiments and guided discovery, in order to achieve systematic change in underlying beliefs and behavioural patterns, which are thought to cause and maintain psychological wellbeing.

The treatment can usually take up to 16 sessions for mild/moderate depression. More sessions may be required for those with more severe and complex needs accessing secondary care.

Mindfulness

Mindfulness has been defined as paying attention in a particular way: on purpose, in the present moment, and non-judgmentally (in contrast to being absorbed in ruminative thinking). Based on meditation principles, it is provided as 8 group sessions each lasting approximately 2 hours and usually there is a follow up session. The emphasis is on formal practices such as meditation and mindful movement, as well as using mindfulness in everyday activities.

Psychodynamic Psychotherapy

- Psychodynamic psychotherapy places emphasis on the importance of the therapeutic relationship including transference and counter transference, how

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17 Waller, 2001. ‘Research report: art therapy and dementia: an update on work in progress’ Inscape 6(2) 67-8. Small scale RCT comparing art therapy with activity groups showed significant reduction in art therapy participant’s depression and improvement in attentiveness, sociability, mental acuity, physical competence and calmness.

difficulties from the past can be repeated in the therapeutic relationship as well as in current relationships and therefore understood and changed. Based on psychodynamic theories of development and of the mind; this includes attention to unconscious as well as conscious mental processes. The therapy involves both expressive and supportive elements.

**Interpersonal Psychotherapy (IPT)**

- A time-limited intervention, between 12 and 20 sessions, which aims to reduce symptoms by working on improving the quality of the patient’s interpersonal relationships. IPT focuses on specific interpersonal problem areas such as grief, role transition and interpersonal disputes. A positive therapeutic alliance is encouraged and a range of therapeutic strategies are employed to encourage the open expression of affect and problem resolution.²⁰

**10. Pharmacological Treatment**

Please refer to the:

**NHS Forth Valley Guidance for the Management of Depression**

And

**National Institute for Health and Clinical Excellence (NICE) clinical guideline 91 on depression in adults with a chronic physical health problem**

**When Starting Antidepressant Therapy;**

Explore any concerns the person has about taking medication and provide information, including:

| • the gradual development of the full antidepressant effect. |
| • the importance of taking medication as prescribed and the need to continue beyond remission. |
| • the potential side effects and drug interactions. |
| • the risk and nature of discontinuation symptoms (particularly with drugs with a shorter half-life, such as paroxetine and venlafaxine). |
| • the fact that addiction does not occur. |

**Also**

- For people, who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly, for example every 2–4 weeks in the first 3 months, and then at longer intervals if response is good.
- For people, who are considered to be at increased risk of suicide or are younger than 30 years, normally see them after 1 week and then frequently until the risk is no longer clinically important.
- If a person experiences side effects early in treatment, provide information and :

- consider monitoring symptoms closely if side effects are mild and acceptable to the person
  Or
- consider stopping or changing to a different antidepressant if the person prefers
  Or
- consider short-term concomitant treatment (usually no longer than 2 weeks) with a benzodiazepine if anxiety, agitation and/or insomnia are problematic, except in people with chronic symptoms of anxiety; use with caution in people at risk of falls.

### Reviewing and Stopping Antidepressant Treatment

#### The following will occur:

- Regular review of treatment for those who have been prescribed an antidepressant.
- People who have a single depressive episode requiring antidepressant treatment, that antidepressant treatment should normally be continued for 6 months following recovery.
- People who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during episodes, should be advised to continue antidepressant for at least 2 years following recovery.
- People on maintenance treatment should be re-evaluated by the GP, taking into account age, comorbid conditions and other risk factors in the decision to continue the treatment beyond two years.

### 11. Primary Care Screening

- The majority of people with depression will be diagnosed and treated within Primary Care Services.
- Primary Care Services will signpost / access local authority and third sector organisations that provide support for those with depression, when necessary.
- Referral will be made to Secondary Care Services for those presenting with moderate / severe depressive symptoms and are at high risk and /or with complex needs.

When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode. (NICE 2009)

“health care professionals should not rely on the interpretation of a score alone when assessing an individual who may have depression but should also consider other factors including degree of impairment, length of episode, history of depression, family history,
other co-morbid disorders and specific circumstances pertaining to individuals”. (NHS QIS 2011).

