Depression

Integrated Care Pathway

For use by all professionals working in Mental Health Services and Partner Agencies, for all people with a diagnosis of Depression in Lanarkshire.
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1. Introduction

Depression is a common mental health condition. It is estimated that 1 in 5 of the adult population in Lanarkshire will experience depression at some stage in their life. For some this will be a single episode of depression, but for others the condition may be recurrent or persistent.

In addition to the impact that depression has on the individual, it is important to remember that depression can severely affect the quality of life of depressed patient’s families, with serious personal, financial, occupational and health implications. WHO estimates that by 2020 depression will be the world’s second most disabling condition after cardiovascular disease.

The majority of cases of depression will be diagnosed and managed in primary care (estimates vary between 90 – 95%), with secondary and tertiary mental health care reserved for treatment resistant, complex cases or where there is a greater risk of psychosis.

Depression can be categorised according to four parameters:

- **Severity** - mild, moderate or severe
- **Symptomatology** - e.g. non-psychotic or psychotic
- **Risk** - to self or others
- **Chronicity** - i.e. single episode, recurrent or persistent.

Depression may arise as a result of the interplay of a number of elements for an individual: biological, social and psychological. A range of treatments are known to be effective including medical, psychological and social interventions. Commonly a combination of different treatment approaches will be used. Treatment choice must take into account patient preference. Clients may present with levels of anxiety or panic which may require concomitant treatment.

1.1 Rationale for Developing the ICP

The ICP was developed from the NHS QIS standards for mental health integrated care pathways, which specify both generic and depression-specific care standards. The generic standards are contained in the NHS Lanarkshire Generic ICP and the condition specific standards in this Depression ICP. These condition specific standards specify care and interventions we would generally expect to be considered for people with depression and focus on both the severity of the service user’s symptoms and the complexity of their needs (see Box 1).

The ICP has been put together by a local development group consisting of NHS staff, service users and carers, local authorities, voluntary organisations and the independent sector (see Appendix 1, Depression ICP development group members). In Lanarkshire various terms are used to describe the people who use mental health services which include, “clients”, “patients” and “service users” and to simplify this we have used the single term “patients” in both the Generic ICP and this condition-specific ICP.
Box 1

**Service users with no complex needs:**
Standards 33 - 36 outline a discrete journey of care for service users with a diagnosis of depression whose complexity of need does not require specialist assessment and treatment (i.e. for this group of patients, the generic care standards do not apply).

**Service users with complex needs:**
Standard 37 addresses the needs of service users with a diagnosis of depression whose complexity of need require a comprehensive assessment. In such instances, the journey of care should follow both the generic care standards and standard 37.

In addition to the ICP standards, depression is one of the focuses of the work of the Mental Health Collaborative (to achieve the Depression Heat Target) and has five key improvement objectives:

- Improve support to Primary Care to enable the delivery of a holistic assessment for people presenting with symptoms of depression,
- Improve evidence based prescribing and compliance with formulary,
- Improve access to non pharmacological interventions including evidence-based psychological therapies, self-help/self management and social supports,
- Improve the understanding of staff, patients and carers of the different options for intervention,
- Routinely monitor outcomes and modify services accordingly.

The Collaborative aims to achieve improvements in the treatment of people with depression in primary care and in the use of data to inform progress. This work will be implemented and monitored through the Depression ICP.

1.2 How to use the Lanarkshire Depression ICP

The Generic ICP will automatically be used for people accessing mental health services in Lanarkshire (with the exception of those people with depression who do not require specialist assessment and treatment in which case only the condition-specific ICP for depression will be used). For all others the Generic ICP will apply and if appropriate, this condition specific ICP will also be used as required. These ICPs are based on a stepped model of care as described in the Lanarkshire Mental Health Strategy. They encompass a culture and values which aim to enable person-centred recovery and strengths-based focus with a move towards positive management of individual risk, maximising choice and access to evidence-based interventions (see Appendix 2, Guidance and Policy Base).

The ICP is designed to be used for any patient over the age of 16 who presents with a primary diagnosis of depression (additionally, people with learning disabilities can access services via the Lanarkshire Learning Disabilities Service). For young people aged 16 or under services can be accessed through the Lanarkshire Child and Adolescent Mental Health Service. When depression is accompanied by symptoms of anxiety, usually treat the depression first. But if the person has an anxiety disorder and comorbid depression or depressive symptoms, consider treating the anxiety disorder first (NICE 2009).
The Depression ICP should not be used for patients where the primary diagnosis is not one of straightforward (unipolar) depression, e.g. postnatal depression, dementia, bipolar disorder, severe personality disorder, schizophrenia, or where the major diagnosis is one of addiction, or indeed where there are other physical causes to explain the depression.