Be alert to possible depression, particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment and consider asking people who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things? (NICE 2009)

Before being diagnosed with depression, the clinician should consider screening for common health issues that can affect mood.

These include:

- Hormonal imbalances
- Thyroid problems
- Vitamin B12 deficiency
- Other nutritional deficiencies
- Electrolyte imbalances or dehydration

Co-morbid medical and physical problems may mask depression and complicate the presentation making assessment much more difficult. Physical illness, age associated factors and social conditions can also exacerbate depression and complicate treatment.

**Long term medical conditions should be screened for depression such as:**

- Ischemic Heart Disease.
- Underlying undiagnosed cancer/cancer.
- Neurological disorders such as Parkinson’s disease and Multiple Sclerosis.
- Cerebrovascular Disease (Stroke).
- Vascular Dementia.
- Chronic Obstructive Pulmonary Disease.
- Chronic renal conditions.

Medication such as anti-Parkinson drugs, opioid analgesics, beta blockers, digoxin, corticosteroids and lipid lowering agents can all be associated with causing depression as a side-effect of treatment.

Residents within care home settings should be screened for depression. Rates of depression including major depression in long term care facilities such as nursing homes are typically up to three times higher than amongst community residents. (Mental Health Foundation UK)

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21 http://www.mentalhealth.org.uk/help-information/mental-health-statistics/older-people/
In hospitalised elderly residents the prevalence of depressive episode ranges between 15 - 50 %.\textsuperscript{22}

\section*{12. Primary Care Assessment}

With regard to assessing the severity of depression in Primary Care and drug treatment options refer to the:

\textbf{NHS Forth Valley Guidance for the Management of Depression}\textsuperscript{23}

General Practitioners (GPs) have a requirement (QOF) to use a recognised assessment tool for depression.

NHS Forth Valley advocates the use of HADs or PHQ-9 tools. \textit{(See appendix 1)}

- The assessment will be repeated between 5 to 12 weeks and thereafter at the discretion of the clinician.

- When a person is referred to secondary care services; a mandatory field is incorporated into the electronic referral (SCI Gateway) for recording of the assessment results. This is to ensure that the assessment is continually utilised to assess the service user as they progress through secondary care settings.

- The GP will offer the ICP Depression leaflet, as appropriate, to the service user on first presentation or within four weeks of initial presentation. This will offer information on self help and wider wellbeing.

- The GP will supplement this information with literature that is assessed to be of benefit to the client. (For example; Mood juice, referral to Beating the Blues).

- The GP will inform the patient of the benefits of physical exercise to alleviate the symptoms of low mood and other lifestyle advice such as the impact of alcohol on the symptoms of depression and interaction with medication.

- Where particular circumstances exist, such as the service user is elderly or has learning disabilities, specialised services or literature will be supplied.

- GPs have the responsibility to use the Depression ICP algorithm for Depression within Primary Care. (NICE Guidelines)

- GPs must record within the clinical notes the date of referral and access to appropriate psychological therapies.

- Appropriate assessments / interventions to exclude/treat any other health problems.

\textsuperscript{22} Royal College of Psychiatrists (2000) “Advances in psychiatric treatment, diagnosis of depression in the elderly”, Mavis, Evans and Mottram, P.

\textsuperscript{23} \url{http://www.nhsforthvalley.com/__documents/qi/CE_Guideline_Depression/Depression.pdf}
13. Risk Assessment and Risk Management in Primary and Secondary Care Settings

In primary care settings factors which would indicate urgent referral to secondary care services are:

- Active suicidal ideas or plans.
- Psychotic symptoms.
- Severe agitation accompanying severe symptoms.
- Severe self neglect.

It is important when assessing the severity of depression to consider any situational stressors or crises that the person may be experiencing currently and include factors such as the misuse of alcohol or drug misuse. Information on secondary care services and the means of referral can be obtained from the Service Information Directory. SID

In secondary care settings, generic guidelines for risk assessment and management will be followed in accordance with the Generic ICP.

Risk assessment will be an ongoing process and will include asking directly about suicidal ideation and intent.

If there is a risk of self-harm or suicide:

- Assess whether the individual has adequate social support and is aware of sources of help.
- Arrange help appropriate to the level of risk.
- Advise the individual to seek help if the situation deteriorates.
- If the person presents considerable immediate risk to themselves or others, refer them urgently to acute specialist mental health services.

Advise the person and their family or carer of the following, and ensure they know how to seek help promptly if required:

Highlight the:

- potential risk for increased agitation, anxiety and suicidal ideation early in their treatment; and to actively seek help for these symptoms and review of treatment if they develop marked and/or prolonged agitation.
- the need to be vigilant for mood changes, negativity, hopelessness and suicidal ideation, particularly when starting or changing treatment and at times of increased stress.

It is important to produce collaborative individualised risk management plans which clearly identify and state the means to manage the risks and are aligned with the overall treatment strategy for the person.
14. Diagnosis and Post Diagnostic Support

Generic guidelines for diagnosis and post diagnostic support will be followed in accordance with the Generic ICP.

Please also link to: ICD10

When working with people with depression and their families and carers:

- build a trusting relationship and explore treatment options with hope and optimism, explaining the different courses of depression and that recovery is possible. Allow the opportunity to discuss this information fully to enable the service user to make an informed choice.
- be aware of possible stigma and discrimination associated with the diagnosis of depression.
- ensure that confidentiality, privacy and dignity are respected.
- provide information about depression and its treatment, support groups and other resources including leaflets/booklets available locally as well as the support and resources that may be available nationally. See Appendix 17.2 for resource list.
- It is important to assess for and identify any visual, spatial and hearing deficits which may impact on communication and ensure that information is given in a suitable format either in audio, visual, print, diagram or picture format where appropriate.
- ensure that comprehensive written information is available in the appropriate language and in audio format if possible; provide independent interpreters if needed.
- be sensitive to diverse cultural, ethnic and religious backgrounds, and aware of possible variations in the presentation of depression.
- ensure competence in using different explanatory models of depression, addressing cultural and ethnic differences when developing and implementing treatment plans.
- ensure that the person can give meaningful and informed consent before treatment starts, especially if they have severe depression or are subject to the Mental Health Act. This will be based on the provision of clear information covering, what the intervention comprises of, what is expected of the person while having it and the likely outcomes (including side effects). This should be provided in both verbal and written formats.

14.1 Support for Carers

It is important to support the families and carers of the depressed person by:

- providing written and verbal information on depression and how they can support the person with depression.
- providing information about local family or carer support groups and voluntary organisations, and helping families or carers to access these.
- offering a carer’s assessment where appropriate.
- negotiating confidentiality and the sharing of information between the person with depression and their family or carers.

24 http://apps.who.int/classifications/apps/icd/icd10online/
When a person has experienced depression for 2 years or more:

- the burden of care upon family and carers is considerable. Troublesome symptoms which can persist are importuning and hypochondrical complaints, increasing demands on care givers but also “negative” features such as lack of interest, poverty of conversation, apathy and withdrawal.

- the mental health of carers suffers under these circumstances and can be helped by giving basic explanations and simple instructions on how to manage problematic behaviours, carrying out supportive work with the carers and working as part of a multi-disciplinary support network so services such as respite can be made available where possible. The model of support is one of collaborative care.

15. Referral to Secondary Care Services (AMH, OPS and LDS)

For people with severe depression, or with moderate depression and complex problems, consider referring to specialist mental health services for a programme of co-ordinated multi professional care.

With regard to treatment and interventions, please refer to:

**NHS Forth Valley Guidance for the Management of Depression**

16. Secondary Care Assessment, Treatment, Review and Discharge

Within secondary care services the Community Mental Health Services will be mainly responsible for the assessment, treatment and overall management of people with moderate and severe depression.

In some circumstances this will include involvement with acute mental health services for those at high risk of self harm.

- For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or interpersonal therapy [IPT]). (NICE). The choice of intervention should be influenced by the duration of the episode of depression and the trajectory of symptoms, any previous course of depression and response to treatment, likelihood of adherence to treatment and any potential adverse effects, person’s treatment preference and priorities.

- For people with a chronic physical health problem there should be a clear agreement between practitioners in primary and secondary care, on the responsibility for monitoring and treating that person. When treating people with complex and severe depression and a chronic physical health problem in specialist mental health services, work closely with physical health services and be aware of possible additional drug interactions.