The ICP is intended to provide a standard model of good care based on the current evidence base and expert opinion. It is important to note that the ICP is a guide to good care but it should never replace sound professional judgement. The professionals’ assessment and judgement will always override the advice of the tool where this is necessary. The ICP is part of the patient record and as with all such records, it will be private and confidential with access governed by the usual rules of confidentiality.

By using this ICP we will be able to produce data about the care and interventions provided to people in Lanarkshire with depression. This information (variance data), will allow us to compare the actual care and interventions given with those planned in the ICP and enable us to identify areas where the ICP should be modified to improve the quality of care provided. The variance information will also identify resource issues, gaps in service availability and future staff training and supervision requirements.
1.3 Patient Journey for People with Depression

To communicate the findings of this ICP we have created a series of flow charts which show the major levels of therapeutic activity (boxes) connected by a series of relationships (arrows), but we are aware that not every potential activity or relationship can be covered in a diagram. In the interests of simplicity we have only included the current major pathways.

The accompanying narrative gives further detail of each tier of the patient journey.

Fuller guidance on the management of depression can be found in the current NICE guideline: [http://www.nice.org.uk/nicemedia/pdf/CG90NICEguideline.pdf](http://www.nice.org.uk/nicemedia/pdf/CG90NICEguideline.pdf)
2. Mental Health and Wellbeing (Tier 0)

2.1 Accessing Tier 0 Services
In Lanarkshire the care and interventions available at Tier 0 to promote or improve a person’s mental health and well being are referred to as ‘Gateway Services’ (illustrated in Table 1) and are provided by health, local authorities, voluntary organisations and independent providers. A comprehensive list of these services has been put together in the North and South Lanarkshire Directories of Services which are available via the NHS Lanarkshire intranet (in the Mental Health Section) or on the Elament website, http://www.lanarkshirementalhealth.org.uk/.

**TABLE 1 Examples of Gateway Services**

| ♦ Befriending                                  | ♦ Leisure and Sports Facilities                      |
| ♦ Black/Ethnic Minority Services               | ♦ Parkinsons                                         |
| ♦ Carers Organisations                         | ♦ Rape Crisis/Victim Support                         |
| ♦ Childcare Facilities/Wellbaby Services       | ♦ Student Services                                   |
| ♦ Counselling Services                         | ♦ Social Work Reception Services                     |
| ♦ Family Planning and Well Woman Clinic        | ♦ Volunteer Services                                 |
| ♦ First Stop Shops                             | ♦ Websites                                           |
| ♦ Housing, Homelessness and Tenancy Support    | ♦ YMCA                                               |

These are services which can generally be accessed by individuals without going through a GP first. When a person does attend their GP or primary care mental health services and initial assessment indicates mild depression which is suitable for self help treatment, treatment options/services such as those described above, or direction to initiatives such as the ‘Healthy Reading Scheme’, we can record the use of these services as part of the ICP. Services such as these may also be used in conjunction with treatment given at different Tiers of the service. Referral to Tier 1 services from these gateway services is usually made by going through the GP either by the person directly or by gateway service personnel with the person’s consent.
3. Primary Care Management of Depression (Tier 1)

The principles for the recognition, assessment and management of depression in primary care for Lanarkshire are based on guidance from SIGN and NICE.

3.1 Recognition
Consider depression in all patients who have:
♦ A previous history of depression
♦ Physical illness
♦ Recent bereavement
♦ Other mental health problems

Guidelines for the treatment of mild depression in Primary Care (NICE)
http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20041224061442159860

Guidelines for the treatment of moderate or severe depression in Primary Care (NICE)
http://gpnotebook.co.uk/simplepage.cfm?ID=x20041224062511159860

3.2 Clinical Diagnosis
i. The diagnosis of depression should be based on ICD 10 or DSM IV diagnostic criteria and the use of the depression assessment tool (PHQ9 or other appropriate validated tool).