- If a person’s chronic physical health problem restricts their ability to engage with a psychosocial or psychological intervention for depression, discuss alternatives with the person, such as antidepressants or delivering the interventions by telephone if mobility or other difficulties prevent face-to-face contact.
• For people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act, consider developing advance decisions and advance statements with the person. Include copies in the person’s care plan in primary and secondary care. Give copies to the person and to their family or carer, if the person agrees.

• For people with depression who are considered to be at significant risk of relapse including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment or who have residual symptoms, should be offered one of the following psychological interventions:
  – individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment.
  – mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.

Generic guidelines for secondary care will be followed in accordance with the Generic ICP. 25

16.1 Community Mental Health Team

The role and remit of the Community Mental Health Team consists of community care involving:

- crisis intervention and support where necessary.
- assessment, care planning, medical and non medical treatment interventions.
- use of validated assessment /outcome measurement tools.
- initiation of medication under the guidance of the Consultant Psychiatrist and monitoring for effectiveness as well adverse side effects.
- risk assessment and management.
- psychological therapies such as solution focused therapy, cognitive behavioural therapy, assertiveness training, alcohol counselling, anxiety management, depression education, carer support and relapse prevention.
- multidisciplinary review of care
- signposting and referral to other services and voluntary agencies

16.2 Acute Psychiatric Inpatient Care

Consider referral to the FVRH Acute Mental Health Unit (AMH and OPS) for people with depression who are at significant risk of suicide, self-harm or self-neglect. Referral will be triaged and appropriate service provided.

Refer to the LDS Generic ICP for more information regarding inpatient care. There are patients with borderline /mild LD who would not be appropriate for Lochview inpatient care and would be more appropriately supported within the FVRH Acute Mental Health Unit. This will be discussed on an individual basis with the FVRH Acute Mental Health Unit.

25 http://www.nhsforthvalley.com/CE/Index.asp
The role and remit of the Acute Inpatient Services includes the above list of interventions and:

- the full range of high-intensity psychological interventions should normally be offered in inpatient settings. However, consider increasing the intensity and duration of the interventions and ensure that they can be provided effectively and efficiently on discharge.

- consider the intensive home treatment team for people who might benefit from early discharge from acute inpatient care.

Secondary care assessment will include:

- repeat of the HADs / PHQ-9, where appropriate, on assessment and compared with the GP generated results. (AMH only.)

- use of appropriate validated tools for OPS, AMH, and LDS.

- symptom profile, suicide risk, treatment history and co morbidities.

- identification of psychosocial stressors, personality factors and any significant relationship difficulties particularly if the depression is chronic or recurrent, coping strategies used, strengths and vulnerabilities.

- psychosocial and occupational functioning.

- identification of the need for psychological treatment, social support and assistance to develop or aid occupational opportunities.

Secondary care treatment will include:

- developing a crisis plan that identifies potential crisis triggers and strategies to manage them and is shared with the person, their GP and other relevant people.

- referral to the Intensive Home Treatment Team, where appropriate, to help manage crisis for people with severe depression who present significant risk.

- monitoring risk in a way that allows people to continue their lives without undue disruption where possible.

- commencement of medication in secondary care mental health services under the supervision of a consultant psychiatrist. Where medication is commenced it should be in accordance with FV prescribing guidelines see section 10.

- considering reintroducing treatments that have been inadequately delivered or adhered to.

- developing a multidisciplinary care plan with the person, and their family or carer if the person agrees which identifies the roles of all professionals’ involved and self management.

- developing advance statements for people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act. Include copies in the person’s care plan in Primary and Secondary Care. Give copies to the person and to their family or carer if the person agrees.

- ensuring that relevant health, social care and third sector services work in partnership when treating a person with complex and severe depression and a chronic physical health and be aware of possible additional drug interactions from treating co-existing illnesses.
16.3 Long Standing Moderate or Severe Depression

If a person with long-standing moderate or severe depression would benefit from additional social or vocational support, consider:

- a rehabilitation programme if depression has resulted in long-term loss of work or disengagement from social activities.
- collaborative care for people with moderate to severe depression and a chronic physical health problem with associated functional impairment whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment or a combination of these. For example working with Parkinson Specialist Services, Stroke Rehab, and Clinical Oncology. (This list is not exhaustive.) Collaborative care should normally include partnership working between primary and secondary physical health services and specialist mental health services.

16.4 Care Planning Review and Discharge

Generic guidelines for secondary care will be followed in accordance with the Generic ICP. 26

- Depending on how service users enter the secondary care services, care planning, review and discharge will be carried out by a Consultant Psychiatrist and/or members of the multi disciplinary team.
- Referrals to other services e.g. third sector; will be considered and carried out as appropriate.
- Some clients with complex histories or social circumstances may be on the Care Programme Approach which involves partnership working with other agencies.
- For service users who disengage from treatment, follow the Did Not Attend / Failure to Engage Guideline.

16.5 Electroconvulsive Therapy (ECT)

- Consider ECT for severe, life-threatening depression and when a rapid response is required, or when other treatments have failed.
- Do not use ECT routinely for people with moderate depression but consider it if their depression has not responded to multiple drug treatments and psychological therapies.
- Ensure the person is fully informed of the risks and benefits associated with having ECT. Make the decision to use ECT jointly with the person if possible and this is documented in the clinical record.
- Document the assessment and consider:
  – the risks associated with a general anaesthetic
  – medical co morbidities
  – potential adverse events, notably cognitive impairment
  – the risks associated with not receiving ECT.

26 http://www.nhsforthvalley.com/qi
- Obtain valid informed consent without pressure or coercion at each ECT session.
- Remind the person of their right to withdraw consent at any point.
- Adhere to recognised guidelines about consent and involve advocates or carers.
- If informed consent is not possible, give ECT only if it does not conflict with a valid advance directive, and consult the person’s advocate or carer.
- For additional information see links below.
  - http://www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/ect.aspx
  - http://www.sean.org.uk/index.htm
- The risks associated with ECT may be greater in older people; exercise particular caution when considering ECT treatment in this group.

### 16.6 Occupational Therapy

- Referral to Occupational Therapy will be considered if it is evident that the service user is having difficulty coping with aspects of everyday living such as domestic or self care tasks, social interaction, access to community supports, leisure, vocational or work activities. This will include service users who have dual diagnosis or have a physical disability.

- O.T.’s assess and treat all of the above areas using an activity based approach which fits well with the behavioural activation component of Cognitive Behavioural Therapy. The overall aim is to strengthen the service users coping skills and assist them in developing activities which will support the improvement of their mental health.

In Forth Valley the O.T. service uses an evidence based model called the Model of Human Occupation but incorporate Psychological Therapy treatment techniques, such as cognitive behavioural techniques, into their practice. O.T. practice also fits well within the overarching Recovery model used within Forth Valley Adult Mental Health Services.

The Model of Human Occupation seeks to explain how occupation is motivated, patterned and performed and offers a broad and integrative view of human occupation. It considers human occupation under 3 headings; Volition (motivation), Habituation (process by which occupation is organised into patterns and routines), and Performance Capacity, (includes the physical and mental abilities which tasks demand). It also considers the physical and social environments in which activity takes place and the interaction between these elements.

Assessments used within the Model of Human Occupation include the Assessment of Motor and Processing Skills (A.M.P.S.), Model of Human Occupation Screening Tool (M.O.H.O.S.T), Occupational Circumstances Assessment Interview Rating Scale (O.C.A.I.R.S), Volitional Questionnaire, Occupational Self Assessment (O.S.A), Worker Role Inventory (W.R.I.), and Worker Environment Impact Scale (W.E.I.S.). Which assessment is used will depend upon the area of occupation being addressed.

Further information can be found via this link;

- Information collated from these assessments will be used to inform O.T. and M.D.T. treatment plans, and may indicate when referral to other services such as social
work or voluntary services will be necessary. Some of these assessments are incorporated into the FACE system so are accessible to O.T staff via this system.

16.7 Physiotherapy interventions for those with Moderate/Severe Depression.

Physical inactivity is now understood to be a modifiable risk factor for depression and other chronic diseases, in addition to links with cardiovascular disease, hypertension, diabetes and obesity. Evidence supports the hypothesis that the risk of depression is inversely associated with physical activity.

There has been a growing recognition that being physically active is associated with improved mental health including improving aspects of mental wellbeing and preventing the development of mental health problems. In addition, the potential for physical activity to alleviate the symptoms of various mental illnesses is noted.27

There is also evidence that physical activity can be effective in alleviating some symptoms in those with clinically defined mental health problems: for example, as an effective treatment for mild, moderate and potentially severe clinical depression.28

There are now clear guidelines relating to the delivery of physical activity interventions in the evidence briefing 29 which have been incorporated into SIGN 114 Non-pharmaceutical management of depression in Adults|30.