Clinical Diagnosis based on guidelines from ICD-10 and NICE Guidelines:
http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20041224060809159860

ii. Depression Assessment Tool

Guide to Scoring PHQ9:
http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

ICP Standard 33a: The care record shows that a validated measure of depression is used at initial assessment and repeated at regular intervals to monitor progress and outcome.
3.3 Assessment

♦ Level of severity:
  - Mild
  - Moderate
  - Severe

♦ Risk (see NICE 2009 quick reference guide page 11)

♦ Exclude potential physical causes

♦ Psycho-social factors, previous or family history of depression

NB – Remember that this ICP applies only to those with a primary diagnosis of depression. There are separate ICPs for bipolar disorder, postnatal depression, dementia, schizophrenia and borderline personality disorder.

A Depression ICP Algorithm using PHQ9 has been developed for use with assessment tools as a guide to the level of severity and possible actions to consider (see Appendix 3).

3.4 Primary Care Treatment: Mild Depression

Based on NICE 2009 (Quick reference guide page 7) and SIGN 2010 (page 4):

♦ Watchful waiting

♦ Consider:
  - signposting
  - sleep and anxiety management
  - structured exercise
  - guided self-help/computerised Cognitive Behavioural Therapy
  - specific psychological interventions

♦ Anti-depressants – not recommended for the initial treatment of mild depression unless (1) other measures have failed or (2) previous history of moderate or severe depression.

♦ Review and repeat PHQ9 or other appropriate validated tool.

ICP Standard 34a: The care record shows that service users receive an assessment of need which leads to interventions appropriate to identified need, with an emphasis on evidence-based self-help, lifestyle advice, physical activity and signposting. This should occur within 4 weeks of initial presentation.

ICP Standard 34b: The uptake of these interventions, in up to 3–4 sessions, are recorded: lifestyle advice (including physical activity, debt and relationships); evidence-based self-help material/guided self-help, and targeted information/signposting about local or national statutory or voluntary organizations.

ICP Standard 35a: The care record shows that: an algorithm for depression-focused brief psychological therapies is followed, and service users are offered an appointment date that is within 6 weeks of referral.

ICP Standard 36a: The care record shows that a local algorithm is followed, detailing the threshold for antidepressant prescribing, psychological therapies, and other evidence-based interventions.
3.5 Primary Care Treatment: Moderate/Severe Depression

Based on NICE 2009 Quick Reference Guide (pages 5-7), SIGN 2010 (pages 5-13):

♦ Risk Assessment. All patients to be assessed for suicide risk by appropriately trained staff following the Lanarkshire Suicide Assessment and Treatment Pathway.

♦ Anti-depressant medication and/or psychological intervention (choice depends on (1) previous history of response (2) consideration of patient preference).

♦ Offer medication to all patients routinely before psychological interventions.
  - For routine care start with an SSRI
  - Continue for 6 months after remission and then review.
  - If patient fails to respond (after 4 weeks) or there is only partial response (after 6 weeks) then:
    o check compliance
    o consider alternatives:
      - increasing SSRI dose in line with NICE and re-assessing after 2 weeks
      - reassess diagnosis and potential aetiological factors
      - consider switching to another anti-depressant
      - consider psychological treatment

♦ Standard measures (as for mild) e.g. sleep, exercise, diet, assess for sick leave.

♦ Review and repeat PHQ9 or other appropriate validated tool – initially after 1 week and then at regular intervals depending on response.

Guidance regarding NHS Lanarkshire Formulary for prescribing anti-depressant medication in Primary Care

3.6 Primary Care Treatment: Severe Depression

♦ As for moderate.

♦ Consider referral to secondary care at earlier stage.

♦ More frequent reviews and regular assessment of risk.

3.7 Referral to Secondary Care

Consider under the following circumstances:

♦ Concern about risk and/or psychiatric symptoms which cannot be managed in primary care.

♦ Not responding to primary care management.

♦ Preference for psychological treatment.

♦ Complexity.

ICP Standard 36b: There are systems agreed by stakeholders to ensure that service users with complex needs are referred for multidisciplinary assessment and management.
4. Secondary Care Management of Depression (Tier 2)

4.1 Primary Care Referral
- **EMERGENCY:** patient seen same day
- **URGENT:** patient seen within 1 week (5 working days)
- **ROUTINE:** as per secondary care community mental health service

4.2 Allocation Meeting
- Referral form to be completed by referrer only.
- A multidisciplinary meeting.
- Held weekly (with locally agreed mechanism for assessing more urgent referrals on a daily basis).
- Discussion with GP or other referrer if more information required.