Based on the evidence, the Physiotherapy Department in Forth Valley has developed a pathway that allows service users, at any point in their care, who are currently inactive, to be identified using the General Practice Physical Activity Questionnaire (GPPAQ). Information on Physiotherapy services can be obtained from the Service Information Directory. SID

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30 SIGN 114 non-pharmaceutical management of depression in adults, Jan 2010
## 17.1 Assessment tools

### Assessment Tools for Depression

<table>
<thead>
<tr>
<th>Name of Assessment: Montgomery Asberg Depression Rating Scale</th>
<th>Abbreviation: MADRS</th>
</tr>
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<tbody>
<tr>
<td><strong>Staff member who can undertake assessment:</strong> Any staff group trained to complete MADRS.</td>
<td></td>
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<tr>
<td><strong>Type of Assessment:</strong> Clinician rated for rating severity of mood in depression</td>
<td></td>
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<tr>
<td><strong>What the results mean:</strong> Measures change if repeated.</td>
<td></td>
</tr>
<tr>
<td><strong>Reference:</strong> The MADRS may be photocopied by individual researchers or clinicians for their own use without seeking permission from the publishers. The scale must be copied in full and all copies must acknowledge the following source: Montgomery, S.A. &amp; Asberg, M. (1979) A new depression scale designed to be sensitive to change. British Journal of Psychiatry, 134, 382-389</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Name of Assessment: Cornell Scale for depression in Dementia</th>
<th>Abbreviation: CSDD</th>
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<tbody>
<tr>
<td><strong>Staff member who can undertake assessment:</strong> Any staff group trained to complete the assessment.</td>
<td></td>
</tr>
<tr>
<td><strong>Type of Assessment:</strong> Specifically to assess signs and symptoms of major depression in dementia on the basis of a semi-structured interview of a qualified informant. The CSDD evaluates a broad spectrum of depressive signs and symptoms and includes items from other depression scales. Information is obtained from interview of a caregiver as well as from direct observation and interview of the patient.</td>
<td></td>
</tr>
<tr>
<td><strong>What the results mean:</strong> Indication &amp; severity of depression.</td>
<td><a href="http://www.qualitynet.org">http://www.qualitynet.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Assessment: Geriatric Depression Scale</th>
<th>Abbreviation: GDS</th>
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<tbody>
<tr>
<td><strong>Staff member who can undertake assessment:</strong> Qualified staff with an understanding of clinical depression.</td>
<td></td>
</tr>
<tr>
<td><strong>Type of Assessment:</strong> Initial assessment of low mood in older adults.</td>
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</tr>
<tr>
<td><strong>What the results mean:</strong> There are several versions of this assessment tool. The versions are governed by the number of questions to be answered. The most popular are the GDS 15, 10 and 4. The GDS 15 has the highest sensitivity rate (92.7%) whilst the GDS 10 and 4 both have higher specificity rates of 78.3%. None of these tools is a substitute for a diagnostic interview by, mental health professionals but the GDS provides a useful tool for baseline measurements of mood and can facilitate the assessment of depression.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Assessment: Glasgow Depression Scale for People with Learning Disabilities</th>
<th>Abbreviation: GDS - LD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff member who can undertake assessment:</strong> Health professionals with an understanding of depression.</td>
<td></td>
</tr>
<tr>
<td><strong>Type of Assessment:</strong> This is an assisted self completion scale used by individuals with mild to moderate learning disabilities.</td>
<td></td>
</tr>
<tr>
<td><strong>What the results mean:</strong> It provides a useful tool for baseline measurements of mood and facilitates further assessment of depression. Therefore it is not a diagnostic tool.</td>
<td></td>
</tr>
</tbody>
</table>
### Name of Assessment: Carer Supplement to the Glasgow Depression Scale for People With a Learning Disability. Abbreviation: GDS-LD/CS

<table>
<thead>
<tr>
<th>Who can undertake assessment:</th>
<th>Carers of those with Learning Disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Assessment:</td>
<td>Carers can report on their direct concerns and observations in a systematic way.</td>
</tr>
<tr>
<td>What the results mean:</td>
<td>It provides a useful tool for baseline measurements of mood and facilitates further assessment of depression. Therefore it is not a diagnostic tool.</td>
</tr>
</tbody>
</table>