4.3 Assessment
- Follow standard CMHT assessment process.
- In particular:
  - repeat risk assessment
  - standardised measure of depression (e.g. PHQ9 or alternative)
  - review previous treatment including medication compliance
  - consider psychosocial input in collaboration with the patient.

4.4 Community Mental Health Team (CMHT) Interventions
The delivery of Psychological Therapies in Lanarkshire is based on the principle of matched care, whereby people referred into the service are matched to the appropriate level of treatment for the level of complexity of their difficulties (NHS Lanarkshire Psychological Therapies Strategy, August 2009). In addition, the recently published Matrix document from the Scottish Government provides health boards with a comprehensive review of the evidence base for psychological therapies and guidance as to how these should be delivered (see Appendix 4 for Matrix depression evidence base). Several psychological therapies/interventions are evidence based for depression and are detailed below. The availability of these interventions in Lanarkshire (together with training and supervision requirements), will be determined through the ongoing implementation of the Psychological Therapies Strategy.
- Behavioural Activation Therapy
- SPIRIT (individual CBT-based intervention)
- Interpersonal Therapy (IPT)
- Mindfulness Groups
- Problem Solving Therapy
- Short term Psychodynamic Therapies
- Psycho-education for depression (individually or in a group setting)
- Monitoring, medication review, informed support, keeping well and relapse prevention
- Referral to other care providers and agencies as appropriate.
4.5 **Inpatient Assessment and Interventions**
Consider inpatient treatment for people who are at significant risk of suicide, self-harm or self-neglect (NICE 2009).

- Follow Generic Inpatient Admission and Discharge ICP.
- The full range of high-intensity psychological interventions should normally be offered in inpatient settings.
- For people who have depression and psychotic symptoms, consider augmenting their treatment plan with antipsychotic medication.

4.6 **Electroconvulsive Therapy (ECT)**
Consider ECT for severe, life-threatening depression and when rapid response is required, or when other treatments have failed (NICE 2009).

- Treat as per NHS Lanarkshire ECT Manual.
5. Tertiary Care Management of Depression (Tier 3)

5.1 Referral
Referrals will generally come from Tier 2 clinicians such as:
- Senior members of CMHTs (such as team co-ordinators, senior charge nurses - referrals can either come from them or team members after MDT discussion)
- Consultant Psychiatrists
- Other high intensity psychological therapists.

NB. Where the primary care referral has made a specific request for a particular form of psychological treatment, and this seems appropriate to the allocation team, the referral would go directly to the appropriate psychological therapist after the CMHT have recorded the referral.

Each locality should build on the existing links between Tier 2 and Tier 3 psychological therapy services to ensure that there is a system to improve communication. For example:
- Written referral guidelines produced by each psychological therapy provider.
- Encouraging telephone discussion between Tier 2 and Tier 3 services with regard to potential referrals (a specific time in the working week might be set aside for this purpose).
- A particular member of the Tier 3 services would take responsibility for liaising with a specific CMHT.

Referrals should be of sufficient complexity/severity to justify referral to Tier 3. A brief description of the type of therapy being proposed should be given by the Tier 2 worker to the service user before a referral is initiated. Where the referral is for a couple both parties should consent before referral is considered.

ICP Standard 37a: The care record shows that those who appear to be resistant to treatment when the local algorithm has been followed to its conclusion are referred for specialist assessment and treatment.

ICP Standard 37b: Where such specialist assessment and treatment cannot be provided locally, there are regional arrangements allowing service users to access appropriate services, e.g. tertiary referral.

5.2 Interim Care
- Maximum waiting time should be 6 months.
- Tier 2 service should make a decision (possibly following discussion with Tier 3) about ongoing need for support/monitoring whilst the patient awaits an appointment with the Tier 3 service.
5.3 Assessment and Interventions

High intensity psychological therapies will be provided by:
- Psychology Services
- Psychotherapy Services
- Specialist Practitioners (e.g. CBT Nurse Therapists)

Interventions available in each locality should include - **Cognitive Behavioural Therapies (CBT)**, **Interpersonal Therapy (IPT)**, **Psychodynamic Therapies** and **Psychological Therapies with a focus on couples work** (see SIGN 2010 and NICE 2009). The availability of these interventions in Lanarkshire (together with these training and supervision requirements), will be determined though the ongoing implementation of the Psychological Therapies Strategy.