### Name of Assessment: The Psychiatric Assessment Schedules for Adults with Developmental Disabilities. Abbreviation: Mini PASSAD

<table>
<thead>
<tr>
<th>Staff member who can undertake assessment:</th>
<th>Qualified staff member who has received appropriate training to use this tool.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Assessment:</td>
<td>A clinical tool which provides a structured framework for assessment and case recognition.</td>
</tr>
<tr>
<td>What the results mean:</td>
<td>Threshold scores are provided for each of the seven diagnostic areas. The instrument comprises 86 psychiatric symptoms and generates a series of sub scores on depression, anxiety and phobia, mania, obsessive compulsive disorder, psychosis, unspecified disorder (including dementia) and pervasive development disorder (autism). If the person reaches or exceeds a threshold the implication is that they probably warrant a diagnosis. However a strong emphasis is placed on clinical interpretation of the results.</td>
</tr>
</tbody>
</table>

### Name of Assessment: Patient Health Questionnaire 9 Abbreviation: PHQ9

<table>
<thead>
<tr>
<th>Staff member who can undertake assessment:</th>
<th>Primary care clinicians.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Assessment:</td>
<td>The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. The PHQ-9 is for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.</td>
</tr>
<tr>
<td>What the results mean:</td>
<td>The primary care clinician should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician. There are two components of the PHQ-9:</td>
</tr>
<tr>
<td></td>
<td>Assessing symptoms and functional impairment to make a tentative depression diagnosis, and</td>
</tr>
<tr>
<td></td>
<td>Deriving a severity score to help select and monitor treatment.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/">http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/</a></td>
</tr>
<tr>
<td>Name of Assessment: Hospital Anxiety and Depression Scale</td>
<td>Abbreviation: HADS</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Staff member who can undertake assessment:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Assessment:</strong> To detect states of anxiety and depression</td>
<td></td>
</tr>
<tr>
<td><strong>What the results mean:</strong></td>
<td></td>
</tr>
</tbody>
</table>

Developed by: Snait h RP and Zig mond AS (UK)

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Reference publication:

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Swindon
SN2 8BR

Email: permissions@gl-assessment.co.uk Website: www.gl-assessment.co.uk
17.2 Resources List for Depression ICP

General Resources
A wide range of mental health information and resources are on the Moodjuice website. This includes information on crisis management. This site is accessible to service users. Please click on link below to access this  [http://www.moodjuice.scot.nhs.uk/index.html](http://www.moodjuice.scot.nhs.uk/index.html)

Specific Resources
Additionally the following list of specific resources can be helpful in the assessment, care and treatment of depression.

- Assessment tools as listed in appendix 1.

Specific Websites

- **Royal College of Psychiatry website** –  
  [http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression.aspx](http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression.aspx)

- **Cochrane Database**  
  [http://www.cochrane.org/](http://www.cochrane.org/)

- **Scottish Recovery Network**  
  The SRN’s role is to act as a catalyst for change by sharing ideas and practice to promote recovery from long-term mental health problems, improving outcomes at all levels.  
  [http://www.scottishrecovery.net/](http://www.scottishrecovery.net/)

- **Depression Alliance**  
  Website provides information and support services.  

- **Samaritans**  
  Callers can contact by telephone, letter, and e-mail. The commitment to making these means of access available 24 hours a day will be maintained by all branches (except Festival and Correspondence branches)  

- **Breathing Space**  
  Breathing Space is a free, confidential phone and web based service for people in Scotland experiencing low mood, depression or anxiety.  
  [http://www.breathingspacescotland.co.uk/bspace/CCC_FirstPage.jsp](http://www.breathingspacescotland.co.uk/bspace/CCC_FirstPage.jsp)

- **Living Life**  
  Provided by NHS 24. Guided Self Help service is available to anyone over the age of 16 and can be accessed either by GP referral or by phoning the number directly on 0800 328 9655. The service is available Monday to Friday 1pm - 9pm. Callers are asked to provide some details and then arrangements are made to receive an assessment appointment to discuss the service and how help can be provided.  
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For other formats contact 01324 590886, text 07990 690605, fax 01324 590867 or e-mail nhsfv-alternativeformats@nhs.net