Treatment may involve individual, group or family work. The length of treatment should in the first instance be up to 20 sessions over 6 - 9 months. The duration of treatment should be longer if progress is being made or if it is felt that further sessions would be beneficial, if for example there is co-morbid personality disorder or other significant psychosocial factors (NICE 2009).

There should be a regular review between therapist and service user to assess progress and decide on further management.

Adequate and appropriate clinical supervision (as per local guidelines) should be provided for all high intensity psychological therapy practitioners.

5.4 Discharge

At the end of the treatment period there should be a review with the patient and a joint decision made about the need for further psychological care. A discharge letter should be produced within 2 weeks by the therapist and sent to the initial referrer plus other relevant agencies. This should be discussed with the service user.

5.5 Inpatient Assessment and Interventions

Inpatient services include:
- Forensic Service
- Addiction Service
- Eating Disorder Service
- Residential Psychotherapy Service
- Antenatal and Postnatal Mental Health and Wellbeing Service.
6. ICP Monitoring

Monitoring of the service provided to each person will take place using:

♦ **Variance Analysis** – questions to be agreed in conjunction with ICP development groups and national QIS ICP programme team.

♦ **Staff, Patient and Carer Surveys** – to be developed in conjunction with ICP development groups, national QIS public involvement group, etc.
## Appendices

### Appendix 1: Depression ICP Development Group Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>NHS Authority</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>Billy Lang</td>
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<td>Ina Smillie</td>
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</tbody>
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**ICP Team:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>Patrícia Kent</td>
<td>ICP Manager</td>
</tr>
<tr>
<td>Janis Dickson</td>
<td>Mental Health ICP Project Assistant</td>
</tr>
</tbody>
</table>
Appendix 2: Guidance and Policy Base to Support Values

Guidance and Policy Base to Support Values (2010)

The Mental Health (Care and Treatment) (Scotland) Act 2003 is underpinned by the Milan principles of reciprocity, respect for equality and diversity in a non-discriminatory manner.

The 10 Essential Shared Capabilities for Mental Health promotes working in partnership, challenging inequalities (social inequality and exclusion), promoting recovery, providing service user centred care and making a difference.

The Scottish Recovery Indicator states the service should provide interventions designed specifically to promote participation in life’s roles, to self manage illness, and to enhance relationships with others.

NHS Lanarkshire’s Organisational Values which commit to quality, patient focused services; quality healthcare environment; continuous improvement; involvement; communication; respect, fairness and consistency; competence and continuous learning.


1. Person centred: providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions
2. Safe: avoiding injuries to patients from care that is intended to help them
3. Effective: providing services based on scientific knowledge
4. Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy
5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
6. Timely: reducing waits and sometimes harmful delays for both those who receive care and those who give care.

Caring and Compassionate Practice is the work of a group from the Nursing, Midwifery and Allied Health Profession (NMAHP) Practice Development Centre in NHS Lanarkshire. It sets out a list of people’s expectations accompanied by statements that set the minimum practice standards for how nurses, midwives, allied health professionals and support workers must work on a day to day basis:

- To be valued as a person
- To feel and be safe
- To be cared for with dignity
- To see NMAHPs make the best possible effort
- To experience courtesy
- To be respected
- To receive kindness.
Appendix 3: Depression ICP Algorithm using PHQ9

Depression ICP Algorithm using PHQ9 (or other appropriate validated tool)
(Complete assessment using tool and repeat at regular intervals)

**No Depression**

**Conclusion based on:**
1) Clinical assessment
2) Self report questionnaire *(PHQ9: 0-4)*

If required:
- Information/ advice
- Self-help
- Signposting

**Mild Depression**

**Diagnosis based on:**
1) Clinical assessment
2) Self report questionnaire *(PHQ9: 5-9)*

- Assessment/ monitoring
- Signposting
- Self help/exercise
- Healthy reading
- Brief psychological intervention
- Medication *(only if previous history or other measures have failed)*

**Moderate/Severe**

**Diagnosis based on:**
1) Clinical assessment
2) Self report questionnaire *(PHQ9: 10-14 [mod], 15-27 [sev]*

- Medication
- Short term psychological intervention
- Signposting
- Other measures as for mild depression

**Referral to Tier 2/3**

Consider if:
- Concern re risk
- Preference for psychological treatment
- Complex

**Not responding to primary care treatment**

- Refer to Tier 2/3 Services

**Review**

- Significant improvement
- Relapse Prevention

**EXIT**
### Appendix 4: Depression MATRIX Evidence Base

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild/moderate</td>
<td>Primary Care/Voluntary settings</td>
<td>Low</td>
<td>Self help guided by therapist input.*</td>
<td>A&lt;sup&gt;1,2&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td>High</td>
<td>Self help in the form of computerised CBT (CCBT)</td>
<td>A&lt;sup&gt;3,4&lt;/sup&gt;</td>
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<td></td>
<td></td>
<td></td>
<td>Structured exercise.</td>
<td>A&lt;sup&gt;6&lt;/sup&gt;</td>
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<td>Behavioural activation.</td>
<td>A&lt;sup&gt;5&lt;/sup&gt;</td>
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<td>CBT.</td>
<td>A&lt;sup&gt;7&lt;/sup&gt;</td>
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<td>IPT.</td>
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| Relapsing         | Primary Care/Secondary Care | High                   | Mindfulness based cognitive therapy to reduce relapse in patients with depression who have had three or more episodes. | A<sup>11</sup> |

| Severe            | Secondary Care            | High                   | CBT                                                                                 | B<sup>12</sup> |

*Guided self help (modelled around the principles of CBT) - greatest effectiveness is associated with input from a therapist to guide progress.*
References


http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/reports/scotlandfullreport.pdf
<table>
<thead>
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<th><strong>Glossary/Abbreviations</strong></th>
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<tr>
<td><strong>Cognitive Behavioural Therapies (CBT)</strong></td>
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<td><strong>Couple Focused Therapy</strong></td>
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**NHS Quality Improvement Scotland (QIS)**

NHS Quality Improvement Scotland was established as a Special Health Board by the Scottish Executive in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHS Scotland. By 'improve', they mean the improving of the experiences of patient/clients and the outcomes of their treatment while in the care of NHS Scotland. They work to achieve these goals through an analysis of scientific evidence, by listening to the needs and preferences of patient/clients and carers, as well as the experiences of healthcare professionals. Web address: [www.nhshealthquality.org](http://www.nhshealthquality.org)
| **National Institute for Clinical Excellence (NICE)** | NICE is part of the NHS. It is the independent organisation responsible for providing national guidance on treatments and care for those using the NHS in England and Wales. Its guidance is for healthcare professionals and patient/clients and their carers, to help them make decisions about treatment and healthcare. NICE guidance and recommendations are prepared by independent groups that include healthcare professionals working in the NHS and people who are familiar with the issues affecting patient/clients and carers. Website address: [www.nice.org.uk](http://www.nice.org.uk). |
| **Psychodynamic Therapies** | This term describes a range of therapies that utilise the central idea that there are different forces (or dynamics) that are present in a person’s relationships and everyday life, some of which may be causing difficulties. Such therapies offer a space to explore those thoughts and feelings of which he or she is aware (conscious) or not aware (unconscious) that are causing distress. The aim is to examine, understand and work through the forces and difficulties, which may have begun in childhood. |
| **Scottish Intercollegiate Guidelines Network (SIGN)** | SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland. Its objective is to improve the quality of healthcare for patients in Scotland by reducing variation in practice and outcome, through the dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. For further information contact: [www.sign.ac.uk](http://www.sign.ac.uk). |
| **Structured Psycho-social Interventions in Teams (SPIRIT)** | The training provides skills-based training in using generic and effective clinical skills in everyday practice. The content of the course uses the five areas assessment Cognitive Behaviour Therapy (CBT) model and offers training that is of great use in every day clinical practice. It includes training in the use of structured self-help materials that can support staff working with patients. |
| **Selective serotonin reuptake inhibitors (SSRI)** | A type of antidepressant medicine that included sertraline, paroxetine, fluoxetine, citalopram, escitalopram and fluvoxamine. They have fewer of the side effects associated with tricyclics and MAOIs, and are less likely to cause drowsiness and dizziness. They can however cause nausea and headaches. |
| **Skills Training on Risk Management (STORM)** | This is a training course to provide frontline workers with the skills required to assess and manage a suicide crisis. Skills are developed through role-rehearsal, self-reflection and feedback. |
| **Variance** | A deviation from an activity set out in an ICP. |
| **World Health Organisation (WHO)** | WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. |